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CABINET 1 MARCH 2006 **PORTFOLIO : HEALTH AND SOCIAL INCLUSION**

CONSULTATIONS ON PRIMARY CARE TRUST, STRATEGIC HEALTH AUTHORITY AND AMBULANCE SERVICE REORGANISATIONS

1. INTRODUCTION

1.1 As part of the development of a patient-led NHS the Government have decided that the current structure of Primary Care Trusts (PCT'S) and Strategic Health Authorities must be changed in order that they are strengthened to meet the challenges that changes in other parts of the NHS will bring.

1.2 To this end the Hampshire and Isle of Wight Strategic Health Authority (STHA) have issued two consultation papers on reconfiguration for consultation with partners and the wider community.

1.3 In addition to these two papers the STHA has also issued a consultation paper on the reconfiguration of the Hampshire Ambulance Service. All three papers have a consultation deadline of the 22 March 2006.

1.4 All the papers represent the local action being taken as a result of national initiatives and are mirrored around the country.

2. BACKGROUND

2.1 The NHS is undergoing some major changes in the way that it operates :-
- 2.1.1 Patient choice in hospital, primary and social care
- 2.1.2 Integrated care and support for people with long-term illnesses
- 2.1.3 More services in community settings
- 2.1.4 Better emergency and out of hours services
- 2.1.5 More support for people to protect and improve their own health

2.2 These changes are demonstrated by service changes such as :-
- 2.2.1 "Practice Based Commissioning" in GP surgeries where groups of surgeries will be responsible for commissioning care for their patients with the help of the local PCT.
- 2.2.2 Patient choice as to where they may receive hospital care.
- 2.2.3 Foundation Hospitals which will receive payment on a per patient basis based on national tariffs.
- 2.2.4 Closer working with local authorities to develop better services to improve the wider health and care needs of local communities. This will include public health.

2.3 Locally these proposed reorganisations come barely a year after the last PCT reorganisation when the New Forest PCT was amalgamated with the Eastleigh and Test Valley South PCT to form the South West Alliance. This reorganisation itself came barely three years after the formation of the New Forest PCT, which itself was formed from the two local Primary Care Groups established in 1999.

2.4 The Strategic Health Authority was formed on a Hampshire and IOW basis in 2002 from the previous Southampton and South West Hampshire Health Authority and two other Health Authorities that represented other parts of Hampshire.

2.5 The ambulance service currently covers Hampshire county only.

3. PROPOSALS

Primary Care Trust

3.1 There are two proposals for PCT reconfiguration outside of Southampton, Portsmouth and the Isle of Wight:-

3.1.1 A single PCT that will include seven existing PCT's or

3.1.2 Three PCT's replacing the existing seven PCT's

3.2 The single PCT will be coterminous with Hampshire County Council.

3.3 The three PCT proposal will include the current South West PCT Alliance covering the New Forest, Eastleigh and Southern Test Valley, but would add the northern part of Test Valley Borough Council so that it would be coterminous with all three district councils. The current Alliance structure would disappear to be replaced by a new PCT, with the disappearance of the New Forest PCT as a separate entity, which currently still exists within the Alliance structure. **APPENDIX A**

Strategic Health Authority

3.4 There are two proposals for the STHA:-

3.4.1 One Authority for the South East coterminous with the Government Office for the South East (GOSE).

3.4.2 Two Authorities for the South East, one covering Hampshire & The Isle of Wight and Thames Valley (covering Berkshire, Buckinghamshire and Oxford) and the other covering Kent & Medway, Surrey and Sussex. **APPENDIX B**

Ambulance Trust

3.5 There is only one proposal for the ambulance trust, namely to merge it with the trusts for Berkshire, Buckinghamshire and Oxfordshire to mirror the proposed STHA for Hampshire and Thames Valley. **APPENDIX C**

4. Discussion

Primary Care Trust
One PCT Option

4.1 Realigning of the NHS in such a drastic form has to be of concern to any local organisation. Once again, the management structures that we work with and develop close partnerships with are being rearranged. This will be the fourth major change in the past seven years. Each reorganisation inevitably leads to a period of inertia as the organisation focuses internally on its issues, rather

than externally on working with the community. This period of inertia can last several years. The latest reorganisation locally is only just complete, with the formation of the South West Alliance between New Forest PCT, Eastleigh and Test Valley South PCT. The paper that is before you today contains two options which have been selected out of an original paper with other options.

4.2 The department of Health have made it quite clear in their correspondence with STHA's, that when presenting consultation documents on the reorganisation, they must provide balanced arguments for all the options that they put forward. It is clear from reading these documents that they are not balanced and that the most favoured option is one single PCT for Hampshire. The presentation of the argument should be clear, transparent and balanced. The paper appears biased towards one option.

4.3 Looking at the issue of a single PCT it is clear that a one organisation representing the whole of Hampshire would be extremely distanced from local people and local issues. It is difficult to believe that it would satisfactorily have a grasp on what are local issues to communities within the Forest.

4.4 If the option of one PCT is pursued, there is a greater likelihood of resources going from the Forest into more deprived and urbanised areas in the County. Inevitably, as resources are distributed based on key deprivation indices, the Forest, despite its rural poverty, would not fare well on such a distribution. Urban areas such as Gosport are likely to receive more attention than local communities. Similarly, leadership is likely to be concentrated on these areas, with far less attention to the Forest, despite its size of population and undeniable needs.

4.5 If a one PCT option were to be pursued, it would be essential that a localised structure for public health be put in place. Public health has been central to the work of the District Council for many years, working together with the Health Authority and PCT on joint funded initiatives to deliver real change and real benefits to the communities in our area. In order for this to continue, we would need strong leadership at a local level from Directors of Public Health or their equivalent. Although there are as yet no details of how the structure beneath a one PCT organisation would work, it is difficult to see how a Hampshire-wide PCT would achieve this satisfactorily. The Council may like to ask for reassurances that if a one PCT option were chosen then some local sub structure will be put in place to support joint work.

4.6 There have been some discussions with the STHA and local authorities in Hampshire on the issues of future local working and there are grounds to believe that there may be a positive response to the needs of local working in districts.

4.7 Although a one PCT option will achieve coterminosity with Hampshire County Council, it will undoubtedly produce an organisation distant from localities in the Forest. The formation of the New Forest PCT greatly improved our joint working in coterminous boundaries, with the needs of the same population at heart. It also enabled our Local Strategic Partnership, which is increasingly important, to develop close links and help to push forward real health improvement on the ground. A Hampshire wide structure, without appropriate sub structures, could seriously undermine these working relationships.

4.8 A positive advantage for a single PCT Structure would be the sheer bargaining power for commissioning of clinical services. Looking at the issues that arose when there were multiple PCTs in Hampshire, it was clear that there were price variations for similar services due to different negotiations that took place. One single PCT and commissioning structure would have economies of scale with greater financial clout with acute hospital trusts and with more people with skills on commissioning.

4.9 A one PCT option would also greatly improve the working with County Council services, especially those in the care sector in the new Adult and Children's Directorates. This will be especially important in view of the recently published Government proposals for changes in the relationships between hospital and care services in the community. Whatever structure is finally chosen working between the health sector and the new arrangements with these directorates will be key.

4.10 Given the financial crisis in the NHS, it is fully understood that there is a need to rationalise structures and release substantial resources by reducing the number of PCT's. However, the consultations do not make it clear how these resources could be maximised for use for front line services. We would welcome feedback from the SHA on this matter. This reorganisation could appear not to be led by the needs of the population or by the needs of a seamless service, but in fact by the need to reduce the vast deficit in funds in the NHS.

4.11 Looking at the Community Services Strategy, it is difficult to believe that a PCT based on the whole of Hampshire will see the local need or value of concentrating so many small hospitals within its western area and it may well be that the hospitals become more vulnerable under a one PCT option.

Three PCT Option

4.12 This option would be much nearer to the structure that already exists and would greatly maintain the relationships and organisational structure that is known to the Council. Present working would be less disrupted and the Forest would be less likely to lose out to other areas as there will be a more local focus on local issues. It will also allow a better local focus for the LSP. The three cluster approach is a good size for public health and it would allow adequate time to concentrate on real local issues, within the Council and the Public Health Team

4.13 The development of Local Area Agreements throughout Hampshire and the Isle of Wight means that it is essential that we have good solid working relationships on the ground. However, it does make it inevitable that there is a certain amount of drift for certain functions being better arranged at a County level. The consultation paper appears to favour a one PCT approach. If this is the case, then perhaps the three sub county areas that are proposed could be substructures for certain functions such as public health. When looking at these substructures it is vital that the Strategic Health Authority consider what Hampshire County Council's arrangements are for Children and Adult Services, so that they make sure that the boundaries fit together and there is coterminosity to allow joint working.

4.14 Practice Based Commissioning will be based upon clusters of GP Practices in localities of which there are four in the New Forest alone. It will be important for the future that there is close working with these arrangements especially for the Council and for public health matters. The three PCT option would be closer to this arrangement, or would need to be the basis for a substructure if the one PCT option were chosen.

Strategic Health Authority (STHA)

4.15 The main function of the STHA will be one of performance management, strategic overview, strengthening the public health function including emergency planning, building commissioning processes and working with other strategic partnerships such as the Government Office.

4.16 Given these functions and the need to work closely with the Government Office (GOSE) there is a strong argument in favour of one STHA coterminous with the boundaries of GOSE. The contrary argument in favour of two STHA's appears less convincing given that GOSE, SEEDA and SEERA all manage to work effectively at this level.

4.17 The Chief Medical Officer has recently issued a letter which makes it clear that there should be one Director of Public Health for Government Offices and STHA's, which seems to indicate a presumption in favour of one STHA.

Ambulance Trust

4.18 The proposals for the Trust are intended to improve organisational efficiency, not change clinical services. The proposal reflects the national plan set out in the document "Consultation on the Reconfiguration of NHS Ambulance Trusts". **APPENDIX D**

4.19 There is a wish to improve the delivery of services to patients to offer more medical advice, coordinate other services for patients who need urgent care, (Hampshire for instance operates the Out of Hours Service), work with primary care to help provide services and continue to operate an improving 999 service. The results of a national study came to the conclusion that this would be best achieved by creating larger Trusts to be able to achieve the infrastructure, capacity and capability to deliver these changes.

4.20 Key to the changes would be the need to fit with other NHS local/regional geographical boundaries for joint planning and service delivery. The view is taken that this is achieved with large organisations with the economies of scale to plan activities, develop procurement and have the capacity to deliver the best service.

4.21 Locally the most pressing issue that has arisen in the past concerning the ambulance service has been the response times when called out by local people. In a rural area such as the New Forest there has been concern that there has been delay in reaching incidents. It would perhaps be a key element of the Council response that it is reassured that any change in the ambulance service configuration would not adversely alter the response times.

4.22 It is a fact that compared to other NHS organisations the ambulance service is the least well known and has a poor record of engaging the Council in how it runs its services, other than when there is a problem. This consultation could be an opportunity for the Council to state that it would hope that there would be greater opportunities in the future for better dialogue and an improved relationship. This may be difficult however with a bigger organisation unless a dedicated resource is provided.

5 CONCLUSION

5.1 The Council has the opportunity to contribute to the consultations on the reconfiguration of the New Forest Primary Care Trust, Hampshire & IOW Strategic Health Authority and the Hampshire Ambulance Trust. The reconfigurations are stated to be taking place to enable the NHS to tackle the changes underway with "Patient Choice", better focus on communities and the introduction of Practice Based Commissioning.

5.2 The change that will have the greatest impact upon the work of the Council concerns that of the PCT, with which the Council has had a close and good relationship since it was founded in 2001. The changes to the Strategic Health Authority, whilst significant for the NHS, have a lesser impact upon the Council. It is unclear what impact the ambulance service changes may have.

5.3 The two proposals for the PCT reconfiguration both have advantages and disadvantages. However given the history of work that the Council has had with the New Forest PCT and more lately the South West Alliance PCT, the option that would maintain the relationship most closely to that which already exists would be the three PCT option. Certainly in terms of the public health function, which is of particular interest, then a more locally based structure would be the most beneficial.

5.4 However there are indications in the consultation paper that the one PCT option is the one that is preferred, most likely because of the strengthening to the commissioning function that this would bring and also closer working with the County Council on the care agenda. However there have also been some discussions with the STHA and local authorities in Hampshire on the issues of future local working and there are grounds to believe that there may be a positive response to the needs of local working in districts.

5.5 On this basis the Council may like to consider whether it looks at some criteria for whichever structure is finally chosen, so that its interests are best represented. Some suggested criteria might be:-

5.5.1 LSP's should be a key building block of any future structure
5.5.2 There should be a strong emphasis on public health work with district councils
5.5.3 Partnership working must continue to be a key element of future work
5.5.4 Ongoing support must be given to joint projects and appointments, including financial support.
5.5.5 District Councils should be involved in the developing Practice Based Commissioning and social care agendas.

5.6 The key to any future working relationship with the PCT, whichever structure is finally chosen, is to ensure that there is some form of structure that recognises and can deliver on local community issues and that will keep the best parts of the local current working arrangements. Page 11 in the consultation document lists the duties a PCT should have in any new arrangement. **APPENDIX A**

5.7 In terms of the Strategic Health Authority it is not clear why there should be two when at the same level as the Government Office many other organisations manage to operate with a single organisation and structure. There is also the danger of another reorganisation at a later date if a two organisation structure is chosen at this stage.

5.8 The reconfiguration of the Ambulance Trust gives in many ways the most difficulty in terms of comment, as its day to day work, outside the emergency service, is the least understood. Certainly it has had little contact with the Council in the past. Only one option is given here which does not feel like a satisfactory situation for any consultation. So the Council may best approach this by considering whether:-

5.8.1 The changes will alter response times and ask for reassurance on this issue

5.8.2 The changes will not detrimentally alter services for local people especially in more rural areas such as the New Forest.

5.8.3 Liaison between the Trust and the Council has been poor in the past and whether the changes will bring about improvement with the Council and other local community groups.

5.9 A final point that needs to be impressed upon the Department of Health, Strategic Health Authority and PCT is the fact that this must be the last major reorganisation for some time. NHS staff have so far proved remarkably resilient in an atmosphere of constant change, but there is evidence that this is proving to be one reorganisation too many, which cannot be good for the public we serve and the services provided.

6. HOUSING, HEALTH AND SOCIAL INCLUSION REVIEW PANEL - COMMENTS

The Housing, Health and Social Inclusion Review Panel have made the following recommendations:-

(a) That one PCT option be preferred however, to ensure that the Council's interests were preserved the following criteria be agreed: -

(i) That LSPs' be a key building block of any future structure.

(ii) That strong emphasis be placed on public health work with district councils.

(iii) That partnership work continues to be a key element of future work.

(iv) That ongoing support be given to joint projects and appointments, including financial support.

(v) That the District Council be involved in the developing Practice Based Commissioning and the social care agenda.

(b) That the option for two Strategic Health Authorities for the South East, one covering Hampshire & The Isle of Wight and Thames Valley (covering Berkshire, Buckinghamshire and Oxford) and the other covering Kent & Medway, Surrey and Sussex be preferred.

(c) That the proposed reconfiguration of the Ambulance Trust be supported, subject to the following: -

(i) The changes not altering response times and that reassurance on this issue be sought.

(ii) The changes not detrimentally altering services for local people especially in more rural areas such as the New Forest.

(iii) The changes result in improved communication between the Ambulance Trust and the Council and other community groups.

(d) That the Chairman write to the Department of Health, the Strategic Health Authority and the PCT stressing the Panel's concerns regarding the rate of change within these organisations and the negative impact on staff morale.

7. PORTFOLIO HOLDER COMMENTS

7.1 The Health & Social Inclusion Portfolio Holder comments:-

The three PCT option will give a more local approach to services for New Forest people, which could be lost with the much larger one PCT option. The bigger an organisation becomes the more distant it becomes in its contact with local people. As such the three PCT option for Hampshire is preferred.

Strategic Health Authority

7.2 The one Strategic Health Authority option is preferred.

Ambulance Trust

7.3 Agrees with the reconfiguration and the criteria put forward by the Review Panel with the additional comment that there is concern that with a larger Trust area local knowledge will be lost, which is of particular concern with rural areas.

8. RECOMMENDATION

8.1 To consider the consultation documents on the reconfiguration of the Primary Care Trust, Strategic Health Authority and the Ambulance Trust and agree a response.

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Background Papers:

Letter to Sir Ian Carruthers and Jonathan Montgomery dated 28 September 2005

Department of Health Briefing Note – Commissioning a patient led NHS gateway ref 5312
Letter from Sir Liam Donaldson (CMO) to Regional Office Directors STHA CX's etc dated 20.01.06

APPENDIX A

Hampshire and Isle of Wight NHS
Strategic Health Authority

CONSULTATION ON NEW PRIMARY CARE TRUST ARRANGEMENTS IN HAMPSHIRE AND THE ISLE OF WIGHT

ENSURING A PATIENT-LED NHS

CONTENTS

For blind and partially sighted people:

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Foreword

In July 2005, the Department of Health published a challenging programme to improve the commissioning of services. But it is a challenge we must all meet if we are to put in place the truly patient-led, high quality healthcare service we know the NHS can be.

