Commissioning a Patient Led NHS
West Midlands Consultation Office
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Staffordshire
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Tel : 0845 257 7045
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14 December 2005

Dear Colleague

PRIMARY CARE TRUSTS CONFIGURATION

Enclosed with this letter is a Consultation document on the new boundaries for Primary Care Trusts in Birmingham and the Black Country. Consultation will take place on a nationwide basis from 14 December until 22 March 2006.

This consultation relates to change to organisational boundaries and does not include any proposals for service change. Following approval from the Department of Health we are consulting on two proposals in line with *'Commissioning a Patient-led NHS'*:

Option 1 to create eight PCTs:

Bring together the current three PCTs of Rowley Regis and Tipton, Wednesbury and West Bromwich, Oldbury and Smethwick to form one PCT covering Sandwell local authority area.
Bring together the current two PCTs of Dudley, Beacon and Castle and Dudley South to form one PCT covering Dudley local authority area.
Bring together North Birmingham PCT and East Birmingham PCT to form one PCT.
The five PCTs of South Birmingham PCT; Heart Of Birmingham PCT; Wolverhampton City PCT; Walsall PCT; Solihull PCT remain as currently configured.

Option 2 to create six PCTs:

Bring together the current three PCTs of Rowley Regis and Tipton, Wednesbury and West Bromwich, Oldbury and Smethwick to form one PCT covering Sandwell local authority area.
Bring together the current two PCTs of Dudley, Beacon and Castle and Dudley South to form one PCT covering Dudley local authority area.
Bring together North Birmingham PCT; East Birmingham PCT; South Birmingham PCT and Heart of Birmingham PCT to form one PCT covering the Birmingham City local authority area.
The three PCTs of Wolverhampton City PCT; Walsall PCT; Solihull PCT remain as currently configured.

We are keen to hear your views on both of these options.

I can assure you all comments received on or before 22 March will be included in the consultation process.

The deadline for all responses is 22 March 2006

Please send your comments to:

Mr David Nicholson CBE
Commissioning a Patient-led NHS
West Midlands Consultation Office
PO Box 2675
Stafford
ST16 9BW

Or by e mailing **wmconsultation@sasha.nhs.uk**

Further copies of the document can be obtained by writing to the address above, by telephoning 0845 257 7045, by e mailing **wmconsultation@sasha.nhs.uk** or on line at **www.nhswestmidlands.org.uk**

We can make arrangements to help those for whom English is not the preferred language. Please contact us by one of the above methods.

I look forward to receiving your comments.

Yours faithfully,

David Nicholson CBE
Chief Executive

Birmingham and The Black Country Strategic Health Authority
Shropshire and Staffordshire Strategic Health Authority
West Midlands South Strategic Health Authority


Consultation on new Primary Care Trusts arrangements in Birmingham and the Black Country

Ensuring a Patient-led NHS

NHS

Primary Care Trust Consultation

The consultation on proposals to establish new Primary Care Trusts in England will take place on a nationwide basis for 14 weeks ending on 22 March 2006. Please let us have your comments. We guarantee comments received on or before this date will be included in the consultation process.

You should send your responses to:

Mr David Nicholson CBE
Commissioning a Patient-led NHS
West Midlands Consultation Office
PO Box 2675
Stafford
ST16 9BW

Or by emailing wmconsultation@sasha.nhs.uk

Further copies of the document can be obtained by writing to the address above, by telephoning 0845 257 7045, by emailing wmconsultation@sasha.nhs.uk or online at www.nhswestmidlands.org.uk

We can make arrangements to help those for whom English is not the preferred language, or require this document in Braille or large print. Please write to the address above or call **0845 257 7045.**

إذا لم تكن اللغة الإنجليزية هي لغتك الأولى أو كنت ترغب في أن يكون هذا المستند مكتوباً بطريقة بريل أو مكتوباً بخط كبير ، فالرجاء الاتصال بالرقم الموجود أدناه.