Spending in the NHS is rising rapidly - from £33 billion in 1997/98 to over £90 billion in 2007/08. This increased investment, together with the hard work of NHS staff and the reforms we have introduced, is transforming our hospitals by reducing waiting times and lists, improved accident and emergency services and more up-to-date buildings.

Although these are improvements of which we should be rightly proud, we know there is more that needs to be done. In essence we need to ensure the NHS provides a service fit for the 21st century.

To deliver a patient-led NHS we need a strong commissioning function that can lead transformation in the NHS. The NHS has recognised it cannot do this alone and therefore needs the support of local authorities and the voluntary and independent sectors.

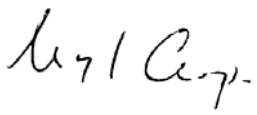
Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

In brief, we need stronger Primary Care Trusts to design, plan and develop better services for patients, to work more closely with local Government, and to support good general practice. The Primary Care Trust will be the custodian of the taxpayer's money, working to ensure that the NHS gets the best value for the public purse.

We need to enable GPs to play a full role in developing better services for patients. This is why the roll out of Practice Based Commissioning is so important.

This new approach to commissioning is about giving the levers to make services more responsive to patients to those best placed to use them. It is about enabling resources to be freed up to reinvest in new services.

Since July, Strategic Health Authorities have been discussing with their local communities how to reconfigure themselves and Primary Care Trusts. This document explains the suggested changes to your communities. I encourage you to have your say in this process to help build organisations that are fit to deliver this exciting vision for patients.



Sir Nigel Crisp KCB

Chief Executive, Department of Health and NHS

Preface

Commissioning a Patient–led NHS

This document sets out proposals for the configuration of Primary Care Trusts in Hampshire and the Isle of Wight as part of the implementation of Commissioning a Patient-led NHS. These proposals alongside those for Strategic Health Authorities and Ambulance Services will have significant implications on how the local NHS is managed and sets out proposals for the future number of Primary Care Trusts in Hampshire and the Isle of Wight.

Your views and those of your organisation are sought on the following proposed options for the reconfiguration of Primary Care Trusts which are:

- a Primary Care Trust for Portsmouth City
- a Primary Care Trust for Southampton City
- Two options for the county of Hampshire:
    - Option A: a single Primary Care Trust coterminous with Hampshire County Council that will comprise the seven existing Primary Care Trusts;
    - Option B: three Primary Care Trusts within Hampshire County Council replacing the seven existing Primary Care Trusts.
- In view of the special circumstances of the Isle of Wight it is proposed to create a single organisation for the commissioning and management of all National Health Services on the Isle of Wight. The proposed new body will oversee the commissioning and management of acute hospital services, mental health services, community services, primary care services and ambulance services.

For legislative purposes, the new organisation will be a Primary Care Trust and will replace the current Isle of Wight Primary Care Trust and Isle of Wight Healthcare NHS Trust. The Local Authority would continue to commission social care services, but the NHS and Local Authority partners would use the Health Act flexibilities and Local Area Agreements to develop joint approaches to the commissioning and provision of health, healthcare, social care and wellbeing for the local population. In the longer term, it is proposed to move towards a fully integrated health and social care organisation but progress is dependent on the National Health Service on the Isle of Wight restoring financial balance.

These proposals have been developed through discussions with local partner organisations and we now want to test these more widely. Your views and comments should be forwarded to us by 22nd March 2006.

Professor Jonathan Montgomery
Chairman

Sir Ian Carruthers OBE
Chief Executive

Hampshire and Isle of Wight Strategic Health Authority

SECTION ONE

BACKGROUND TO COMMISSIONING A PATIENT-LED NHS

This section sets out the background to “Commissioning a Patient-led NHS”

1 YOUR NHS

1.1 Important new changes in the way your local NHS is structured and managed are planned. Your views will be crucial.

1.2 The proposals at the heart of this consultation will mean new geographical boundaries for Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) across England. The solutions proposed in this document will be unique to your area and will reflect the needs, preferences and health priorities of your local communities.

1.3 Why is this so important? While most of us are passionate about the sort of services we receive in the NHS – the quality, speed and convenience of care – how many of us want to get tied up with organisational hierarchies and the mechanics of the service? We, as patients, want to receive the care we need, at the time we need it and in a setting that is convenient to us.

1.4 The answer is simple. The changes proposed here will be the defining factor in whether the NHS can sustain the huge improvements it has already achieved and go on to realise its fundamental aim: to deliver a better, more responsive health service that gives people the control and choice they have a right to expect as patients and taxpayers.

2 ACHIEVING A PATIENT-LED NHS

2.1 Becoming a truly patient-led service is the next big challenge for the NHS. But what does it really mean for patients and how will we make it happen?

2.2 As a starting point the Government has captured and shared this vision in its cornerstone document, *Creating a Patient-led NHS*. It describes what patient-led services actually look like from a patient's point of view. Everyone involved in a patient-led service makes sure they:

- respect people for their knowledge and understanding of their own clinical condition and how it impacts on their life;
- support them in using this knowledge to manage their long-term illnesses better;
- provide people with the information and choices that allow them to feel in control and fit their care around their lives;
- treat people with dignity and respect, recognising them as human beings and as individuals, not just people to be processed;
- ensure people always feel valued by the health and care service and are treated with respect, dignity and compassion;

- understand that the best judge of an individual's experience is the individual;

- ensure that the way clinical care is booked, communicated and delivered is as trouble free as possible for the patient and minimises the disruption to their life; and

- explain what happens if things go wrong and why, and agree the way forward.

2.3 These are the sort of benefits we can all understand and that we want for ourselves and our families. They are the tangible end result of policies already in place to introduce:

- patient and client choice – not just in hospitals but in primary and social care too;

- better, more integrated support and care for people with long-term illnesses;

- a wider range of services in convenient community settings;

- faster, more responsive emergency and out-of-hours services; and

- more support to help people improve and protect their own health.

2.4 But for the local organisations working hard to put all these improvements in place, the system itself can often get in the way – including barriers between different professional groups and organisational boundaries.

2.5 This is why we are consulting on these major changes to how your local NHS is structured. Making a patient-led NHS a reality right across the NHS and other agencies will take more than a shared aspiration: it will need change. New standards of care; new skills, freedoms and incentives for staff; new systems for planning, securing and paying for services; and new organisations.

2.6 The NHS is not coming to this challenge from a standing start. There have been enormous changes in the NHS since the publication of the *NHS Plan* in 2000 and huge progress towards providing better, faster and more convenient healthcare.

2.7 In the ten years from 1997, levels of investment in the NHS in staff and services will have almost tripled, from £33 billion to more than £90 billion. The NHS has recognised it cannot do this alone. It will also need the support of local authorities and the voluntary and independent sectors, who within 2004-5 accounted for £17.5 billion of this expenditure, employing over 1.4 million people. Along with the hard work and commitment of the 1.3 million NHS staff, this investment has genuinely transformed the quality of care people are receiving every day in health and social care:

- waiting times for hospital treatment have dropped significantly;
- fewer people are dying from killers such as cancer and heart disease;
- accident and emergency services are faster and better; and
- people now have real choice about when and where they receive their hospital treatment.

2.8 But this is only part of the journey. As much as 90 per cent of all our contact with the NHS happens not in hospitals but in primary care and community settings – that's in GP surgeries, community clinics, walk-in centres and even our own homes. And it's this reality that is driving a huge challenge for the NHS: to change our health service from one that does things 'to' and 'for' people, to one that works 'with' people – involving patients and carers, listening and responding to what they say.

2.9 Choice and diversity of services are as important for patients in primary care, as they are for those needing hospital treatment. And one of the best ways to give patients more choice and say about their local services is to give the healthcare professionals closest to them – GPs and their practice teams – a front-line role in securing the best possible services on their behalf. This is called 'Practice Based Commissioning'.

2.10 It will mean that GPs have more say in deciding how health services are designed and delivered – ensuring they reflect the choices their patients and communities are making. It will encourage fresh thinking and trigger new ideas for the way services are run.

2.11 We need stronger Primary Care Trusts to design, plan and develop better services for patients, to work more closely with local Government, and to more effectively support good general practice. In short, Primary Care Trusts need to strengthen their commissioning function.

3 WHAT DO WE MEAN WHEN WE TALK ABOUT 'COMMISSIONING'?

3.1 At its simplest 'commissioning' is the term used to describe the processes by which the NHS spends its money. It is the processes by which the NHS plans and pays for services while assuring their quality, fairness and value for money.

3.2 Strong, imaginative commissioning is essential for creating a patient-led NHS. Commissioning will stimulate the development of a wider range of services in response to the preferences, lifestyles and needs of the local population. At the same time commissioning will help ensure that NHS resources are spent on the areas of most need.

3.3 In the past commissioning has largely been conducted through high level planning and block (fixed cost) contracts between purchasers and providers of care. This has given financial certainty in the system, but few incentives to understand and respond to the needs and preferences of patients.

3.4 This is now changing. A new financial system, Payment by Results, means that hospitals are paid a standard fee for the patients they treat. Money will truly follow patients. Patient choice will see patients deciding on where they want to be treated, determine the referrals to individual hospitals, and eventually how many patients each hospital treats.

3.5 Since April 2005 GPs have been able to become more involved with commissioning through an approach known as 'Practice Based Commissioning'. The aim is to have universal coverage of Practice Based Commissioning by the end of 2006.

3.6 These changes provide an opportunity and a need to change the way we approach commissioning and the organisational arrangements to support commissioning.

4 THE WIDER PICTURE

4.1 Under Practice Based Commissioning GPs and practice staff will have access to a commissioning budget and will lead developments to produce more responsive local services.

4.2 Practices will pay the national tariff for most hospital services, but crucially only for those services their patients use. Practice Based Commissioning will allow GPs and Primary Care professionals to develop and fund innovative community services as an alternative to hospital for some patients. GPs will have a much greater say in the services to be provided to their patients.

4.3 Primary Care Trusts will support and manage the operation of Practice Based Commissioning. They will, on behalf of their practices, provide practice budgets, clinical and financial information to help GPs and negotiate contracts for the services required.

4.4 Primary Care Trusts will play a crucial role in working with their practices to design, plan and develop better services for patients. They will conduct needs assessments of their local communities and work closely with local authorities so that the wider health and care needs of local communities are addressed. There are lessons concerning commissioning that can be learnt from local authorities.

4.5 The Primary Care Trust will be the custodian of the taxpayer's money, working to ensure the NHS maximises the benefits of its resources and secures high quality responsive services.

4.6 The focus for Strategic Health Authorities will be on building the new system of commissioning and then maintaining a strategic overview of the NHS in their area.

4.7 Strategic Health Authorities will continue to provide leadership and performance management to the NHS. They will be responsible for ensuring that key national objectives are delivered and that services are high quality, safe and fair. Taking forward this agenda will need good leadership, within both the NHS as well as other local services.

4.8 Over time, as we move towards all NHS Trusts achieving Foundation status, performance management will increasingly be focused on the commissioners of services.

5 WHAT DOES THIS MEAN FOR PRIMARY CARE TRUSTS?

5.1 Many of the improvements seen in the NHS in recent years can be attributed to the hard work and skills of Primary Care Trusts. But as the landscape of a patient-led NHS continues to change, bringing with it the new challenges of greater choice, more diverse services and improved health, so too will Primary Care Trusts need to adapt and develop.

5.2 Practice Based Commissioning will be central to all this and Primary Care Trusts will need to play a lead role in supporting GPs and practices as they step into their new commissioning functions, and in managing new relationships with a wider range of providers. While Primary Care Trusts will be key to making the new system a success, the new processes should actually support them.

5.3 There is no national blueprint for the number or shape of Primary Care Trusts - different regions will invariably need different solutions. In some areas, for instance, the formation of larger Primary Care Trusts may be seen as the key to really effective local commissioning and service planning. For others, smaller Primary Care Trusts may fit local needs better.

5.4 In many cases the geographical areas of the new Primary Care Trusts are likely to broadly match those of local authorities. This will encourage better co-ordination between health, social care and other local services and boost the population-related spending power of Primary Care Trusts.

6 THE PRIMARY CARE TRUST ROLE IN MORE DETAIL

6.1 The core roles and functions of Primary Care Trusts are set out below. As we continue to develop the health reform policies there may be additional roles and functions identified for Primary Care Trusts. An initial view of the new Primary Care Trust role is as follows:

- improve and protect the health of the population they serve by assessing need and having a robust public health delivery system including emergency planning;
- secure, through effective commissioning, a range of safe and effective primary, community, secondary and specialised services (some specialised services will be commissioned nationally, others by groups of Primary Care Trusts[1]) which offer high quality, choice, and value for money;
- reduce health inequalities and ensure that the role of individuals is recognised and utilised at local level;
- develop and sustain strong relationships with GPs and their practices and implement a system of Practice Based Commissioning;
- work closely with local authority partners and other commissioners to ensure integrated commissioning of health and social care, including emergency planning;
- ensure that nurses, midwives and allied health professionals play a key role in improving the health of local populations;
- stimulate the development of a range of nursing, midwifery and allied health professional providers;
- provide appropriate clinical leadership in a system of diverse providers;
- develop robust communication and involvement systems to manage relationships and engage with their local residents and communities;
- ensure that a range of services are provided for their communities in ways that most appropriately meet their local needs.

[1] There is currently a review of specialised commissioning underway. This is due to report in spring 2006.

6.2 The overall management of the health system will continue to develop as we fully implement Payment by Results and patient choice and move towards greater plurality of provision through NHS Foundation Trusts and greater independent sector involvement.

6.3 The Department of Health has a significant programme of policy development work on the future regulation and management of the health system overall. Further guidance in 2006 will set out the implications of this work for Strategic Health Authorities, Primary Care Trusts and other NHS bodies.

7 PROTECTING STAFF

7.1 The proposals set out in this document mean important changes for staff working in the current Strategic Health Authorities and Primary Care Trusts. In what is likely to be an unsettling time, it will be vital to ensure that staff are fully consulted on the local proposals and have the opportunity to use their experience and creativity in shaping new services.

7.2 The new structure must also be implemented fairly and transparently in a way which protects the position of staff who transfer to other organisations and gives them new opportunities to utilise their skills and experience.

7.3 The Department of Health will shortly be publishing a human resources framework to outline the relevant appointment processes for the new Strategic Health Authorities and Primary Care Trusts, and to support staff through these changes.

8 NEXT STEPS

8.1 This document is one of a series of separate consultation exercises on the proposed boundaries and structures for each new Primary Care Trust. Proposals for the new Strategic Health Authority boundaries are also being consulted on at local level in a similar way.

8.2 The proposals, which follow, outline plans to create a number of new Primary Care Trusts from the present ten in the Strategic Health Authority. They describe the implications of these changes for staff, local people, the NHS and its partner organisations.

8.3 No final decisions have yet been taken and this is your opportunity to genuinely influence the future shape of your local NHS services. At the end of the consultation, the Strategic Health Authority will report the results of the consultation and advise the Secretary of State for Health whether she should make the proposed orders to dissolve or establish a Primary Care Trust.

8.4 A full explanation of how to comment and by when is set out on pages 29 and 30.

SECTION TWO

PROPOSALS FOR THE CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

This section sets out the proposals for the configuration of Primary Care Trusts in Hampshire

1 THE PRESENT CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

1.1 Commissioning a Patient-led NHS was published on 28th July 2005 and sets out a series of major changes in the way health services are commissioned and managed in future to reflect patient choice.

1.2 Strategic Health Authorities were asked to develop proposals for the implementation of Commissioning a Patient–led NHS in their local health communities in consultation with Primary Care Trusts, NHS Trusts, Local Authorities, Patient and Public Involvement Forums, Local Professional Committees and other partner and stakeholder organisations.

1.3 This document on which your views are sought is one of three consultation documents supporting the implementation of Commissioning a Patient-led NHS and focuses on the configuration of Primary Care Trusts in Hampshire and the Isle of Wight.

1.4 The existing pattern of Primary Care Trusts and local authorities in Hampshire is described in Table 1. Figure 1 on the following page is a map of the current configuration of Primary Care Trusts and Local Authorities across Hampshire and the Isle of Wight.