यदि हिंदुस्तानी आपकी प्राथमिक भाषा न हो या आपको अपना आवेदन या अनुरोधपत्र ब्रेल या बड़े प्रिंट में चाहिए, तो कृपया ऊपर दिए पते, संदेश भेजने, ई-मेल या फ़ोन द्वारा संपर्क करें।

ਜੇ ਪੰਜਾਬੀ ਤੁਹਾਡੀ ਪਹਿਲੀ ਭਾਸ਼ਾ ਨਹੀਂ ਹੈ ਜਾਂ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਬਰੇਲ ਜਾਂ ਵੱਡੀ ਛਪਾਈ ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ, ਤਾਂ ਕ੍ਰਪਾ ਕਰਕੇ ਉੱਪਰ ਲਿਖੇ ਪਤੇ ਉੱਤੇ ਲਿਖੋ ਜਾਂ ਫ਼ੋਨ ਕਰੋ।

જો તમારી પ્રથમ ભાષા અંગ્રેજી ન હોય અથવા તમને આ દસ્તાવેજ બ્રેઇલમાં કે મોટી છપાઇમાં જોઇતો હોય, તો કૃપા કરીને નીચે આપેલા નંબર પર સંપર્ક કરો.

যদি আপনি চাহেন আমরা অনুরোধটি বাংলা ভাষায় গ্রহণ করতে পারি অথবা ব্রেইল বা বড় অক্ষরে মুদ্রিত আকারে পেতে চান, তাহলে অনুগ্রহ করে নীচের ঠিকানায় যোগাযোগ করুন।

ਜੇ ਤੁਹਾਨੂੰ ਸ਼ੁਰੂ ਵਾਲਾ ਲੰਬੇਰਾ ਨਹੀਂ ਹੈ ਜਾਂ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਬ੍ਰੇਲ ਜਾਂ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਹੇਠਾਂ ਦਿੱਤੇ ਐਡਰੈਸ ਤੇ ਲਿਖਕੇ ਕਰੋ।

اگر آپ کی اصل زبان انگریزی نہیں ہے یا آپ یہ دستاویز بریل یا بڑے حروف میں چاہتے ہیں تو براہ کرم مندرجہ ذیل نمبر پر رابطہ کریں۔

Consultation on new Primary Care Trusts arrangements in Birmingham and the Black Country

Ensuring a Patient-led NHS

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.

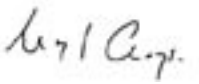
Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

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 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

The paper entitled "Commissioning a Patient-led NHS" published on 28 July 2005 by Sir Nigel Crisp, Chief Executive of the NHS, focused on creating a step change in the way services are commissioned by front line staff, to reflect patient choices.

Creating a patient-led NHS and improving the health of the whole population requires:

- better engagement with local clinicians in the design and commissioning of services;
- a rapid and universal roll out of General Practice-based Commissioning (PbC);
- Primary Care Trusts (PCT) support for PbC and performance management, through contracts, of all Trust Providers;
- a review of the functions of Strategic Health Authorities (SHAs) to support commissioning and contract management.

These changes complement the major national policies of Choice of Provider, Payment by Results and the development of the NHS Foundation Trusts Programme and Practice-based Commissioning.

This document outlines in detail the future role of Primary Care Trusts (PCTs) nationally in ensuring a step change to commissioning health services and improving the health of the whole population.

Birmingham and The Black Country SHA, in considering the role PCTs will undertake within a reformed NHS, believes it is clear that the current lack of coterminosity with local authority boundaries, in particular social services, compromises real progress on a range of issues for some of our smaller PCTs. In the Black Country, this lack of coterminosity has affected pace of service change, and, in some areas prevents patient pathways from being clearly defined and delivered. In addition, management capability and capacity in many of our smaller Black Country PCTs is spread thinly, while in others there is duplication of effort.