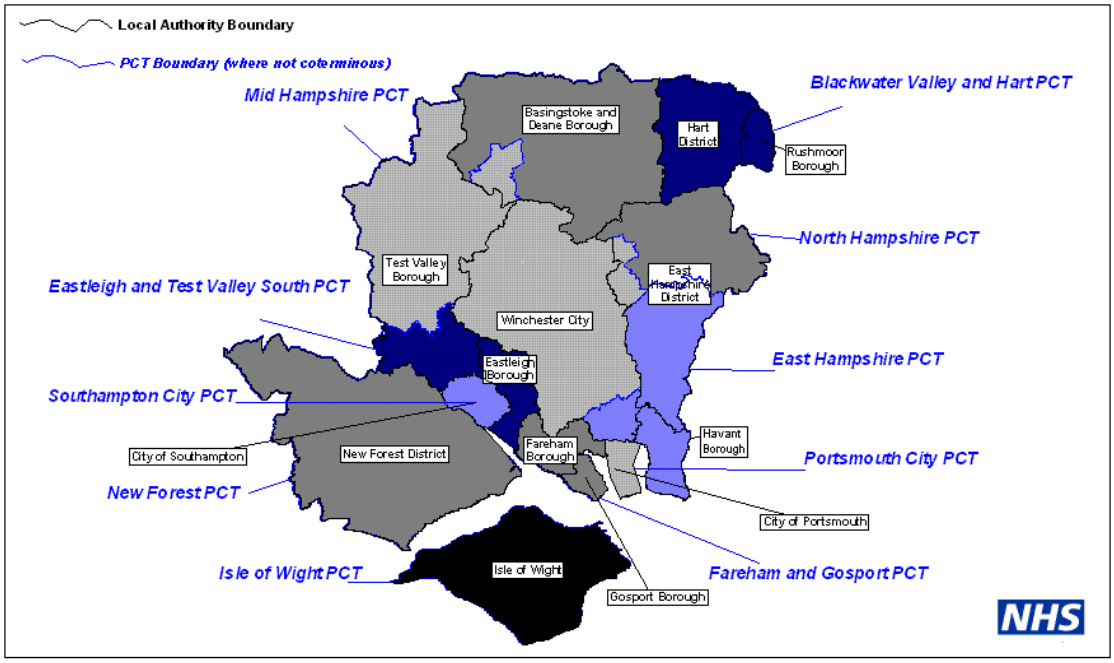
TABLE 1: EXISTING PRIMARY CARE TRUSTS AND LOCAL AUTHORITIES IN HAMPSHIRE

Primary Care Trust (PCT)	Unitary/County Authority	District and Borough Council(s)[2]	Population[3]
Blackwater Valley and Hart PCT	Hampshire County Council	Hart District Council and Rushmoor Borough Council	175,700
East Hampshire PCT	Hampshire County Council	Havant Borough Council and the southern part of East Hampshire District Council	170,800
Eastleigh and Test Valley South PCT	Hampshire County Council	Eastleigh Borough Council and the southern part of Test Valley Borough Council	161,600
Fareham and Gosport PCT	Hampshire County Council	Fareham Borough Council and Gosport Borough Council	186,300
Mid Hampshire PCT	Hampshire County Council	Winchester City Council and the northern part of Test Valley Borough Council	175,400
New Forest PCT	Hampshire County Council	New Forest District Council	171,200

[2] Whilst this table indicates the main relationships between Primary Care Trusts and district councils there are some local variations in wards. For example, Whitchurch (Basingstoke and Deane Borough Council) is part of Mid Hampshire PCT.
[3] Based on Office for National Statistics mid-year estimates 2003

North Hampshire PCT	Hampshire County Council	Basingstoke and Deane Borough Council and the northern part of East Hampshire District Council	210,000
Portsmouth City Teaching PCT	Portsmouth City Council		188,700
Southampton City PCT	Southampton City Council		221,100

FIGURE 1: EXISTING PRIMARY CARE TRUSTS IN HAMPSHIRE AND ISLE OF WIGHT



1.5 Currently, seven Primary Care Trusts and one NHS Trust in Hampshire have formed into pairs to share a Chief Executive and senior management team. These clusters of NHS organisations are:

- Blackwater Valley and Hart Primary Care Trust and North Hampshire Primary Care Trust;
- East Hampshire Primary Care Trust and Fareham and Gosport Primary Care Trust;
- Eastleigh and Test Valley South Primary Care Trust and New Forest Primary Care Trust;
- Mid Hampshire Primary Care Trust and Winchester and Eastleigh Healthcare NHS Trust.

2 THE FUTURE CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

2.1 The future configuration of Primary Care Trusts has to meet the following key criteria:

- securing high quality, safe services;
- improving health and reducing health inequalities;
- improving the engagement of GPs and rollout of Practice Based Commissioning with demonstrable practice support;
- improving public involvement;
- improving commissioning and the effective use of resources;
- managing financial balance and risk;
- improving co-ordination with Social Services through greater congruence of Primary Care Trusts and Local Government boundaries;
- delivering at least 15% reduction in management and administrative costs.

2.2 New Primary Care Trusts will need to operate at a number of levels. For example, the level of decision taking in setting the strategic framework for health and health care improvement may mean working with consortia of Primary Care Trusts. The strategic framework will also form the basis for the operation of Practice Based Commissioning at the practice or locality level, and health improvement with District and Borough Councils.

2.3 At the heart of the changes proposed is the aim that decisions should be taken at the most appropriate level which is closest to the frontline so that delivery is secured and risk is minimised. This will be achieved by the greater engagement of clinicians and the public and by ensuring there is decentralisation of decision taking which operates within a strong framework of accountability.

2.4 Taking into account these factors the proposed configuration for Primary Care Trusts in the county of Hampshire is as follows:

- a Primary Care Trust covering the City of Portsmouth;
- a Primary Care Trust covering the City of Southampton;
- options for the county of Hampshire:
    - Option A: a single Primary Care Trust that will comprise seven existing Primary Care Trusts; or

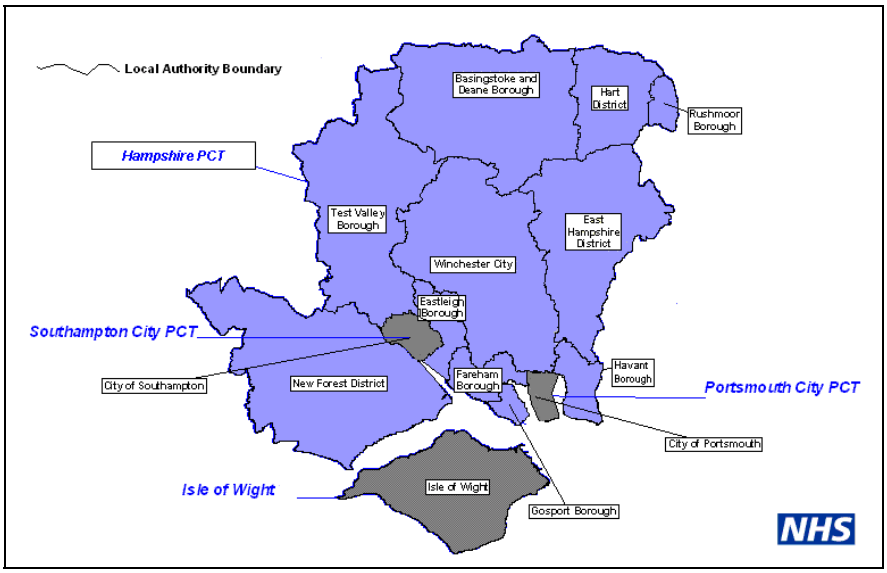
- o Option B: three Primary Care Trusts replacing the existing seven Primary Care Trusts.

2.5 Table 2 shows the population numbers served by these proposed new organisations and their relationships with Local Authorities, under Option A (a single Primary Care Trust for Hampshire). Figure 2 is a map which illustrates Option A.

TABLE 2: PROPOSED NEW PRIMARY CARE TRUSTS AND EXISTING LOCAL AUTHORITIES IN HAMPSHIRE, FEATURING OPTION A

Proposed Primary Care Trust	Unitary/County Authority	Borough and District Councils	Population '000s
Hampshire PCT	Hampshire County Council	Basingstoke & Deane Borough Council, East Hampshire District Council, Eastleigh Borough Council, Fareham Borough Council, Gosport Borough Council, Hart District Council, Havant Borough Council, New Forest District Council, Rushmoor Borough Council, Test Valley Borough Council, Winchester City Council	1,251.0
Portsmouth City Teaching PCT	Portsmouth City Council		188.7
Southampton City PCT	Southampton City Council		221.1

FIGURE 2: PROPOSED NEW PRIMARY CARE TRUSTS IN HAMPSHIRE: OPTION A

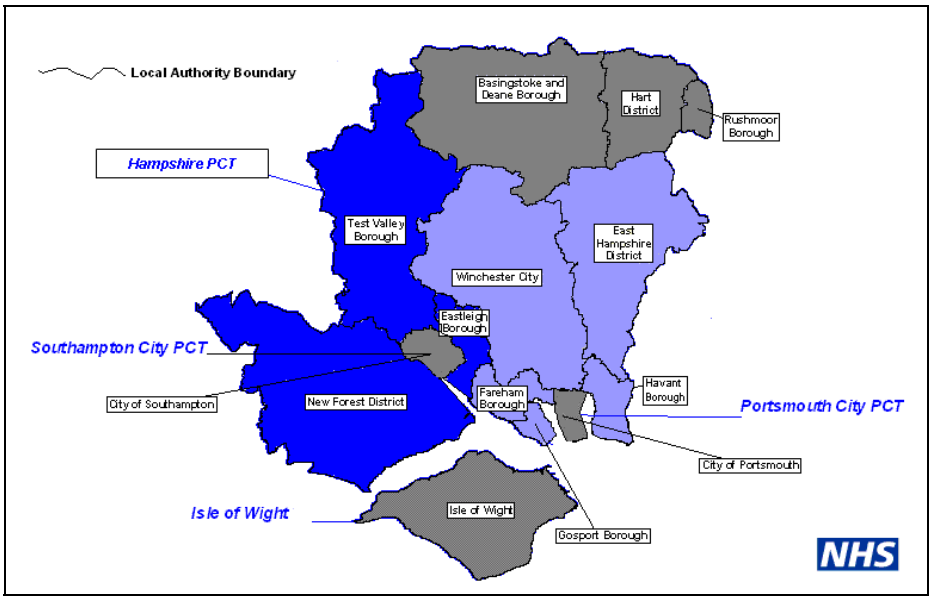


2.6 Table 3 shows the population served by these proposed new organisations and their relationships with Local Authorities under Option B (three Primary Care Trusts for Hampshire). Figure 3 is a map which illustrates Option B.

TABLE 3: PROPOSED NEW PRIMARY CARE TRUSTS AND EXISTING LOCAL AUTHORITIES IN HAMPSHIRE, FEATURING OPTION B

Proposed Primary Care Trust	Unitary/Local Authority	Borough and District Councils	Population '000s
Eastern Hampshire PCT	Hampshire County Council	East Hampshire District Council, Fareham Borough Council, Gosport Borough Council, Havant Borough Council, Winchester City Council	522.5
Northern Hampshire PCT	Hampshire County Council	Basingstoke & Deane Borough Council, Hart District Council, Rushmoor Borough Council,	330.1
Western Hampshire PCT	Hampshire County Council	Eastleigh Borough Council, New Forest District Council, Test Valley Borough Council,	398.4
Portsmouth City Teaching PCT	Portsmouth City Council		188.7
Southampton City PCT	Southampton City Council		221.1

FIGURE 3: PROPOSED NEW PRIMARY CARE TRUSTS IN HAMPSHIRE: OPTION B



2.7 There are several ways of dividing the county of Hampshire into three areas, each with its own Primary Care Trust and with boundaries coterminous with Local Authorities. The area covered by Winchester City Council could be linked with any of the three Primary Care Trusts in Option B. It is proposed that the population served by Winchester City Council is included in the area covered by the new East Hampshire Primary Care Trust because it provides a geographical link between East Hampshire, Havant, Fareham and Gosport.

2.8 A third option for the county of Hampshire, that it should have two Primary Care Trusts, received no support during informal soundings with local stakeholders. Consequently it has not been included for consideration in this submission.

2.9 The proposals and either of the Options A and B will meet the criteria in paragraph 2.1 on page 16.

3 THE PROPOSED CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

3.1 The Hampshire and Isle of Wight Strategic Health Authority wishes to consult formally on the proposal that there should be:

- a Primary Care Trust covering the City of Portsmouth;
- a Primary Care Trust covering the City of Southampton.

3.2 It also wishes to consult on the two options for the county of Hampshire, namely:

- Option A: a single Primary Care Trust that will comprise the seven existing Primary Care Trusts;
- Option B: three Primary Care Trusts replacing the existing seven Primary Care Trusts.

3.3 It would also be helpful to receive comments should Option B be favoured whether the population within Winchester City Council boundaries should be part of Eastern Hampshire or either of the other two proposed new Primary Care Trusts in Hampshire.

3.4 Table 4 sets how the proposals for change in the county of Hampshire meet the criteria set out in paragraph 2.1.

TABLE 4: ASSESSMENT OF OPTIONS FOR PRIMARY CARE TRUST CONFIGURATION IN HAMPSHIRE

Criteria	Option A: One Primary Care Trust in the county of Hampshire	Option B: Three Primary Care Trusts in the county of Hampshire
Secure high quality, safe services	The size of the PCT will give it significant influence with provider organisations. See also the comments about commissioning, below.	The PCTs will have adequate influence with provider organisations. See also the comments about commissioning, below.
Improve health and reduce inequalities	Improved health and reduced inequalities will be achieved by these issues being made mainstream items in the strategic framework of the PCT so that resources flow accordingly .Local decision making will be decentralized to locality ,neighborhood and general practice level. This is the appropriate level to secure engagement with the public and partner orgainisations. It will be facilitated through local strategic partnerships and the devolved management arrangements arising from the modus operandi of the Primary Care Trust. This configuration will provide greater focus and capability to deliver Choosing Health than the current arrangements Borough and District Councils are entirely on the patch of one PCT and will therefore have a one-to-one relationship with local authorities. This relationship will be important in improving the health of communities. Scarce human resources in public health will be deployed more effectively, and a single point of leadership of public health is likely to improve delivery of *Choosing Health*.	Improved health and reduced inequalities will be achieved by these issues being made mainstream items in the strategic framework of the PCT so that resources flow accordingly. Local decision making will be decentralized to locality, neighborhood and general practice level. This is the appropriate level to secure engagement with the public and partner organisations. It will be facilitated through local strategic partnerships and the devolved management arrangements arising from the modus operandi of the Primary Care Trust .This configuration will provide greater focus and capability to deliver Choosing Health than the current arrangements. Borough and District Councils are entirely on the patch of one of the three PCTs and will therefore have a one to one relationship with local authorities. Scarce resources in public health will be more stretched unless the PCTs share these resources and leadership of the function
Improve engagement of GPs and rollout Practice Based Commissioning	Either option will require PCTs to organise themselves effectively on a locality basis, particularly the single large PCT for Hampshire. Greater consistency in the implementation of Practice Based Commissioning is more likely under this option.	Either option will require PCTs to organise themselves effectively on a locality basis. Individual PCTs in the three-PCT option would still be too large to rely simply on a central organisation to achieve engagement with clinicians.

Criteria	Option A: One Primary Care Trust in the county of Hampshire	Option B: Three Primary Care Trusts in the county of Hampshire
Improve public involvement	The single large PCT will have to design its organisation to have effective leadership and presence in localities. This is possible to do. Such a large organisation will be driven to do it in order to avoid public criticism that it is too large and too remote.	Even three PCTs will be in danger of being too remote from localities unless they design their organisations to have effective leadership and presence in localities.
Improve commissioning and effective use of resources	The size of the PCT will give it significant influence with provider organisations and considerable scope to develop choice and competition. It will be able to recruit and develop the very best specialist commissioning talent.	Each of the three PCTs will have moderate influence with provider organisations and less scope to develop choice and competition.
Manage financial balance and risk	Three of the six current PCTs ended the financial year 2004/05 with very large deficits (almost £25M in aggregate). The single, large PCT will have a considerable financial allocation and a very significant scope to manage financial risk.	The new PCTs will have less scope to manage financial risk.
Improve coordination with social services	The single PCT will enjoy a one-to-one relationship with Hampshire County Council. This will simplify organisational relationships and give more opportunity for county-wide collaboration.	This option will result in a three-to-one relationship with Hampshire County Council. This will be as complex as the current arrangements which the County Council has found difficult. PCTs will have to be more effective, under this option, at agreeing common policy across the county.
Deliver at least 15% management cost savings	There is opportunity to realize savings. Three management teams will reduce to one. The contribution to the share of the £8m savings in Hampshire and the Isle of Wight will be achieved	There is less scope for management cost savings as the current six PCTs already share three management teams. The contribution to the share of the £8m savings in Hampshire and the Isle of Wight will be achieved

3.5 Table 5 (overleaf) sets how Southampton City Primary Care Trust and Portsmouth City Primary Care Trust meet the criteria set out in paragraph 2.1.

TABLE 5: ASSESSMENT OF PORTSMOUTH CITY PRIMARY CARE TRUST AND SOUTHAMPTON CITY PRIMARY CARE TRUST

Criteria	Portsmouth City Primary Care Trust and Southampton City Primary Care Trust
Secure high quality, safe services	The scale of the Primary Care Trust means that it will need to work with other Primary Care Trusts in commissioning services so that benefits are realised.
Improve health and reduce inequalities	Improved health and reduced inequalities will be achieved by these issues being made mainstream items in the strategic framework of the Primary Care Trust so that resources flow accordingly. Local decision making will be decentralised to locality, neighbourhood and general practice level. This is the appropriate level to secure engagement with the public and partner organisations. It will be facilitated through local strategic partnerships and the devolved management arrangements arising from the modus operandi of the Primary Care Trust. This configuration will provide greater focus and capability to deliver Choosing Health than the current arrangements.
Improve engagement of GPs and rollout Practice Based Commissioning	Action plans are in place to achieve universal coverage and this will improve general practitioner involvement at practice and locality level. The continuation of Professional Executive Committees will ensure engagement on strategic issues. The Strategic Framework for the Primary Care Trust will be devised from a bottom up approach so that the direction of travel for the Primary Care Trust commands the support of the general practitioners, clinicians, users, carers and the wider public.
Improve public involvement	Public involvement will be achieved by users, carers and the public input to strategic and local commissioning activities. Users will be engaged in Practice Based Commissioning, focus groups on key issues at practice and locality levels and through involvement in fora established to test specific strategic issues. This will also be achieved through better working with partner bodies, market/commercial research, and Overview and Scrutiny Committees. The Primary Care Trust will establish local structures to ensure that the strategic direction is co-created by and commands the confidence of the users, carers and public.
Improve commissioning and effective use of resources	The configuration will mean that stronger commissioning leverage will only be achieved if the Primary Care Trust works with other Primary Care Trusts to achieve the concentration of skills and management capacity to deliver more effective use of resources.
Manage financial balance and risk	The scale of the Primary Care Trust may make it difficult to manage risk and financial balance without collective working with other Primary Care Trusts in the commissioning process.
Improve coordination with social services	The Primary Care Trust is coterminous with the unitary local authority. This will aid progression in terms of integrating health and social care as well as delivering Choosing Health. It will also mean the Local Area Agreement can be a strong vehicle to drive transformation and this will be strengthened by the one to one relationships with Social Care Authorities.
Deliver at least 15% management cost savings	This configuration may make it difficult to deliver the required savings to achieve the Primary Care Trust target savings share of the £8 million for Hampshire and Isle of Wight.

SECTION THREE

PROPOSALS FOR THE ORGANISATION OF THE NATIONAL HEALTH SERVICE ON THE ISLE OF WIGHT

This section sets out the proposals for the future organisation of the National Health Service on the Isle of Wight

1 THE SPECIAL CIRCUMSTANCES OF THE ISLE OF WIGHT

1.1 The Isle of Wight has the largest population of any United Kingdom island with a resident population of 136,000 and visitor numbers doubling this figure at peak holiday periods. Population growth is projected together with an increasingly ageing population profile. The transport links to the mainland all entail significant travel time and cost. Public Sector organisations consequently have some unique challenges in maintaining safe, accessible and sustainable services.

2 THE PRESENT CONFIGURATION ON THE ISLE OF WIGHT

2.1 At present there is a Primary Care Trust on the Isle of Wight serving a population of 136,000 people. The Primary Care Trust was established in April 2001, and has a modest provider role. It employs 160 staff in directly-managed services and has a budget of approximately £7 million for service provision.

2.2 The Isle of Wight Healthcare NHS Trust was created in 1997. It is unique within the United Kingdom in terms of the breadth of its service provision. It manages the ambulance service, mental health and some community services as well as acute services on the Isle of Wight.

2.3 At present the Isle of Wight Primary Care Trust and the Isle of Wight Healthcare NHS Trust share a Chief Executive and senior management team.

2.4 The Isle of Wight Council is a Unitary Authority which has existed since 1995. Adult Services on the Isle of Wight (formerly called Social Services) is a division of the Adult and Community Services Directorate of the Council. The Directorate also contains housing, culture and leisure services. The areas which are most closely associated with health services are adult services and some elements of housing. The Adult Services division has a gross budget of £48 million and includes some directly-managed service provision and commissioning.

2.5 A long-standing aim of the NHS bodies and the Local Authority on the Isle of Wight has been the creation of a single integrated organisation covering health and social care.

3 THE FUTURE CONFIGURATION ON THE ISLE OF WIGHT

3.1 Four options for organising health and social care on the Isle of Wight have been considered:

- Option 1 - A stand alone Isle of Wight Primary Care Trust to commission health services with remaining provider functions

transferred out. The Isle of Wight Healthcare NHS Trust and Local Authority Social Services would continue to be managed separately.

- Option 2 - A new organisation which would commission health services and manage all NHS provider services. It would replace the current Primary Care Trust and NHS Trust on the Isle of Wight. The Local Authority would continue to commission social care. However, NHS and Local Authority partners would use Health Act flexibilities and Local Area Agreements to develop joint commissioning approaches to the health and well-being agendas. Internal and external governance arrangements would establish a clear separation, within the new organisation, between the commissioning and provider functions to ensure a rigorous and objective approach to competition and choice.

- Option 3 - A new organisation to commission health and social care. The Isle of Wight Healthcare NHS Trust and Local Authority provider services would continue to be managed separately.

- Option 4 - Under this option a Primary Care Trust spanning part of mainland Hampshire and the Isle of Wight would commission services for the local population. A variety of configurations are possible. For example, either Southampton City Primary Care Trust or Portsmouth City Teaching Primary Care Trust might extend its scope to cover the Isle of Wight. The Isle of Wight Healthcare NHS Trust and Local Authority Social Services would continue to be managed separately.

3.2 The preferred option is Option 2 with a single NHS organisation to cover NHS commissioning and provision and to develop a joint arrangement with social care. This arrangement would require rigorous external scrutiny through the performance management arrangements of the Strategic Health Authority to ensure that improved health and healthcare is achieved for the benefit of the local population.

3.3 This proposal would not, however, meet all the criteria set out in 'Commissioning a Patient-led NHS'. However, there are special circumstances on the Isle of Wight which make a strong argument for a different model of organisation. The special circumstances include:

- the Isle of Wight is relatively remote with a very restricted overnight ferry connection to the mainland, and disproportionately long travel times to the mainland during daytime hours. 'Local Services' inevitably means 'services on the Isle of Wight' because of these commuting difficulties;

- other configurations involving a Primary Care Trust covering part of mainland Hampshire and the Isle of Wight may not be seen to be sufficiently sensitive to the needs of the Isle of Wight population;

- it would be costly to sustain separate NHS commissioning and provider organisations on the Isle of Wight. Greater savings would be made for reinvestment in front-line services if Option 2 were adopted;

- the limited nature of competition on the Isle of Wight, given that most residents express a strong preference for being treated locally;

- arrangements can be put in place to provide separation between commissioning and provider responsibilities within the proposed organisation;

- the proposed organisation would be coterminous with the Isle of Wight Council, a Unitary Local Authority;

- there are well developed proposals with strong local support to bring health and social care together in a new organisation.

3.4 Table 4 shows the one-to-one relationship between the NHS and the local authority on the Isle of Wight.

TABLE 4

Proposed organisation	Unitary/Local Authority	Borough and District Council	Population '000s
One NHS organisation for the Isle of Wight	Isle of Wight Council		136.3

4 THE PROPOSED CONFIGURATION ON THE ISLE OF WIGHT

4.1 In view of the special circumstances of the Isle of Wight, the Hampshire and Isle of Wight Strategic Health Authority wishes to consult on the proposal that there should be a single organisation for the commissioning and management of all National Health Services on the Isle of Wight. The proposed new body will oversee the commissioning and provision of acute hospital services, mental health services, community services, primary care services and ambulance services.

4.2 For legislative purposes, the new organisation will be a Primary Care Trust and will replace the current Isle of Wight Primary Care Trust and Isle of Wight Healthcare NHS Trust. The Local Authority would continue to commission social care services, but the NHS and Local Authority partners would use the Health Act flexibilities and Local Area Agreements to develop joint approaches to the commissioning and provision of health, healthcare, social care and wellbeing for the local population. In the longer term, it is proposed to move towards a fully integrated health and social care organisation but progress is dependent on the National Health Service on the Isle of Wight restoring financial balance.

4.3 Your views are invited on the proposal to create a single organisation to commission and manage health services on the Isle of Wight.

SECTION FOUR

CONSULTATION PROPOSALS

This section summarises the proposals for local consultation and seeks your views

1 CONSULTATION PROPOSALS

1.1 These proposals are for organisational and managerial changes to the Primary Care Trusts in Hampshire and the Isle of Wight.

1.2 Together with proposals for Strategic Health Authorities and Ambulance Services which are being consulted on separately but simultaneously they will reduce management and administrative costs and release £8 million to invest in frontline clinical services in Hampshire and the Isle of Wight.

1.3 These proposals will not change the way clinical services are delivered although they should improve the way those services are run. If the new organisations want to make any changes to services later, these would subject to local engagement and consultation.

1.4 In summary the proposals for local consultation on Commissioning a Patient-led NHS in Hampshire and the Isle of Wight centre on :

- retaining a Primary Care Trust for Portsmouth City
- retaining a Primary Care Trust for Southampton City
- reconfiguring Primary Care Trusts in the County of Hampshire based on the following two options :
    - Option A: a single Primary Care Trust coterminous with Hampshire County Council that will comprise the seven existing Primary Care Trusts;
    - Option B: three Primary Care Trusts within Hampshire County Council replacing the seven existing Primary Care Trusts.
- the creation of a single organisation to commission and manage all health services on the Isle of Wight. This organisation will oversee the commissioning and management of acute hospital services, mental health services, community services, primary care services and ambulance services.

1.5 Work will continue with the Isle of Wight Council to integrate health and social care and it is envisaged in the longer term that an organisation covering health and social care may be established when the NHS on the Isle of Wight recovers financial balance. This will be subject to a separate further consultation at the appropriate time

1.6 For legislative purposes, the new organisation will be a Primary Care Trust and will replace the current Isle of Wight Primary Care Trust and Isle of Wight Healthcare NHS Trust. The Local Authority would continue to commission social care services, but the NHS and Local Authority partners would use the Health Act flexibilities and Local Area Agreements to develop joint approaches to the commissioning and provision of health, healthcare, social care and wellbeing for the local population.

1.7 The proposals for the Isle of Wight would see the future dissolution of the Isle of Wight Healthcare NHS Trust. Responsibility for making decisions on the dissolution of NHS Trusts rests with the Secretary of State and responsibility for consulting on this has been delegated through this process to the Hampshire and Isle of Wight Strategic Health Authority.

1.8 A separate consultation document is being issued on the configuration of Ambulance Services and views are being sought on whether Ambulance Services should continue to be managed by the new organisation or by the proposed new Ambulance Trust covering Berkshire Buckinghamshire Hampshire and Oxfordshire.

2 LOCAL CONSULTATION

Timetable for Local Consultation

2.1 The following table sets out the timetable for consultation.

DATE	ACTIVITY
14th December 2005 :	Three local consultations begin on the reconfiguration of Strategic Health Authorities, Primary Care Trusts and Ambulance Trusts.
22nd March 2006:	Consultation ends.
12th April 2006:	Submit findings from consultation to the Secretary of State for Health.

2.2 This is part of a wider consultation on Strategic Health Authority, Primary Care Trust and Ambulance Service configuration across the whole of England.

Copies of the Consultation Document

2.3 Information about this consultation is being distributed widely, including to the following:

- Members of Parliament;
- County, unitary and district local authorities;
- Health Overview and Scrutiny Committees;

- Patient and Public Involvement Forums;
- Primary Care Trusts and NHS Trusts in Hampshire and the Isle of Wight;
- Private health care providers in Hampshire and the Isle of Wight;
- Universities in Hampshire and the Isle of Wight;
- Unions and Professional Associations including Local Medical, Dental, Ophthalmic and Pharmaceutical Committees;
- Town and Parish Councils;
- Councils for Voluntary Service;
- NHS staff and primary care practitioners in Hampshire and the Isle of Wight;
- Public libraries in Hampshire and the Isle of Wight.

2.4 Printed copies of this consultation document and a summary leaflet are available:

In writing from: Director of Corporate Affairs
Hampshire and Isle of Wight Strategic Health Authority
Oakley Road
Southampton SO16 4GX

By e-mailing us: consultation@hiowha.nhs.uk

2.5 The consultation document is also available from our consultation website at **hiow.nhs.uk/cplnhs**

Making Your Views Known

2.6 Views and comments on these proposals should be sent:

In writing to: Sir Ian Carruthers OBE
Chief Executive
Hampshire and Isle of Wight Strategic Health Authority
Oakley Road
Southampton SO16 4GX

By e-mail to: consultation@hiowha.nhs.uk

By fax to: 023 8072 5587 marked "**CPLNHS consultation**"

2.7 We will also be organising local meetings to discuss these proposals. Details of these meetings will shortly be available from the above address and from our consultation website at **hiow.nhs.uk/cplnhs**. They will also be advertised in the local press.

2.8 We look forward to hearing from you and receiving your comments.

APPENDIX B

Hampshire and Isle of Wight NHS
Strategic Health Authority

CONSULTATION ON NEW STRATEGIC HEALTH AUTHORITY ARRANGEMENTS IN HAMPSHIRE AND THE ISLE OF WIGHT

ENSURING A PATIENT-LED NHS

CONTENTS

For blind and partially sighted people:

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Foreword

In July 2005, the Department of Health published a challenging programme to improve the commissioning of services. But it is a challenge we must all meet if we are to put in place the truly patient-led, high quality healthcare service we know the NHS can be.

Spending in the NHS is rising rapidly - from £33 billion in 1997/98 to over £90 billion in 2007/08. This increased investment, together with the hard work of NHS staff and the reforms we have introduced, is transforming our hospitals by reducing waiting times and lists, improved accident and emergency services and more up-to-date buildings.

Although these are improvements of which we should be rightly proud, we know there is more that needs to be done. In essence we need to ensure the NHS provides a service fit for the 21st century.

To deliver a patient-led NHS we need a strong commissioning function that can lead transformation in the NHS. The NHS has recognised it cannot do this alone and therefore needs the support of local authorities and the voluntary and independent sectors.

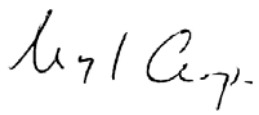
Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

In brief, we need stronger Primary Care Trusts to design, plan and develop better services for patients, to work more closely with local Government, and to support good general practice. The Primary Care Trust will be the custodian of the taxpayer's money, working to ensure that the NHS gets the best value for the public purse.

We need to enable GPs to play a full role in developing better services for patients. This is why the roll out of Practice Based Commissioning is so important.

This new approach to commissioning is about giving the levers to make services more responsive to patients to those best placed to use them. It is about enabling resources to be freed up to reinvest in new services.

Since July, Strategic Health Authorities have been discussing with their local communities how to reconfigure both themselves and Primary Care Trusts. This document explains the suggested changes to your communities. I encourage you to have your say in this process to help build organisations that are fit to deliver this exciting vision for patients.



Sir Nigel Crisp KCB

Chief Executive, Department of Health and NHS

Preface

Commissioning a Patient-led NHS

This paper sets out proposals for the configuration of Strategic Health Authorities in the South East as part of the implementation of 'Commissioning a Patient-Led NHS'. These proposals alongside those for Primary Care Trusts and Ambulance Services will have significant implications for planning of health and commissioning of health services in the South East and have been developed following discussion across the health communities.

Your views and those of your organisation are sought on proposals for the replacement of the four existing Strategic Health Authorities in the South East with:

- either one Strategic Health Authority covering the whole of the South East;

or

- two Strategic Health Authorities, one based on the existing Hampshire and Isle of Wight and Thames Valley (including; Berkshire, Buckinghamshire and Oxfordshire), and one based on Kent and Medway and Surrey and Sussex Strategic Health Authorities.

Your views and comments are invited on the way forward and these should be sent to us by 22 March 2006.

Professor Jonathan Montgomery
Chairman

Sir Ian Carruthers OBE
Chief Executive

Hampshire and Isle of Wight Strategic Health Authority

SECTION 1

BACKGROUND TO
'COMMISSIONING A PATIENT-LED NHS'

This section sets out the background to "Commissioning a Patient-Led NHS"

1 YOUR NHS

1.1 Important new changes in the way your local NHS is structured and managed are planned. Your views will be crucial.

1.2 The proposals at the heart of this consultation will mean new geographical boundaries for Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) across England. The solutions proposed in this document will be unique to your area and will reflect the needs, preferences and health priorities of your local communities.

1.3 Why is this so important? While most of us are passionate about the sort of services we receive in the NHS – the quality, speed and convenience of care – how many of us want to get tied up with organisational hierarchies and the mechanics of the service? We, as patients, want to receive the care we need, at the time we need it and in a setting that is convenient to us.

1.4 The answer is simple. The changes proposed here will be the defining factor in whether the NHS can sustain the huge improvements it has already achieved and go on to realise its fundamental aim: to deliver a better, more responsive health service that gives people the control and choice they have a right to expect as patients and taxpayers.

2 ACHIEVING A PATIENT-LED NHS

2.1 Becoming a truly patient-led service is the next big challenge for the NHS. But what does it really mean for patients and how will we make it happen?