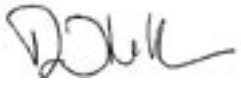
In a city the size of Birmingham, however, coterminosity would result in one of the largest PCTs in the country, covering a population of almost one million. The advantages of enhanced partnership working need to be weighed against the risks of creating an organisation too large to relate to either its population or its GPs. Effective implementation of Practice-based Commissioning requires PCTs of sufficient size to carry out their functions as outlined in "Commissioning a Patient-led NHS", whilst having enough local focus to understand and reflect the needs of their populations and facilitate meaningful clinical engagement.

We are therefore proposing within this consultation document a preferred configuration which would establish eight PCTs within the current Birmingham and The Black Country SHA area.

This preferred configuration would merge Dudley, Beacon and Castle PCT and Dudley South PCT to create a new organisation and merge Oldbury and Smethwick PCT, Wednesbury and West Bromwich PCT, and Rowley Regis and Tipton PCT to create a new organisation. North Birmingham PCT and East Birmingham PCT would also be merged to create a new organisation. The proposal would retain the existing PCTs of Wolverhampton PCT, Walsall PCT, Solihull PCT, Heart of Birmingham PCT and South Birmingham PCT.

The proposed new organisations would be developed with a locality structure in order to retain the benefits achieved by PCTs working closely with primary care, other NHS organisations and metropolitan, borough and city councils. The proposed new PCTs would also be supported by a Commissioning Hub across the West Midlands in order to make best use of the resources and skills available.

Having considered the future role PCTs will be required to undertake as outlined within this document we would be keen to hear your views on whether the preferred option best meets these criteria.



David Nicholson
Chief Executive

Elisabeth Buggins
Chairman
(on behalf of the Board)

Your NHS

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

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.

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.

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.

Achieving a patient-led NHS

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?

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.

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.

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.

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.

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.

In the eight 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 2004/05 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.

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.

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'.

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.

We need stronger PCTs 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.

What do we mean when we talk about 'commissioning'?

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.

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.

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.

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.

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.

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

The wider picture

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.

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.

PCTs 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.

PCTs 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.

The PCT 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.

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

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

What does this mean for PCTs?

Many of the improvements seen in the NHS in recent years can be attributed to the hard work and skills of PCTs. 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 PCTs need to adapt and develop.

Practice-based Commissioning will be central to all this and PCTs 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 PCTs will be key to making the new system a success, the new processes should actually support them.

There is no national blueprint for the number or shape of PCTs - different regions will invariably need different solutions. In some areas, for instance, the formation of larger PCTs may be seen

as the key to really effective local commissioning and service planning. For others, smaller PCTs may fit local needs better.

In many cases the geographical areas of the new PCTs 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 PCTs.

The PCT role in more detail

The core roles and functions of PCTs are set out below. As we continue to develop the health reform policies there may be additional roles and functions identified for PCTs. An initial view of the new PCT 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 PCTs) 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.

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.

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 SHAs, PCTs and other NHS bodies.

Protecting staff

The proposals set out in this document mean important changes for staff working in the current SHAs and PCTs. 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.

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.

The Department of Health has recently published a human resources framework to outline the relevant appointment processes for the new SHAs and PCTs, and to support staff through these changes.

Next steps

This document is one of a series of separate consultation exercises on the proposed boundaries and structures for each new PCT. Proposals for the new SHA boundaries are also being consulted on at local level in a similar way.

The proposals which follow outline plans to create a number of new PCTs from the present twelve in the SHA. They describe the implications of these changes for staff, local people, the NHS and its partner organisations.

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 and advise the Secretary of State for Health whether she should make the proposed orders to dissolve or establish a PCT.

A full explanation of how to comment and by when is set out on the inside front cover including arrangements for people with impaired vision, hearing or other special needs.