2.2 As a starting point the Government has captured and shared this vision in its cornerstone document, *Creating a Patient-led NHS*. It describes what patient-led services actually look like from a patient's point of view. Everyone involved in a patient-led service makes sure they:

- respect people for their knowledge and understanding of their own clinical condition and how it impacts on their life;
- support them in using this knowledge to manage their long-term illnesses better;
- provide people with the information and choices that allow them to feel in control and fit their care around their lives;
- treat people with dignity and respect, recognising them as human beings and as individuals, not just people to be processed;
- ensure people always feel valued by the health and care service and are treated with respect, dignity and compassion;

- understand that the best judge of an individual's experience is the individual;

- ensure that the way clinical care is booked, communicated and delivered is as trouble free as possible for the patient and minimises the disruption to their life; and

- explain what happens if things go wrong and why, and agree the way forward.

2.3 These are the sort of benefits we can all understand and that we want for ourselves and our families. They are the tangible end result of policies already in place to introduce:

- patient and client choice – not just in hospitals but in primary and social care too;

- better, more integrated support and care for people with long-term illnesses;

- a wider range of services in convenient community settings;

- faster, more responsive emergency and out-of-hours services; and

- more support to help people improve and protect their own health.

2.4 But for the local organisations working hard to put all these improvements in place, the system itself can often get in the way – including barriers between different professional groups and organisational boundaries.

2.5 This is why we are consulting on these major changes to how your local NHS is structured. Making a patient-led NHS a reality right across the NHS and other agencies will take more than a shared aspiration: it will need change. New standards of care; new skills, freedoms and incentives for staff; new systems for planning, securing and paying for services; and new organisations.

2.6 The NHS is not coming to this challenge from a standing start. There have been enormous changes in the NHS since the publication of the *NHS Plan* in 2000 and huge progress towards providing better, faster and more convenient healthcare.

2.7 In the ten years from 1997, levels of investment in the NHS in staff and services will have almost tripled, from £33 billion to more than £90 billion. The NHS has recognised it cannot do this alone. It will also need the support of local authorities and the voluntary and independent sectors, who within 2004-5 accounted for £17.5 billion of this expenditure, employing over 1.4 million people. Along with the hard work and commitment of the 1.3 million NHS staff, this investment has

genuinely transformed the quality of care people are receiving every day in health and social care:

- waiting times for hospital treatment have dropped significantly;
- fewer people are dying from killers such as cancer and heart disease;
- accident and emergency services are faster and better; and
- people now have real choice about when and where they receive their hospital treatment.

2.8 But this is only part of the journey. As much as 90 per cent of all our contact with the NHS happens not in hospitals but in primary care and community settings – that's in GP surgeries, community clinics, walk-in centres and even our own homes. And it's this reality that is driving a huge challenge for the NHS: to change our health service from one that does things 'to' and 'for' people, to one that works 'with' people – involving patients and carers, listening and responding to what they say.

2.9 Choice and diversity of services are as important for patients in primary care, as they are for those needing hospital treatments. And one of the best ways to give patients more choice and say about their local services is to give the healthcare professionals closest to them – GPs and their practice teams – a front-line role in securing the best possible services on their behalf. This is called 'Practice Based Commissioning'.

2.10 It will mean that GPs have more say in deciding how health services are designed and delivered – ensuring they reflect the choices their patients and communities are making. It will encourage fresh thinking and trigger new ideas for the way services are run.

2.11 We need stronger Primary Care Trusts to design, plan and develop better services for patients, to work more closely with local Government, and to more effectively support good general practice. In short, PCTs need to strengthen their commissioning function.

3 WHAT DO WE MEAN WHEN WE TALK ABOUT 'COMMISSIONING'?

3.1 At its simplest 'commissioning' is the term used to describe the processes by which the NHS spends its money. It is the processes by which the NHS plans and pays for services while assuring their quality, fairness and value for money.

3.2 Strong, imaginative commissioning is essential for creating a patient-led NHS. Commissioning will stimulate the development of a wider range of services in response to the preferences, lifestyles and needs of the local

population. At the same time commissioning will help ensure that NHS resources are spent on the areas of most need.

3.3 In the past commissioning has largely been conducted through high level planning and block (fixed cost) contracts between purchasers and providers of care. This has given financial certainty in the system, but few incentives to understand and respond to the needs and preferences of patients.

3.4 This is now changing. A new financial system, Payment by Results, means that hospitals are paid a standard fee for the patients they treat. Money will truly follow patients. Patient choice will see patients deciding on where they want to be treated, determine the referrals to individual hospitals, and eventually how many patients each hospital treats.

3.5 Since April 2005 GPs have been able to become more involved with commissioning through an approach known as 'Practice Based Commissioning'. The aim is to have universal coverage of Practice Based Commissioning by the end of 2006.

3.6 These changes provide an opportunity and a need to change the way we approach commissioning and the organisational arrangements to support commissioning.

4 THE WIDER PICTURE

4.1 Under Practice Based Commissioning GPs and practice staff will have access to a commissioning budget and will lead developments to produce more responsive local services.

4.2 Practices will pay the national tariff for most hospital services, but crucially only for those services their patients use. Practice Based Commissioning will allow GPs and primary care professionals to develop and fund innovative community services as an alternative to hospital for some patients. GPs will have a much greater say in the services to be provided to their patients.

4.3 Primary Care Trusts will support and manage the operation of Practice Based Commissioning. They will, on behalf of their practices, provide practice budgets, clinical and financial information to help GPs and negotiate contracts for the services required.

4.4 Primary Care Trusts will play a crucial role in working with their practices to design, plan and develop better services for patients. They will conduct needs assessments of their local communities and work closely with local authorities so that the wider health and care needs of local communities are addressed. There are lessons concerning commissioning that can be learnt from local authorities.

4.5 The Primary Care Trust will be the custodian of the taxpayer's money, working to ensure the NHS maximises the benefits of its resources and secures high quality responsive services.

4.6 The focus for Strategic Health Authorities will be on building the new system of commissioning and then maintaining a strategic overview of the NHS in their area.

4.7 Strategic Health Authorities will continue to provide leadership and performance management to the NHS. They will be responsible for ensuring that key national objectives are delivered and that services are high quality, safe and fair. Taking forward this agenda will need good leadership, within both the NHS as well as other local services.

4.8 Over time, as we move towards all NHS Trusts achieving NHS Foundation Trust status, performance management will increasingly be focused on the commissioners of services.

5 WHAT DOES THIS MEAN FOR STRATEGIC HEALTH AUTHORITIES?

5.1 Developing diverse community services which give patients more choice, earlier diagnosis, and better support if they have long-term illnesses, will certainly mean major organisational changes for Strategic Health Authorities and Primary Care Trust.

5.2 Strategic Health Authorities will continue to provide an important range of functions, but will be better equipped for these through their:

- **numbers:** There is likely to be a smaller number of more streamlined SHAs. This is because they will be responsible for a reduced number of larger Primary Care Trusts, and a smaller number of NHS Trusts as more gain NHS Foundation Trust status (NHS Foundation Trusts are not accountable to Strategic Health Authorities);

- **boundaries:** Their boundaries will largely match those of Government Offices for the Regions, helping Strategic Health Authorities to work more closely and strategically with public sector partners to streamline services;

- **role:** The focus for Strategic Health Authorities will be on building the new system of commissioning and then maintaining a strategic overview of the NHS and its performance in their area. They will be responsible for ensuring that the organisations commissioning and providing local services are doing so in a way which meets the key national objectives of a healthier nation and care services which are high quality, safe and fair and responsive to changing circumstances.

6 THE STRATEGIC HEALTH AUTHORITY ROLE IN MORE DETAIL

6.1 As we continue to develop the health reform policies there may be additional roles and functions identified for Strategic Health Authorities. An initial view of the new Strategic Health Authority role is as follows:

- maintain a strategic overview of the NHS and its needs in their area;
- improve and protect the health of the population they serve by having a robust public health delivery system including emergency planning;
- provide leadership and performance management for effective delivery of government policy for health and health protection through NHS commissioned services;
- provide leadership for engagement of health interests in the development of strategic partnerships across the public sector (working with Government Offices of the Regions, Regional Assemblies, Skills Councils and Regional Development Agencies) to secure delivery of government policy;
- build strong commissioning processes, organisations and systems;
- ensure NHS Trusts are in a position to apply for NHS Foundation Trust status by 2008/09;
- work with regulators and external inspectorates to develop the local health community, including ensuring choice and plurality of provision and managing the consequences of clinical performance failure and patient safety breaches;
- promote better health and ensure that the NHS contribution to the wider economy is recognised and utilised at regional level;
- lead the NHS on emergency and resilience planning and Management;
- work closely with the Department of Health to inform and support policy development and implementation and handle routine Parliamentary, Ministerial and the Department of Health business;
- improvement of research and development strategic development and delivery in each health economy in conjunction with the Healthcare Commission and UK Clinical Research Network;
- provide an effective communications link with the Department of Health, facilitating clear and consistent messages.

6.2 The system of management of the health system will continue to develop and change as we fully implement Payment by Results and patient choice, and move towards greater plurality of provision through NHS Foundation Trusts and greater independent sector involvement.

6.3 The Department of Health has a significant programme of policy development work on the future regulation and management of the health system overall. Further guidance in 2006 will set out the implications of this work for Strategic Health Authorities, Primary Care Trusts and other NHS bodies.

7 PROTECTING STAFF

7.1 The proposals set out in this document mean important changes for staff working in the current Strategic Health Authorities and Primary Care Trusts. In what is likely to be an unsettling time, it will be vital to ensure that staff are fully consulted on the local proposals and have the opportunity to use their experience and creativity in shaping new services.

7.2 The new structure must also be implemented fairly and transparently in a way which protects the position of staff who transfer to other organisations, and gives them new opportunities to utilise their skills and experience.

7.3 The Department of Health have recently published a human resources framework to outline the relevant appointment processes for the new Strategic Health Authorities and Primary Care Trusts, and to support staff through these changes.

8 NEXT STEPS

8.1 This document is one of a series of separate consultation exercises on the proposed boundaries for each local Strategic Health Authority. Proposals for the new Primary Care Trust boundaries are also being consulted on at local level in a similar way.

8.2 The proposals, which follow, outline plans to create either one or two new Strategic Health Authorities from the present four in the south east region. They describe the important implications of these changes for staff, local people, the NHS and its partner organisations such as the voluntary sector.

8.3 Each Strategic Health Authority will be individually consulting its local stakeholders on the proposals. This consultation is undertaken by Hampshire and Isle of Wight Strategic Health Authority, Thames Valley Strategic Health Authority. Surrey Sussex and Kent and Medway Strategic Health Authorities are also consulting on the establishment of new Strategic Health Authorities in the South East.

8.4 A national consultation is also taking place on a proposed reconfiguration of Ambulance Trusts. Hampshire and the Isle of Wight Strategic Health Authority will be working with Thames Valley Strategic Health Authority on this. If you would like to know more about the proposals please contact the Directorate of Corporate Affairs at the Hampshire and Isle of Wight Strategic Health Authority to request a copy of the consultation document or alternatively it can be found on the Department of Health website.

8.5 No final decisions have yet been taken and this is your opportunity to genuinely influence the future shape of your local NHS services. At the end of the consultation, the SHA will report the results of the consultation to the Secretary of State for Health, who will then decide if the proposals can go ahead.

8.6 A full explanation of how to comment and by when is set out on pages 21 and 22.

SECTION 2

PROPOSALS FOR THE CONFIGURATION OF STRATEGIC HEALTH AUTHORITIES IN THE SOUTH EAST

This section sets out the proposals for the configuration of Strategic Health Authorities in the South East

1 PROPOSED NEW STRATEGIC HEALTH AUTHORITY ARRANGEMENTS

1.1 'Commissioning a Patient-led NHS' was published on 28 July 2005 and asked Strategic Health Authorities to develop proposals for the implementation of 'Commissioning a Patient-led NHS' in their local health community in consultation with Primary Care Trusts, NHS Trusts, Local Authorities, Patient and Public Involvement Forums, Local Professional Committees and other partner and stakeholder organisations.

1.2 This document sets out proposals for Strategic Health Authority arrangements in Hampshire and the Isle of Wight. This is one of three consultation documents supporting the implementation of 'Commissioning a Patient-led NHS' and focuses on the configuration of Strategic Health Authorities in the South East. Separate consultation documents are available that discuss arrangements for Primary Care Trusts and Ambulance Services in Hampshire and the Isle of Wight.

2 THE LOCAL AREA AND ITS PEOPLE

2.1 Hampshire and the Isle of Wight is in the region covered by the Government Office for the South East (GOSE).This is the largest Government Office area in the country stretching around London from Thanet in the southeast to Hampshire in the Southwest and to Aylesbury Vale, Buckinghamshire and Milton Keynes in the northwest. It covers a population of eight million people living in three million households and has 19 county and unitary authorities and 55 district council areas.

2.2 Hampshire and the Isle of Wight have a combined population of approx 1.8million people, the majority of whom live in the area served by Hampshire County Council (1.2m approximately). Unitary authorities serve the populations of Southampton City (approximately 220,000), Portsmouth City (approximately 190,000) and the Isle of Wight, (approximately 135,000).

3 HEALTH AND HEALTH CARE

3.1 The overall pattern of health in the South East is good and appears close to national norms but this obscures some areas of significant need and complex challenges. People living in the south east are both relatively high users of health services and report being significantly less satisfied with services than other areas of England. Despite its apparent prosperity there are a number of areas of deprivation, which also have a higher incidence of serious illness and early death.

3.2 Since 2002 there have been four Strategic Health Authorities in South East England:

- Hampshire and the Isle of Wight
- Kent and Medway
- Surrey and Sussex
- Thames Valley (covering the Counties of Berkshire, Buckinghamshire and Oxford)

3.3 Table 1 shows the local authority relationships and the population in existing Strategic Health Authorities and across the South East of England.

TABLE 1: RELATIONSHIPS BETWEEN LOCAL AUTHORITIES AND STRATEGIC HEALTH AUTHORITIES IN THE SOUTH EAST OF ENGLAND

LOCAL GOVERNMENT	STRATEGIC HEALTH AUTHORITY AREAS				
	Kent and Medway	Surrey and Sussex	Hampshire and Isle of Wight	Thames Valley	South East
Number of County Councils	1	3	1	2	7
Number of Unitary Authorities	1	1	3	7	12
Number of District Councils	12	23	11	9	55
Population	1.7m	2.5m	1.8m	2.2m	8.2m

4 PROPOSALS FOR THE FUTURE CONFIGURATION OF STRATEGIC HEALTH AUTHORITIES

4.1 Strategic Health Authorities face a new and challenging environment as mentioned earlier in this document with new policies being implemented in a number of areas. Ministers have set the framework for delivering a Patient- Led NHS. Clearly the wider changes mean it is appropriate to focus on the management changes to ensure future organisations are fit for purpose.

4.2 The following key criteria have been established for assessing proposals for future Strategic Health Authority configuration:

- consistency with the boundaries of the Government Office for the South East;

- significant savings in management and administrative costs for reinvestment in front line clinical services;

- enhanced effectiveness and *fitness for purpose* giving due consideration to the:

    - size and diversity of the area and population served;

    - number and complexity of health systems and organisations within them;

    - number and complexity of other partner organisations in the area with which the Strategic Health Authority will be expected to form effective functional relationships;

    - scale of the challenge to meet national performance and financial targets.

4.3 Two options for the configuration of Strategic Health Authorities in the South East have been considered against these criteria:

- one Strategic Health Authority for the South East replacing the existing four Strategic Health Authorities, coterminous with the Government Office of the South East;

- two Strategic Health Authorities for the South East, one covering Kent and Medway, Surrey and Sussex the other covering Hampshire and the Isle of Wight and Thames Valley. Both these proposed Strategic Health Authorities would be within the boundaries of the Government Office for the South East.

4.4 The criteria are considered in the Table 2.

TABLE 2: CRITERIA FOR STRATEGIC HEALTH AUTHORITY CONFIGURATION

	OPTIONS FOR STRATEGIC HEALTH AUTHORITY CONFIGURATION	
Criteria	**One Strategic Health Authority in the South East**	**A Strategic Health Authority for Hampshire, Isle of Wight and Thames Valley**
Government Office boundaries.	Precisely coterminous boundaries: one-to-one relationship between the Strategic Health Authority and the Government Office.	South East Region divided into two; a two-to-one relationship between Strategic Health Authorities and the Government Office.
Management cost savings.	Management cost savings estimated at £7 million.	Management cost savings estimated at £3.5 million.