Current PCT configuration within the Birmingham and Black Country area

Birmingham and Black Country Strategic Health Authority area is currently served by 12 PCTs:

Current PCT	Population (000)	Local Authority
Birmingham and The Black Country	2,309	
Dudley Beacon and Castle	104	Dudley Metropolitan Borough Council (MBC)
Dudley South	198	
Solihull	199	Solihull MBC
Walsall	245	Walsall MBC
Wolverhampton	239	Wolverhampton City Council
Oldbury and Smethwick	102	Sandwell MBC
Rowley Regis and Tipton	82	
Wednesbury and West Bromwich	114	
North Birmingham	169	Birmingham City Council
Eastern Birmingham	231	
South Birmingham	341	
Heart of Birmingham	285	

* The population totals are rounded and represent estimated weighted populations for 2004.

Proposals for change and options considered

Existing PCT configuration arrangements offer a number of strengths. However "Commissioning a Patient-led NHS" outlines a significantly changed role for PCTs as outlined in this document.

In considering the role PCTs will undertake within a reformed NHS, a number of issues have informed our judgement. It is clear that management capacity and strategic leverage with Foundation Trusts and other providers will be key. The current lack of coterminosity with local authority boundaries compromises real progress on a range of issues for some of the smaller PCTs in the Black Country. Although regular joint liaison and planning has, in general, been sustained, this lack of coterminosity has affected pace of service change, particularly regarding joint commissioning arrangements and appointments and, in some areas prevents patient pathways from being clearly defined and delivered. In addition, management capability and capacity in many of the PCTs are spread thinly, while in others there is duplication of effort further compromising the ability of PCTs to function effectively.

The benefits from coterminosity also need to be balanced against the need for sufficient local focus to deliver Practice-based Commissioning and effectively tackle health inequalities, and the ability to drive strategic change with local acute providers. There are also potential risks and benefits of further change, judged against the degree to which existing PCTs have met their statutory duties for financial balance and meeting Government targets. Other relevant factors include existing and planned infrastructure to support the role of PCTs across the West Midlands.

Infrastructure

In order to make best use of the resource available to PCTs in the future all PCTs will plan to establish Shared Back Office Services. In moving to a Shared Services model PCTs will be expected to investigate options which include other Partners such as the Local Authority.

The region already has infrastructure to support collaborative commissioning of specialised services and this will be enhanced and developed to meet the requirements and challenges of "Commissioning a Patient-led NHS". In addition the SHAs within the West Midlands will work with PCTs and PbCs to establish a 'Commissioning Business Support Agency' (CBSA) to be in place on establishment of any new organisations. It is likely to operate on a patch basis. The role of the CBSA will be to provide professional support to commissioners as clients to enable them to maximise the impact of commissioning. It will provide a range of services to be agreed with commissioners in the following categories:

- Systems and business support (activity/ payments/reporting)
- Planning and forecasting support
- Support for service analysis/pathways development
- Support for service specification/contracts
- Support in contract management

This business support agency will not hold commissioning budgets. Responsibility and accountability for commissioning of services and for prioritisation of expenditure remains with PCTs and PbCs. The CBSA will interconnect with any national systems that are introduced for managing NHS-wide financial transactions.

Options considered

In considering arrangements for the current Birmingham and The Black Country Strategic Health Authority, the criteria set out in "Commissioning a Patient-led NHS" formed the basis of our deliberations.

Doing nothing and maintaining the status quo failed to satisfy any of the nine criteria detailed within "Commissioning a Patient-led NHS". In particular, the lack of coterminosity between the smaller PCTs in the Black Country with the local authorities undermines any aspiration to increase the coordination of commissioning and provision with social services departments. The lack of "critical mass" within these small organisations also compromises the management

of financial risk and, in general, reduces the scope for achievement of operational efficiency and value for money. The extent of savings required (15 per cent of management costs) would also be difficult to achieve without any mergers, without seriously affecting the managerial capacity of the smaller PCTs to carry out the functions set out in "Commissioning a Patient-led NHS". This option was not shortlisted for consultation on this basis.

The Birmingham and The Black Country Strategic Health Authority is therefore consulting on two options:

Option 1: 8 PCTs

Create five coterminous PCTs in the Black Country, reduce Birmingham PCTs from four to three

- Merge two Dudley PCTs to create a single PCT for Dudley, merge three Sandwell PCTs (Oldbury and Smethwick, Wednesbury and West Bromwich and Rowley Regis and Tipton) to create one PCT for Sandwell
- Leave Wolverhampton PCT, Walsall PCT and Solihull PCT[1] as at present
- Merge North Birmingham PCT and Eastern Birmingham PCT to create one PCT, leaving South Birmingham PCT and Heart of Birmingham PCT as at present

This would create one PCT in Dudley, coterminous with the local authority, one PCT in Sandwell, coterminous with the local authority and three PCTs in Birmingham, not coterminous with the local authority, leaving Walsall, Wolverhampton and Solihull as at present and result in eight PCTs rather than 12 as at present across Birmingham and the Black Country.

[1] Solihull PCT and Solihull LA have recently finished a separate formal consultation process on merging some functions to establish a Care Trust. The PCT and LA now need to formally apply to Secretary of State for approval to establish a Care Trust, and demonstrate how this development would be consistent with the principles set out in "Commissioning a Patient-led NHS".

Option 2: 6 PCTs

Create five coterminous PCTs in the Black Country and merge all Birmingham PCTs to create one coterminous organisation

- Merge two Dudley PCTs to create a single PCT for Dudley, merge three Sandwell PCTs (Oldbury and Smethwick, Wednesbury and West Bromwich and Rowley Regis and Tipton) to create one PCT for Dudley
- Leave Walsall PCT, Wolverhampton PCT, Solihull PCT[1] as at present
- Merge North Birmingham PCT, Eastern Birmingham PCT, South Birmingham PCT and Heart of England PCT to create one Birmingham PCT

This would create one PCT in Dudley, coterminous with the local authority, one PCT in Sandwell, coterminous with the local authority and one PCT in Birmingham, coterminous with the local authority, leaving Walsall, Wolverhampton and Solihull PCTs as at present. This would result in six PCTs rather than 12 as at present.

Option Appraisal

Each of the two options put forward has been assessed against the criteria detailed in "Commissioning a Patient-led NHS", taking into account local circumstances and performance. In addition initial views of key stakeholders were sought through a pre consultation exercise. The key risks and benefits of each of the two options are set out overleaf.

Option 1

Create five coterminous PCTs in the Black Country, reduce Birmingham PCTs from four to three

Option 1: Implications for the Black Country

The current PCT boundaries in Dudley and Sandwell do not mirror the approach taken by the relative Metropolitan Borough Councils. In this environment, having a single health organisation for both Dudley and Sandwell respectively would be a major advantage. A single PCT for Dudley and Sandwell would allow for consistent strategies across the boroughs; facilitate more effective commissioning, and enable them to better hold provider organisations to account; make better use of resources and reduce duplication and support and enhance social care developments.

The proposed mergers would allow the combined PCTs to plan more effectively for the future, to reduce the differences in the levels of services between different areas in the boroughs and to reduce the cost of management, releasing more money for patient services. The proposed changes represent a real opportunity to make a difference to the health and well-being of the boroughs' residents and to the services that they can expect to receive.

The merger of these relatively small PCTs also allows them to be of a size sufficient to achieve the necessary skills and focus on commissioning, whilst achieving the necessary savings on management spend, allowing re-investment back into front line services.

The risks of this option are, as with any organisational change, the potential for disruption and distraction from the delivery agenda. Although there are clear benefits to coterminosity, there may be risks that a very local focus on the different towns within Dudley and Sandwell will be lost. However, a firm local focus could be maintained and strengthened through Practice-based Commissioning and the continued development of clinical engagement. Following the pre-consultation exercise, the overwhelming majority of respondents supported merging the two Dudley PCTs and merging the three PCTs in Sandwell. This consensus reflects the fact that in both of these boroughs the PCTs and local authorities had already decided to recommend a merger prior to the publication of "Commissioning a Patient-led NHS".