Effectiveness: size and diversity.	Serves a diverse population of 8.2 million; very weak regional identity in the public mind; commentators perceive the proposed single Strategic Health Authority as very remote; difficult east-west communications.	The Hampshire, Isle of Wight and Thames Valley Strategic Health Authority would serve a population of 3.8 million; weak regional identity; proposed Strategic Health Authority perceived as less remote; good north-south and east-west communications.
Effectiveness: number and complexity of healthcare organisations.	As many as 18 proposed Primary Care Trusts, two Ambulance Trusts, 37 NHS Trusts, NHS Foundation Trusts or Care Trusts. At the limits of what can be effectively performance managed.	As many as 11 proposed Primary Care Trusts, one Ambulance Trust, 16 NHS Trusts, NHS Foundation Trusts or Care Trusts. Within the limits of what can be effectively performance managed.
Effectiveness: number and complexity of other partner organisations.	Seven County Councils, 12 Unitary Authorities, 55 Borough and District Councils, 83 Parliamentary Constituencies, three Medical Schools. A very challenging set of political and managerial relationships.	Three County Councils, ten Unitary Authorities, 20 Borough and District Councils, 39 Parliamentary Constituencies, two Medical Schools. A manageable set of political and managerial relationships.
Effectiveness: the scale of the financial recovery.	The combined deficit of the four Strategic Health Authorities at the end of 2004/05 was the greatest in the NHS. There is a very high risk that management capacity in one intermediate body covering the South East will be inadequate to deliver the recovery programme and maintain financial balance.	The management capacity in two intermediate bodies covering the South East is more likely to deliver the recovery programme and maintain financial balance.

4.5 The Department of Health has said it would like the new strategic health authorities to follow government office boundaries but that it may be appropriate in some cases to have more than one Strategic Health Authority relating to a single Government Office. Having considered the options carefully the four existing Strategic Health Authorities in the South East believe it would be appropriate to have two Strategic Health Authorities in the southeast in view of:

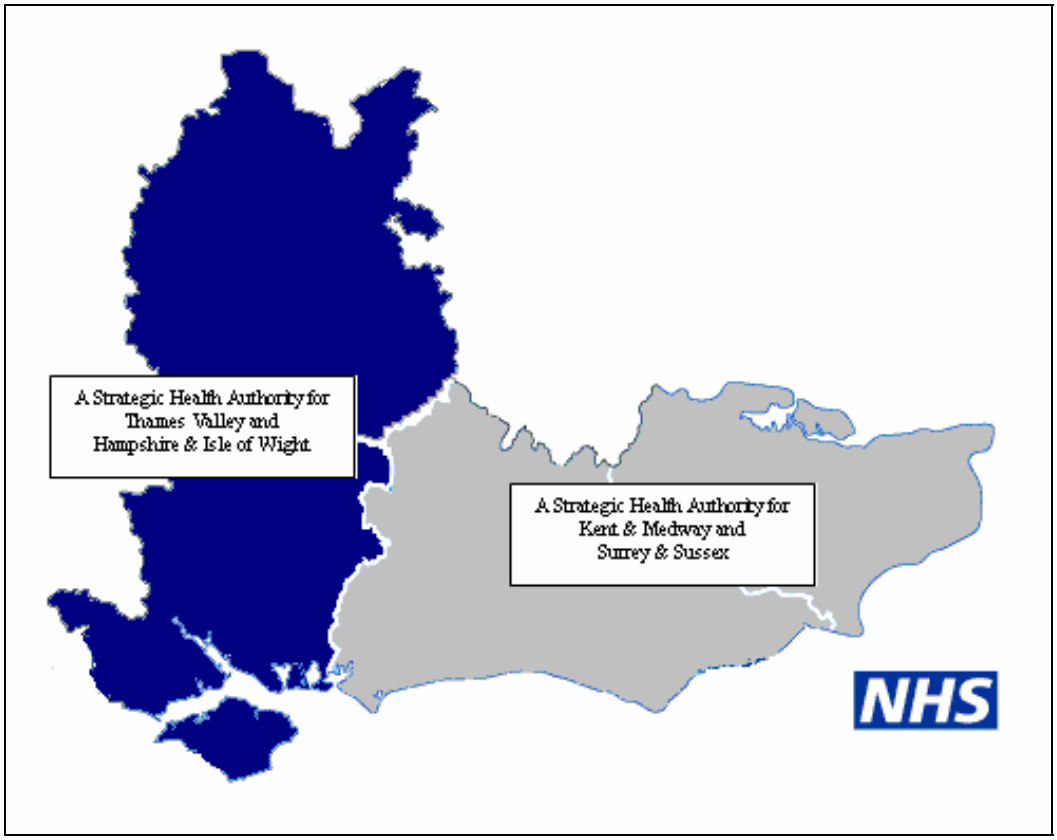
- **scale -** the south east government office area is the highest and most densely populated of the Government Office Regions - and is set to undergo further significant growth;
- **population profile** - the socio economic and demographic mix creates significant health challenges;
- **complexity -** it would be very difficult for one organisation to develop effective working relationships with so many health and other organisations in such a large area;

- **systems challenges -** health organisations in the south east have to tackle some of the most challenging financial and performance issues in the country.

4.6 The four Strategic Health Authorities consider that a new Strategic Health Authority spread across the whole of the Government Office of the South East region would be less able to exercise leadership and improve health and health care than two authorities each supporting half the area.

4.7 Figure 1 provides a map showing two Strategic Health Authorities in South East England.

FIGURE 1: PROPOSED NEW STRATEGIC HEALTH AUTHORITIES IN SOUTH EAST ENGLAND



5 LOCAL CONSULTATION

Timetable for Local Consultation

5.1 The following table sets out the timetable for consultation.

DATE	ACTIVITY
14th December 2005 :	Three local consultations begin on the reconfiguration of Strategic Health Authorities, Primary Care Trusts and Ambulance Trusts.
22nd March 2006:	Consultation ends.
12th April 2006:	Submit findings from consultation to Secretary of State for Health

5.2 This is part of a wider consultation on Strategic Health Authority configuration across the whole of England.

Copies of the Consultation Document

5.3 Information about this consultation is being distributed widely, including to the following:

- Members of Parliament;
- County, unitary and district local authorities;
- Health Overview and Scrutiny Committees;
- Patient and Public Involvement Forums;
- Primary Care Trusts and NHS Trusts in Hampshire and the Isle of Wight;
- Private health care providers in Hampshire and the Isle of Wight;
- Universities in Hampshire and the Isle of Wight;
- Unions and Professional Associations including Local Medical, Dental, Ophthalmic and Pharmaceutical Committees;
- Town and Parish Councils;
- Councils for Voluntary Service;
- NHS staff and Primary Care Practitioners in Hampshire and the Isle of Wight;
- Public libraries in Hampshire and the Isle of Wight.

5.4 Printed copies of this consultation document and a summary leaflet are available:

In writing from: Director of Corporate Affairs
Hampshire and Isle of Wight Strategic Health Authority
Oakley Road
Southampton SO16 4GX

By e-mailing us: consultation@hiowha.nhs.uk

5.5 The consultation document is also available from our consultation website at **hiow.nhs.uk/cplnhs**

Making Your Views Known

5.6 Views and comments on these proposals should be sent:

In writing to: Sir Ian Carruthers OBE
Chief Executive
Hampshire and Isle of Wight Strategic Health Authority
Oakley Road
Southampton SO16 4GX

By e-mail to: consultation@hiowha.nhs.uk

By fax to: 023 8072 5587 marked "**CPLNHS Consultation**"

5.7 We will also be organising local meetings to discuss these proposals. Details of these meetings will shortly be available from the above address and from our consultation website at **hiow.nhs.uk/cplnhs**. They will also be advertised in the local press.

5.8 We look forward to hearing from you and receiving your comments.

APPENDIX C

Hampshire and Isle of Wight NHS
Strategic Health Authority

CONSULTATION ON THE RECONFIGURATION OF NHS AMBULANCE TRUSTS IN HAMPSHIRE AND THE ISLE OF WIGHT

ENSURING A PATIENT-LED NHS

This document sets out local proposals for the configuration of NHS Ambulance Trusts in Hampshire and the Isle of Wight and supplements the national consultation document "Configuration of NHS Ambulance Trusts in England"

CONTENTS

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or

E-mail us at: consultation@hiowha.nhs.uk

Foreword

This document sets out proposals for the configuration of Ambulance Services within Hampshire and the Isle of Wight and should be read in conjunction with the national consultation document "Configuration of NHS Ambulance Trusts in England" and alongside the local consultation documents on the proposed new Strategic Health Authority and Primary Care Trust configuration in the South East of England and Hampshire and the Isle of Wight respectively.

Your views and those of your organisation are sought on proposals for the reconfiguration of NHS Ambulance Trusts namely:

- that a new NHS Trust is created to provide an ambulance service across the Counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire;

- that in view of the special circumstances the responsibility for the management of the ambulance service remains on the Isle of Wight as part of the function of the proposed new body that will oversee the commissioning and management of all National Health Services on the Isle of Wight.

These proposals have been developed through discussions with local partner organisations and we now want to test these more widely. Your views and comments should be forwarded to us by 22nd March 2006.

Professor Jonathan Montgomery
Chairman

Sir Ian Carruthers OBE
Chief Executive

Hampshire and the Isle of Wight Strategic Health Authority

PROPOSALS FOR THE CONFIGURATION OF AMBULANCE SERVICES IN HAMPSHIRE AND THE ISLE OF WIGHT

This section sets out the proposals for the future organisation of Ambulance Services within Hampshire and the Isle of Wight

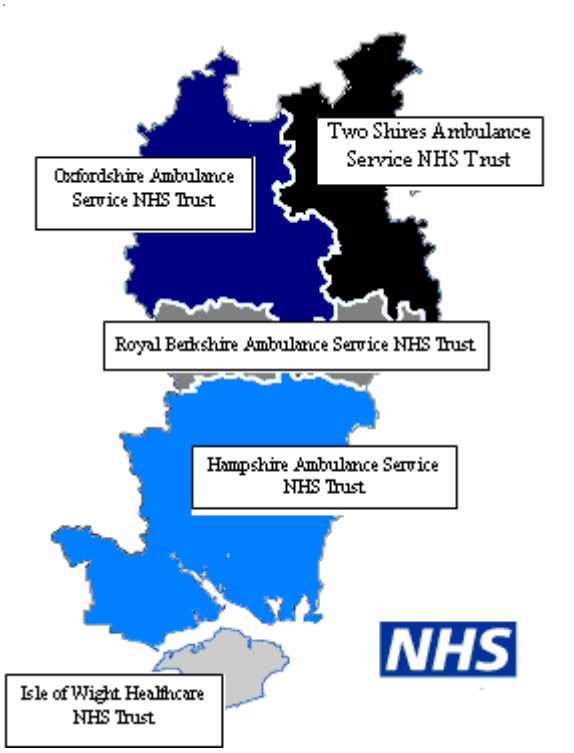
1 PROPOSALS FOR THE CONFIGURATION OF AMBULANCE SERVICES IN HAMPSHIRE AND THE ISLE OF WIGHT

1.1 It is proposed that a new NHS Trust is created to provide an ambulance service in the area covered by the proposed new Strategic Health Authority in Thames Valley and Hampshire. This new NHS Trust would encompass the following existing ambulance services:

- Royal Berkshire Ambulance NHS Trust;
- Buckinghamshire area within the Two Shires Ambulance NHS Trust;
- Hampshire Ambulance Service NHS Trust;
- Oxfordshire Ambulance NHS Trust.

1.2 The current configuration of the Ambulance Services NHS Trusts is shown in Figure 1.

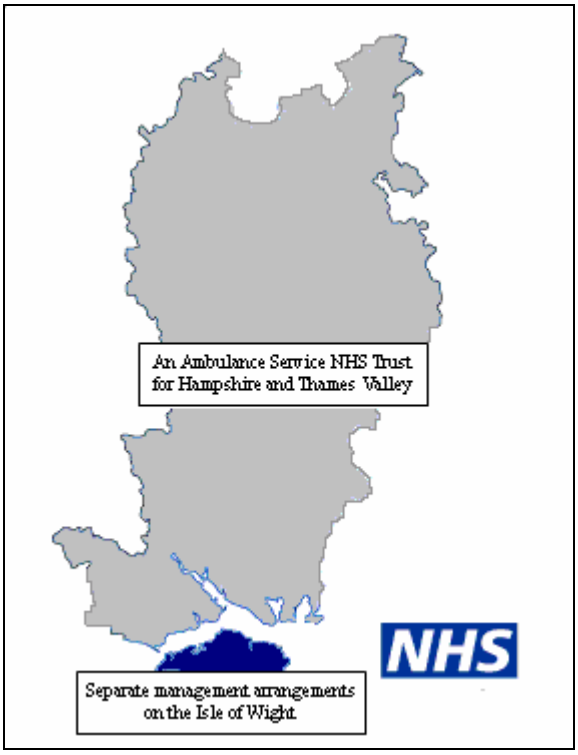
FIGURE 1: CURRENT AMBULANCE SERVICES IN THAMES VALLEY, HAMPSHIRE AND ISLE OF WIGHT



Note that Two Shires Ambulance NHS Trust also provides ambulance services in Northamptonshire

1.3 Currently the ambulance service on the Isle of Wight is managed by the Isle of Wight Healthcare NHS Trust and it is proposed that ambulance services should continue to be managed by the proposed single NHS organisation on the Isle of Wight. The proposed new NHS Trust for ambulance services and the management arrangements for the ambulance service on the Isle of Wight are shown in Figure 2.

FIGURE 2: FUTURE CONFIGURATION OF AMBULANCE SERVICES IN THAMES VALLEY, HAMPSHIRE ISLE OF WIGHT



1.4 The rationale for this proposed unique arrangement is the special circumstances of the Isle of Wight. These are detailed in Section 3 of the consultation document outlining proposals for the configuration of Primary Care Trusts in Hampshire and the Isle of Wight. In summary, the reasons include:

- the Island is relatively remote with restricted overnight transport to the mainland and disproportionately long travel times during the day. In many cases “local Services” inevitably means “services on the Isle of Wight” because of these commuting difficulties;
- the wish to ensure a service that is sensitive to the needs of the Isle of Wight population;
- the gains from close integration with urgent care and other health and social care services on the Island;
- the well developed proposals with strong local support to bring health and social care services together in a new organisation.

1.5 It is recognised that the resulting Ambulance Service will be much smaller than in any other part of the country and it would be performance managed and ‘benchmarked’ to ensure it remains fit for purpose.

1.6 Under this proposal the Isle of Wight would continue working with neighbouring NHS Ambulance Trusts to ensure the benefits of sharing best practice and

collaborating in areas such as emergency planning, audits, staff education and development and procurements are maintained and enhanced.

1.7 The alternative option would be for Ambulance Services on the Isle of Wight to be provided as part of the proposed NHS Ambulance Trust covering Berkshire, Buckinghamshire, Oxfordshire and Hampshire.

2 CONSULTATION PROCESS

2.1 These proposals are for organisational and managerial changes to the NHS Ambulance Trusts in Hampshire and the Isle of Wight and form part of the national proposals set out in the national consultation document “Configuration of NHS Ambulance Trusts in England”. They need to be considered alongside proposals for Strategic Health Authorities and Primary Care Trusts which are being consulted upon separately but simultaneously to this consultation.

2.2 These proposals will not change the way clinical services are delivered although they are intended to improve the way those services are run.

2.3 In summary the proposals for Hampshire and the Isle of Wight are:

- that a new NHS Trust is created to provide an Ambulance Service across the Counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire;

and

- that in view of the special circumstances of the Isle of Wight it is proposed to retain the management of the Ambulance Service on the Isle of Wight as part of the function of the proposed new organisation which would commission and manage National Health Services on the Isle of Wight.

2.4 The organisational proposals for the Isle of Wight would see the future dissolution of the Isle of Wight Healthcare NHS Trust, the current provider of the Ambulance Service. For legislative purposes, the new organisation will be a Primary Care Trust and will replace the current Isle of Wight Primary Care Trust and Isle of Wight Healthcare NHS Trust. Responsibility for making decisions on the dissolution of NHS Trusts rest with the Secretary of State and responsibility for consulting on this has been delegated through this process to the Hampshire and Isle of Wight Strategic Health Authority.

Timetable for Local Consultation

2.5 The following sets out the timetable for consultation.

DATE	ACTIVITY
14th December 2005	Three local consultations begin on the reconfiguration of Strategic Health Authorities, Primary Care Trusts and Ambulance Trusts.
22nd March 2006	Consultation ends.
5th April 2006	Submit findings from consultation on ambulance services to the Secretary of State for Health.

2.6 This is part of a wider consultation on Strategic Health Authority, Primary Care Trust and Ambulance Service configuration across the whole of England.

Copies of the Consultation Document

2.7 Information about this consultation is being distributed widely, including to the following:

- Members of Parliament;
- Police and Fire Authorities;
- County, unitary and district local authorities;
- Health Overview and Scrutiny Committees;
- Patient and Public Involvement Forums;
- Primary Care Trusts and NHS Trusts in Hampshire and the Isle of Wight;
- Private health care providers in Hampshire and the Isle of Wight;
- Universities in Hampshire and the Isle of Wight;
- Unions and Professional Associations including Local Medical, Dental, Ophthalmic and Pharmaceutical Committees;
- Town and Parish Councils;
- Councils for Voluntary Service;
- NHS staff and Primary Care Practitioners in Hampshire and the Isle of Wight;
- Public libraries in Hampshire and the Isle of Wight.

2.8 Printed copies of this consultation document and a summary leaflet are available:

In writing from: Director of Corporate Affairs
Hampshire and Isle of Wight Strategic Health Authority
Oakley Road
Southampton SO16 4GX

By e-mailing us: consultation@hiowha.nhs.uk

2.9 The consultation document is also available from our consultation website at **hiow.nhs.uk/cplnhs**

Making Your Views Known

2.10 Views and comments on these proposals should be sent:

In writing to: Sir Ian Carruthers OBE
Chief Executive
Hampshire and Isle of Wight Strategic Health Authority
Oakley Road
Southampton SO16 4GX

By e-mail to: consultation@hiowha.nhs.uk

By fax to: 023 8072 5587 marked "**CPLNHS consultation**"

2.11 We will also be organising local meetings to discuss these proposals. Details of these meetings will shortly be available from the above address and from our consultation website at **hiow.nhs.uk/cplnhs**. They will also be advertised in the local press.

2.12 We look forward to hearing from you and receiving your comments.

APPENDIX D

Configuration of NHS Ambulance Trusts in England

Consultation Document

Configuration of NHS Ambulance Trusts in England

Consultation Document

DH INFORMATION READER BOX

Policy HR / Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document Purpose	Consultation/Discussion
ROCR Ref:	**Gateway Ref:** 5600
Title	Configuration of NHS Ambulance Trusts in England – Consultation Document
Author	Department of Health
Publication Date	14 December 2005
Target Audience	Including but not limited to: ambulance trusts, SHAs, PCTs, NHS trusts, foundation trusts, emergency care leads, staff in ambulance trusts, voluntary organisations and other groups, trade unions, MPs, patient and public involvement forums and other groups representing patients and the public, local authorities including overview and scrutiny committees and appropriate local services including emergency services
Circulation List	
Description	Consultation
Cross Ref	**N/A**
Superseded Docs	**N/A**
Action Required	Response sent to SHA (see pages 22-23)
Timing	14 December 2005 – 22 March 2006
Contact Details	Ambulance Policy 11th Floor New King's Beam House 22 Upper Ground London SE1 9BW
For Recipient Use	

Your ambulance trust – your views

NHS ambulance trusts are the first and often the most important contact for the six million people who call 999 each year. The range of care they provide is also expanding, to take healthcare to patients who need an emergency response, providing urgent advice or treatment to patients who are less ill, and care to those whose condition or location prevents them from travelling easily to access healthcare services.

In order to support these improvements to patient care, the way that ambulance trusts are structured and managed needs to change. Your views are crucial in shaping these plans.

The changes proposed here will help ambulance trusts to deliver a better, more responsive, more efficient service that people have a right to expect as patients and taxpayers.

We want your opinions on how NHS ambulance trusts will be structured. Make sure you have your say.

Process

1 This consultation document has been produced to allow a wide range of individuals and organisations to discuss and contribute their views on proposals to re-shape NHS ambulance trusts in England.

2 This consultation will last 14 weeks. Please return all responses by 22 March 2006.

3 These proposed changes are purely administrative and managerial and do not involve changes to service provision. However, notwithstanding this point, we would welcome feedback from a wide range of individuals, groups or organisations that may have an interest in them, including but not limited to:

- NHS and social care organisations, including ambulance trusts
- staff in ambulance trusts
- patient and public involvement forums and other groups representing patients and the public
- voluntary organisations and other groups
- trade unions
- MPs
- local authorities, including overview and scrutiny committees and appropriate local services including emergency services.

4 Full details of how to let us know your views are set out on page 21 of this document.

Background

Progress to date

5 There have been enormous changes in the NHS since the publication of the NHS Plan in 2000, and huge progress towards providing better, faster, more convenient healthcare. In the ten years since 1997, levels of investment in the NHS in staff and services will have almost tripled, from £33 billion to more than £90 billion. Along with the hard work and commitment of 1.3 million staff, this investment and the reform that has accompanied it have genuinely transformed the quality of care people are receiving every day in the NHS:

- waiting times for hospital treatment have dropped significantly
- fewer people are dying from killers such as cancer and heart disease
- in accident and emergency (A&E) departments, over 19 out of 20 people are now seen and treated in less than four hours, with well over half in and out in less than two hours
- people now have real choice about when and where they receive their hospital treatment.

6 We have thousands of extra clinicians, including 15% more ambulance clinicians than in 1997. With two and a half times as many ambulance trainees as in 1997, the number of front-line ambulance clinicians is set to expand further. We are investing in new hospitals and GP surgeries, new ambulances and new ambulance equipment. At the same time we are taking steps to improve clinical governance, standards and patient safety. In other words, we are making sure we improve the quality as well as the quantity of the services we offer.

7 Ambulance trusts reach over three-quarters of critically ill patients (Category A) within eight minutes. This has been achieved in spite of annual increases in demand of about 6-7% a year. They answer almost six million 999 calls a year and attend almost five million incidents. They provide a range of other services, from information, monitoring and capacity management services for the local NHS, to providing primary care out of hours services and working as part of the primary care team to provide a range of healthcare services to patients in their local communities.

8 The range of care they provide is also expanding. A wider range of diagnostic equipment is now used, for example there is now a 12 lead electro-cardiogram (ECG)

on every ambulance enabling staff to more accurately assess and treat patients with cardiac-related chest pain. A wider range of medicines and interventions are also now used to save lives. Examples include the extension to emergency medical technicians and paramedics of the use of nebulisation to administer oxygen and other medicines to relieve severe breathing difficulties, in particular for asthmatics and sufferers of chronic obstructive pulmonary disease; or the administration of clot-busting drugs by paramedics to help minimise the effect of heart attack. Improved training and the development of new roles such as emergency care practitioners means that ambulance clinicians can better assess, diagnose and care for an increasing range of patients in their homes and at the scene.

How ambulance services will continue to improve

9 In 2004-2005 Peter Bradley CBE, Chief Executive of London Ambulance Service NHS Trust and National Ambulance Adviser, led a review of ambulance services (published in June 2005) that considered how we could build on this success. He was supported by a reference group of stakeholders including ambulance trust chief executives, clinicians and NHS managers. His report, *Taking Healthcare to the Patient: Transforming NHS Ambulance Services*[1] sets out a series of recommendations that will transform ambulance services over the next five years so that they can:

- offer more medical advice to callers who need urgent advice and support
- provide and co-ordinate an increasing range of other services for patients who need urgent care, including treatment at home
- work as part of the primary care team to help provide services and support to patients with long-term conditions
- continue to provide rapid, high-quality 999 services to emergency patients.

10 This will have the following benefits:

- patients will receive improved care, consistently receiving the right response, first time, in time
- more patients will be treated in the community, and potentially one million fewer people will go to A&E unnecessarily
- greater job satisfaction for staff because they can use their additional knowledge and skills to care for patients
- more effective and efficient use of NHS resources
- more people able to care for themselves and look after their health.

1 A copy of the review can be found at dh.gov.uk/assetRoot/04/11/42/70/04114270.pdf

Why changes to service organisation are necessary

11 90% of people's contact with the NHS happens not in hospitals but in primary care and community settings – in GP surgeries, community clinics, walk-in centres and in people's homes. It is better for patients and taxpayers if long-term conditions such as diabetes and heart disease, care for the elderly, and other injuries and illnesses that do not require hospital care are dealt with in the local community, rather than in hospitals.

12 The focus of services needs to shift more towards patient-centred care, towards prevention, and moving more services – like diagnostics, treatment of less serious illnesses and injuries, and other services – out of hospital wherever it is safe and effective to do so and ensuring all communities get the services they need. We need to continue to reduce administrative costs, releasing further resources for front-line care.

13 In order to achieve these improvements, one of the recommendations from the review was that ambulance trusts should be larger, and that there should be significantly fewer of them so that ambulance trusts would have the infrastructure, capacity and capability to deliver and sustain the changes needed.

14 The Department of Health accepted this recommendation, subject to full consultation about the number of trusts and how they would be structured. This is what this consultation focuses on. It is not about the services provided by ambulance trusts; it is about the size ambulance trusts should be and the geographical boundaries they should have.

15 We want to build on the improvements that the NHS has made, and create a truly patient-centred health service. But for the local organisations working hard to make this a reality, the system itself can often get in the way – including barriers between different professional groups and organisational boundaries.

16 That is why there are also consultations underway around the boundaries of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). Making a patient-led NHS a reality right across the NHS will take more than a shared aspiration: it will need change. New standards of care; new skills, freedoms and incentives for staff; new systems for planning, securing and paying for services; and new organisations.

17 At present, ambulance trusts in England are working very hard to care for their patients and to continually improve the services they deliver. But we know that there is more that they could do, if they had greater capacity to plan for tomorrow as well as dealing with today and if artificial barriers to integrated planning and service delivery such as lack of co-terminosity with other service providers and planners were removed.

18 Demand for ambulance services is increasing by around 6% a year. Ambulance trusts are increasing their capacity in response to this rise. However, this costs money. We need to ensure that taxpayers' money is being used to best effect, in order to maximise the impact on patient care. Our view is that this is not achieved through small organisations trying to deal with increasingly complex agendas, or through duplication of procurement, planning activities and support services but through collaboration, getting best value, and having the capacity to work in the depth necessary to deliver the best possible service to patients that makes the best use of their most valuable resource – their staff.

19 Performance and quality of service varies amongst the existing 31 ambulance trusts in England. The creation of 11 much larger organisations would provide us with an opportunity to lift the quality of the lowest, and set a new, high, benchmark where world class services are provided for patients across the country. It would mean that trusts would have the strategic capacity to provide high quality leadership while retaining the best of what can be delivered locally.

20 Ambulance trusts need to fit with NHS and local/regional organisational boundaries to support joint planning and service delivery of health services. In addition, they have a duty to work at a regional level to plan for events such as chemical, biological, radiological or nuclear incidents, terrorist attack or natural disasters. Having fewer, larger trusts would make it simpler to build the effective relationships with stakeholders that are so important in successfully dealing with major incidents and in the effective delivery of integrated patient-centred health services. Larger trusts have greater capacity and capability to respond to major incidents of all kinds and to maintain heightened levels of preparedness over longer periods. Larger trusts would also be more self-sufficient and would not need to rely so much on what are often complex agreements with other emergency and ambulance services to support them if there was a major incident.

21 Police forces and authorities in England and Wales have also recognised the benefits of larger organisations and are currently evaluating options for restructuring. It is expected that in view of the benefits of co-terminous boundaries with other agencies, new strategic forces should not cross Government Regional Office boundaries unless there is a compelling case to do so.

22 We believe that these proposals would put the NHS in the best position to provide more convenient, consistently high-quality and appropriate mobile healthcare for the people of England.

The proposal

23 This document sets out how we propose ambulance services in England should be structured in the future.

24 To enable the NHS to provide more convenient, consistently high-quality and appropriate mobile healthcare we propose that there should be 11 large, integrated ambulance trusts.

25 The benefits of this proposal are:

- more investment in front-line services
- more opportunities for staff
- improved planning for, and ability to handle, chemical, biological, radiological or nuclear incidents, terrorist attacks or natural disasters
- better equipped and trained workforce and the ability to adopt best practice quickly and consistently
- better use of resources to support high performance in all trusts
- greater capacity to carry out research and check that patient care is of the highest standard
- greater influence in planning and developing better patient services, both regionally and nationally
- greater financial flexibility and resilience, ability to plan and make longer-term investment decisions
- financial savings achieved through greater purchasing power and economies of scale
- improved contingency planning to make sure that the control room (where the 999 calls are received and the ambulances are dispatched) will stay fully operational regardless of any information technology or service disruption
- improved human resource management, organisational and leadership development
- increased investment in new technologies.

The proposed restructure

26 We have taken the following factors into account when developing these proposals.

Size – would they be able to deliver?

27 Ambulance trusts should be large enough to improve strategic capacity (including recruitment and retention of high calibre senior managers and leaders to transform their organisations) and to allow sustained investment in human resource management, service development and clinical leadership.

28 Ambulance trusts need to be sufficiently large to have the financial capacity and flexibility to deliver high-quality emergency ambulance services.

29 At the same time, trusts need as far as possible to serve a reasonably similar population and we need to be mindful of factors that affect how ambulance services are provided such as road networks, geography, population distribution and location of other health services.

30 If these proposed trusts are established, they would need to ensure that current good performance and practice is maintained and that good practice is spread across the proposed new trusts' areas for the benefit of all patients. They would also need clear local management and operational structures that reflect the different communities they serve. This would be a key consideration for the proposed new trusts (if established) when determining new management and operational arrangements and would need to be agreed with PCTs, as commissioners of ambulance services for their populations and discussed with other stakeholders.

Structure – how would they fit with other service providers?

31 Following the publication of *Commissioning a Patient-led NHS*[2], SHAs are proposing fewer, larger SHAs, generally following Government Regional Office boundaries. There are also proposals for changes to the configuration of PCTs. PCT and SHA configurations are the subject of separate consultation. To support joint planning and service delivery ambulance trusts should fit, as far as possible, with other NHS boundaries, particularly the proposed SHA boundaries. This does not necessarily mean an exact match: for instance, one SHA could potentially contain two ambulance trusts (or vice-versa).

2 dh.gov.uk/assetRoot/04/11/67/17/04116717.pdf

32 To support joint planning of emergency services, it also makes good sense for the trust areas to be in line with other government boundaries, in particular the Government Regional Offices. Ambulance trusts have a duty to plan at regional level, therefore larger trusts would have an advantage in building the relationships with stakeholders that are so important in successfully dealing with major incidents. Larger trusts would also be more self-sufficient and would not need to rely on other emergency services and ambulance services from outside their area to support them if there was a major incident.

33 The benefits of these proposals are set out in more detail later in this document.

Our recommendation

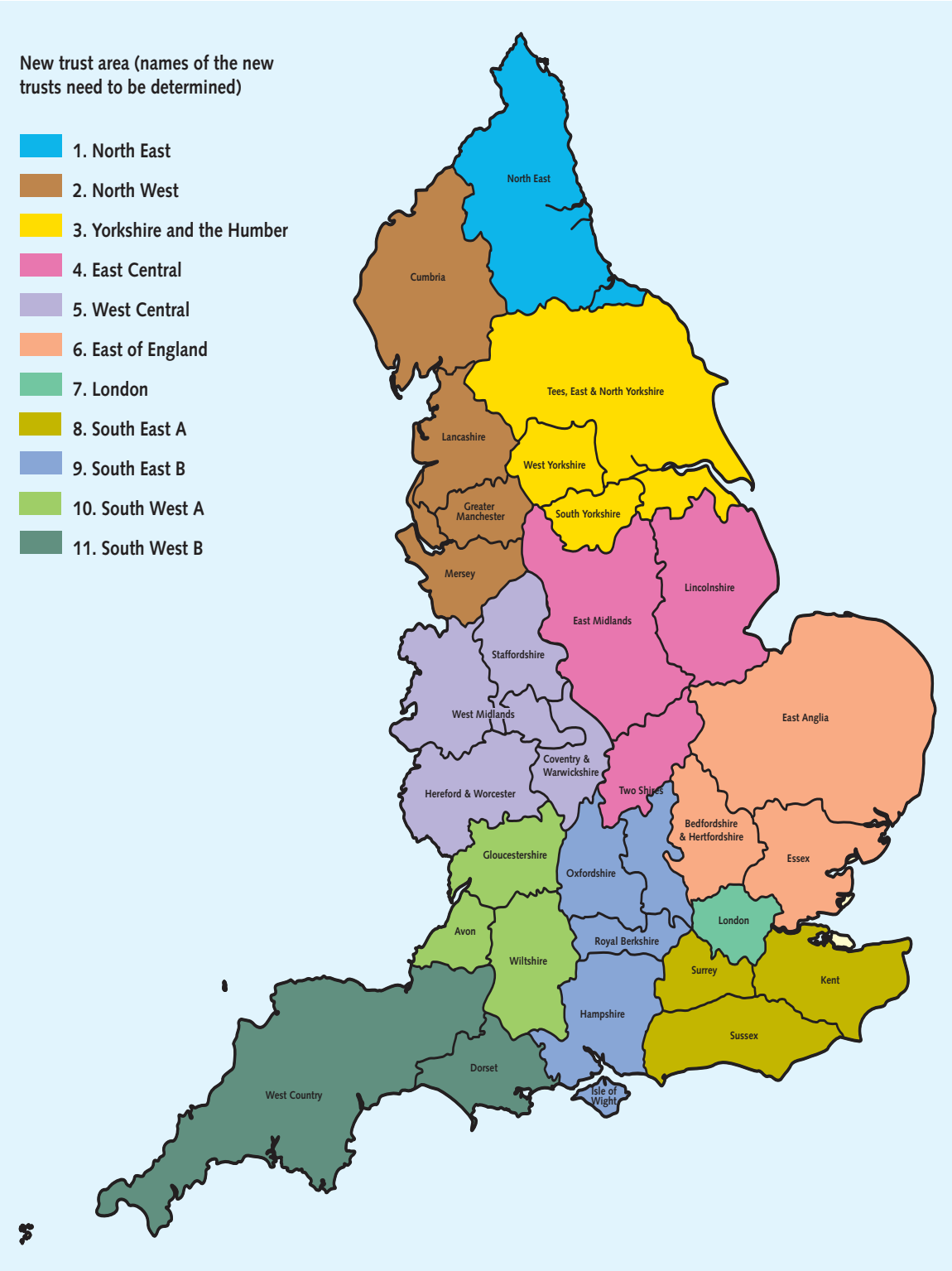
34 There should be 11 ambulance trusts organised around Government Office of the Region boundaries. For the most part, this has resulted in common boundaries with the Government Regional Offices. However, there are two areas which we have recommended splitting in two: the south east and the south west. The reasons for this are explained overleaf.

35 If these proposals are accepted, it is intended that the staff, property, rights and liabilities of the existing trusts will be transferred, for the most part, into the trusts that will be established in their place. Therefore, consultation with staff about the proposal to transfer the staff, property, rights and liabilities from existing ambulance trusts to the proposed trusts will take place over the next few months. The table and map overleaf set out the proposals and the likely destination of staff, property, etc if these proposals were adopted.

Proposed ambulance trusts

Current ambulance trusts (local authority areas specified in brackets where a current trust would be split)	New trust area (names of the new trusts need to be determined)
• North East • Part of Tees, East and North Yorkshire (Hartlepool, Middlesbrough, Redcar and Cleveland, Stockton-on-Tees)	1. North East
• Cumbria • Lancashire • Mersey Region • Greater Manchester	2. North West
• Part of Tees, East and North Yorkshire (North Yorkshire, York, East Riding of Yorkshire, Kingston upon Hull) • West Yorkshire • South Yorkshire • Part of Lincolnshire (North and North East Lincolnshire)	3. Yorkshire and the Humber
• East Midlands • Lincolnshire (excluding North and North East Lincolnshire) • Half of Two Shires (Northamptonshire only)	4. East Central
• West Midlands • Hereford & Worcestershire • Coventry & Warwickshire • Staffordshire	5. West Central
• East Anglian • Essex • Bedfordshire & Hertfordshire	6. East of England
• London	7. London
• Kent • Surrey • Sussex	8. South East A
• Hampshire • Royal Berkshire • Oxfordshire • Half of Two Shires (Buckinghamshire and Milton Keynes only) • Isle of Wight (see paragraph 39)	9. South East B
• Avon • Gloucestershire • Wiltshire	10. South West A
• Dorset • West Country	11. South West B

Proposed ambulance trust configuration



The South East Government Region

36 This is a large geographical area, which is densely populated. High levels of patients are often transferred to London. This makes it a challenging area to manage. Bringing eight ambulance trusts together would be a huge and complex undertaking. Therefore we are proposing that there should be two trusts in this region.

The South West Government Region

37 This is an area with low population compared with the other proposed trusts. However, it covers a large geographical area. The populations of the two proposed trusts, South West A and South West B, are very different, with for example Devon, Cornwall, Dorset and Somerset (South West B) experiencing large seasonal fluctuations in population.

38 In addition, patients, staff and other stakeholders in Avon, Gloucestershire and Wiltshire (South West A) have already indicated that merging these three ambulance trusts is the right solution for their area. Based on this feedback, ministers have accepted the SHA's recommendation that Avon, Gloucestershire and Wiltshire Ambulance Service NHS Trusts should form a single trust. Therefore, Avon, Gloucestershire and Wiltshire SHA will not be consulting again on this proposal as part of this consultation.

Isle of Wight

39 There will be separate consultation on the Isle of Wight to find out if there should be a single NHS organisation on the Isle of Wight responsible for all aspects of healthcare, including providing ambulance services on the island. Under this proposal, the Isle of Wight would continue working with neighbouring ambulance trusts to ensure the benefits of sharing best practice and collaborating in areas such as emergency planning, audit, staff education and development, and procurement were maintained and enhanced. The alternative (as shown on the map in this document) would be for ambulance services on the Isle of Wight to be provided as part of the proposed ambulance trust South East B.

London

40 The London SHAs will not be consulting on these proposals, as there are no changes proposed to how London Ambulance Service NHS Trust is structured.

Other areas

41 In some areas there may be specific boundary issues that are of local concern. These, as with any other issues, will be covered through the local consultation process, and views fed back by SHAs to the Department of Health, at the end of the consultation process. We need to hear your opinions on the structure of ambulance services so that a decision can be made. No decision has yet been made.

42 This table sets out some information about the proposed trusts:

New Trust	Expenditure on emergency ambulance services (2003-04)[3]	Resident population	Approx size of area covered (sq. miles)	Calls received 04/05 (000s)	Incidents attended 04/05 (000s)	Square miles per single incident
North East	£44m	2.5m	3,000	273	222	13
North West	£90m	7m	5,400	780	677	25
Yorkshire and the Humber	£71m	5.4m	7,500	560	460	16
East Central	£56m	3.4m	6,000	441	352	17
West Central	£75m	5.3m	6,000	608	482	12
East of England	£82m	6.2m	7,500	544	458	39
London	£145m	7m	600	1,154	827	1
South East (A)	£67m	4.5m	3,600	460	378	10
South East (B)	£49m	3.9m	4,600	343	266	17
South West (A)	£30m	2.1m	3,100	201	159	19
South West (B)	£52m	2.6m	6,300	259	244	26

3 Expenditure on emergency ambulance services, not ambulance trusts as a whole are listed here. Patient transport services and other expenditure by ambulance trusts are excluded. The reason for this is to provide a consistent basis for comparison. Not all ambulance trusts provide patient transport services across all their area, and some ambulance trusts provide other services for their area or for England. Patient transport services currently provided by ambulance trusts would be transferred to the proposed new ambulance trusts, should they be established.

The benefits

Overall benefits

43 These proposals would provide:

- improved patient care by raising the standards of service provided by all trusts to the level of the best
- reduced management costs, which would be re-invested over a number of years in front-line ambulance staff, equipment and services
- further improvements to the way that ambulance trust plan for and deal with terrorist attacks or natural disasters
- improved patient care through greater capacity to check that patients are receiving quality care, that clinical staff are performing to standard and to undertake research into areas for improvement
- better and more effective management, a better equipped and trained workforce and the ability to adopt best practice quickly and consistently
- greater financial flexibility and resilience, ability to plan and make longer-term investment decisions
- more opportunities for staff.

Benefits for patients

Raising standards

44 Fewer trust boards governing larger organisations would have the capability and capacity to develop strategic plans to deliver high-quality services both now and in the future. A wider strategic view would create the potential to improve standards by looking at more efficient use of resources across a region rather than on an individual county or trust basis. This would allow greater flexibility to use resources according to local need.

45 Larger trusts would have greater ability to check (audit) how well patient care is being provided and to use that knowledge to improve the quality of patient care.

More investment in front-line services

46 Having fewer ambulance trusts would have the potential to cut bureaucracy and improve procurement. Millions of pounds could be released for investment in front-line services once transition is complete.

47 This money would be re-invested in urgent care, providing more front-line staff, equipment and services as well as in strengthening the management teams needed to lead the proposed new ambulance trusts.

48 Larger trusts sharing boundaries with other NHS organisations would have more influence on the future direction of service provision across the NHS, particularly in terms of emergency and urgent care, for example integrating the development of new roles and ways of working that allow staff to offer better patient care, such as helping patients at the scene of the incident or in their homes or putting patients in contact with other healthcare services in their area.

49 There would also be opportunities for the trusts to become more efficient by sharing good practice and pooling resources. This would improve how equipment and supplies are managed and how vehicles are purchased and used. These larger organisations would have greater economies of scale, lower overhead costs and better opportunities to manage resources and greater flexibility to plan for the future.

Responding quickly and effectively to local needs

50 Existing trusts already cover diverse groups of patients with different healthcare requirements. Most trusts provide services to both urban and rural communities. Existing trusts already recognise that different communities have different requirements from their ambulance trusts and seek to deliver services tailored to particular communities within their area. For example, home visiting as part of the local primary healthcare team, community responders in rural areas, or primary care out of hours services. Responding to the needs of different local communities would continue and would also be developed further, supported by improved training, and with consistent standards and systems in place to ensure that the best possible care is provided to patients.

51 Ambulance trusts would remain accountable to the public in the way they provide their services. The current arrangements to make sure that patients and the public are consulted on changes to service provision, and that services are designed and provided to meet the needs and requirements of the populations they serve, would continue to apply. These include:

- overview and scrutiny committees (OSCs) consist of elected representatives for each local authority area. An OSC may review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority and must receive prompt responses from the NHS to any reports or recommendations it makes. Ambulance trusts will also have to consult OSCs on any proposal for a substantial development of the health service or a substantial variation in the provision of such service in the area of the local authority
- PCTs utilise detailed knowledge about the health needs of their population to ensure that services provided by ambulance trusts and other parts of the NHS and social care meet the needs of their population
- patients' forums consist of members of the public appointed to represent their local area. Their functions are, broadly, to monitor and review the range and operation of services of the trust for which they are established, to obtain the views of patients and carers about these matters and to make reports based on the review and the views of patients to the trust. They may also refer matters to their local OSC and to their national representatives, the Commission for Patient and Public Involvement in Health

- Section 11 of the Health and Social Care Act 2001 places a duty on NHS trusts, NHS foundation trusts, PCTs and SHAs to ensure that persons to whom they do or may provide services (or their representatives) are involved in or consulted on:

  (a) the planning of the provision of those services

  (b) the development and consideration of proposals for changes in the way those services are provided

  (c) decisions to be made by that body affecting those services.

52 Any future changes to service provision would be a matter for the proposed new trusts and would be subject to local consultation as outlined above.

Support good performance

53 Currently not all ambulance trusts meet key response time requirements set by the Department of Health. Some small trusts are high performers as are some large trusts. However, the proposed larger ambulance trusts could support sustained good performance by creating the potential for better use of existing resources, better equipment and the capacity to better exploit the latest technology. It could also enhance flexibility to direct resources to the most appropriate areas – including across current trust boundaries.

Benefits for staff

54 Staff in the ambulance service work day in, day out to deliver high-quality patient care. They are its most valued resource and will play a vital role in delivering change and improvements.

55 Staff need to have a supportive infrastructure in place to deliver the best possible care for patients. Larger trusts would offer the following benefits to staff:

- more money will be invested in staff, vehicles and equipment thanks to savings made on bureaucracy and overheads
- improved working environment for staff, to help them to carry out their demanding roles in the most effective way possible
- greater capacity to develop management and front-line staff and to invest more resources in education and development
- more opportunities for staff to extend their skills and work more flexibly
- more essential specialist staff than many current trusts can afford. This would include, for example, more advanced practitioners, improved clinical audit and research teams
- greater scope to improve clinical leadership and provide clinical supervision and direction for staff. A larger organisation will be more financially and organisationally viable and able to provide a more stable environment for staff with access to a wide range of services to support them in their clinical work
- more employment opportunities leading to increased retention of staff and greater opportunities for career progression.

56 We are fully aware that any organisational change can be difficult for staff. If the proposals go ahead, everything possible will be done to ensure a rapid, smooth transition for staff into the new organisations.

Savings for re-investment in front-line services

57 Benefiting patients is at the heart of these proposals. These changes are not being proposed to save money, but to improve the quality of service provided to patients by re-investing resources where they will make the most difference for patients.

58 Nevertheless, estimates indicate that if these proposals were implemented, after transition costs, millions of pounds a year could be released for re-investment in patient care and staff, equipment and services.

59 There would need to be investment in creating and running these new organisations – but we believe that this investment will be worth it.

Reduced overheads

60 How overheads would be reduced would be a matter for each of the proposed new ambulance trusts to determine. Some examples of how this might happen include:

- reductions in the senior management costs of running 31 separate organisations
- fewer boards, with fewer executives, chairs and non-executive directors. There will be some initial costs associated with early retirement and redundancy, but in the long term this offers the greatest potential in real savings
- reducing duplication between trusts in terms of management services, project management and information technology
- fewer headquarters will mean savings in relation to rent, rates, heat, light and power
- better purchasing arrangements. Some of this will be done at a national level with single procurements to save money and get better contracts, some at trust level
- larger budgets, providing greater flexibility to invest in the future
- common technology
- potential for sharing resources, e.g. control room and call answering functions when and where appropriate.

Re-investment

61 This would be a matter for the new ambulance trusts in discussion with their PCTs. Any money saved will be re-invested directly into urgent care services that benefit patients. This could include:

- more staff and services to support front-line services
- staff training and education giving them the competency to do more detailed assessments and treat a wider range of patients at the scene and to provide clinical advice and help to patients over the phone
- equipment and vehicles.

62 Money would also be used to invest in the new organisation and management team to make sure it has the leadership capacity and capability to deliver the recommendations set out in *Taking Healthcare to the Patient*, and to meet increasing demand from patients.

What happens next?

63 This document is intended to form the basis for consulting with a wide range of individuals and organisations on the proposals to create 11 ambulance trusts in England.

64 SHAs will co-ordinate consultation in their areas in order to give as many people the opportunity to participate as possible.

65 This document will be available on the internet at dh.gov.uk/consultations and will be distributed by SHAs to interested groups and individuals.

66 If you would like to give a view on the proposals you can do so by writing to, or e-mailing your SHA at the addresses overleaf.

67 **The deadline for all responses is 22 March 2006.**

68 Once the consultation period has ended, responses will be collated, summarised, and put to Department of Health ministers to support them in making a final decision on ambulance trust boundaries.

Proposed trust	Postal address for sending feedback	E-mail address for sending feedback	Other contact details
North West	Jean Scott Consultation Office, FREEPOST, North West NHS Consultations	consult@cmha.nhs.uk	Freephone: 0800 389 1366
North East	David Flory County Durham & Tees Valley SHA, Teesdale House, Westpoint Road, Thornaby, Stockton-on-Tees, Cleveland TS17 6BL	carole.langrick@cdtvha.nhs.uk	Tel: 01642 666755
Yorkshire and the Humber	Jeremy Clough FREEPOST, North & East Yorkshire and Northern Lincolnshire SHA, St John's House, Innovation Way, York Science Park, Heslington, York YO10 5NY	AmbulanceConsult@neynlha.nhs.uk	Tel: 01904 724500 Fax: 01904 427096
East Central	Freepost RLYT-HCXH-ZEZA Ambulance Consultation, Trent SHA, Nottingham NG10 5QG	ambulanceconsultation@tsha.nhs.uk	
West Central	David Nicholson CBE Commissioning a Patient-Led NHS, West Midlands Consultation Office, PO Box 2675, Stafford ST16 9BW	wmconsultation@sasha.nhs.uk	Tel: 0845 2577045 Fax: 0845 2577046
East of England *Bedfordshire & Hertfordshire:*	Ruth Davison Bedfordshire & Hertfordshire SHA, Tonman House, 63-77 Victoria Street, St Albans, Hertfordshire AL1 3ER	capln@bhsha.nhs.uk	
Essex:	Wendy Smith Essex SHA, Swift House, Hedgerows Business Park, Colchester Road, Chelmsford, Essex CM2 5PF	enquiries@essexsha.nhs.uk	Tel: 01245 397635 Fax: 01245 397631
Norfolk, Suffolk & Cambridgeshire:	Consultations Co-ordinator Norfolk, Suffolk & Cambridgeshire SHA, Victoria House, Capital Park, Fulbown, Cambridge, Cambridgeshire CB1 5XB	consultation@nscsha.nhs.uk	Tel: 01223 597567 Fax: 01223 597686

Proposed trust	Postal address for sending feedback	E-mail address for sending feedback	Other contact details
South East A	Ambulance Consultation Kent and Medway SHA, FREEPOST MA1339, Preston Hall, Aylesford ME20 7BR	consultationcpl@kentmedway.nhs.uk	Tel: 01622 713163 Fax: 01622 713116
South East B *Thames Valley:*	Freepost RLYT-TYSG-THTA Nick Relph, Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Cowley, Oxford OX4 2LH	cplfeedback@tvha.nhs.uk (please title your email 'Ambulance Consultation')	Fax: 01865 337099 marked 'Ambulance Consultation' Text: 07775 544974
Hampshire & the Isle of Wight:	Sir Ian Carruthers Hampshire and Isle of Wight SHA, Oakley Road, Southampton SO16 4GX	consultations@hiowha.nhs.uk	Fax: 02380 725587 marked 'CPL Consulation'
South West B *Devon and Cornwall:*	Ian Williams South West Peninsula SHA, Peninsula House, Kingsmill Road, Tamar View Industrial Estate, Saltash, Cornwall PL12 6LE	ian.williams@swpsha.nhs.uk	
Dorset and Somerset:	Sir Ian Carruthers Dorset and Somerset SHA, Wynford House, Lufton Way, Lufton, Yeovil, Somerset BA22 8HR		
National stakeholders	Ambulance Consultation 11th Floor, New King's Beam House, 22 Upper Ground, London SE1 9BW	emergencycare@dh.gsi.gov.uk	

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The ambulance consultation document can be found on the internet at dh.gov.uk/consultations

A version of the document is available in French, Turkish, Punjabi, Gujarati, Urdu, Bengali, Chinese, Vietnamese, Arabic and Hindi. The document is also available as an English audio-cassette tape, in braille and large print. Please call 0800 298 3009 or email brian.caves@k-international.com to request a copy.

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