Option 1: Implications for Birmingham

In Birmingham, there are currently four PCTs, although there are already shared management arrangements in place between North and Eastern Birmingham PCTs. Whilst the proposal to create three PCTs in Birmingham is not coterminous with the local authority, it would build on the existing configuration of social services boundaries within the city and the increasing delegation of commissioning to localities. Whilst there are clear advantages to creating PCTs that are coterminous with local authorities, there are several reasons why this may not be the optimal solution for Birmingham.

The proposal to create three rather than four (or one) PCTs for Birmingham would allow for PCTs of sufficient size to carry out their functions as outlined in "Commissioning a Patient-led NHS", while having enough local focus to understand and reflect the needs of their populations and facilitate meaningful clinical engagement within local health economies. Many of the benefits of size have already been achieved through existing arrangements for shared services.

Creating three PCTs in Birmingham also reduces the disruptions and risks associated with any organisational change; reflects some of the natural geographical boundaries within the city

and crucially builds on existing relationships between commissioners, primary care contractors and the major acute providers of services. Creating three PCTs would also reflect real differences in the diverse population of Birmingham, where there are significant pockets of diversity and homogeneity and could reflect the way the city has also organised its self in area structures to make it more responsive to people's needs in different parts of the city. The three areas could easily relate to three PCTs, a decentralised model of care to allow a local approach to health inequalities.

The risks of creating three rather than one PCT for Birmingham are that opportunities for more effective partnership working could be missed, and the potential for reducing costs and duplication of functions not realised. However, the current four PCTs already collaborate successfully on a number of back office functions such as financial services, IT, estates and public health. There would be opportunities for the proposed three Birmingham PCTs to expand this collaboration, both to ensure economies of scale and to progress partnership with the local authority. This could help counterbalance the savings forgone through retaining three organisations. The proposed three Birmingham PCTs could also benefit from the broader collaborative commissioning arrangements described above. If the proposal to create three PCTs for Birmingham is accepted, partnership working with the local authority would remain a priority, and the new organisations would be expected to build upon existing good practice at a sector level to deliver an extended range of formal joint arrangements.

Creating three PCTs in Birmingham would avoid major organisational change in an area which has been very successful in achieving financial balance and meeting Government targets, would reflect the fact that the three proposed PCTs are of an equivalent size to proposed PCT configuration across the rest of the Birmingham and The Black Country SHA area and would allow managers and clinicians to focus on further improvements in the health and services of local people. Some who responded in the pre-consultation exercise also argued that one PCT was inevitable at some point and that it was prudent to move to one PCT now, rather than face more change in the future.

Option 2

Create five coterminous PCTs in the Black Country and merge all Birmingham PCTs to create one coterminous organisation

Option 2: Implications for the Black Country

The risks and benefits for the proposed changes to Black Country PCTs are as described in Option 1.

Option 2: Implications for Birmingham

The benefits of creating one PCT for Birmingham would essentially be that it would be coterminous with the local authority. This could improve relationships and partnership working at a city wide level. It could also provide a PCT of substantial size and leverage, able to hold to account strong provider Foundation Trusts.

Creating one PCT for Birmingham could maximise the opportunity for the rationalisation of management costs and avoid duplication of roles and functions at board level. It would facilitate partnership working with the local authority, other city wide organisations and be a clear point of contact for organisations such as those representing the professional interests of contractors. Creating one PCT for a population of over one million would provide Birmingham with a commissioning function with real economic buying power, with a strong voice to negotiate and innovate on behalf of its population.

In a city the size of Birmingham, coterminosity would result in one of the largest PCTs in the country, covering a population of over one million. The advantages of enhanced partnership working would need to be weighed against the risks of creating an organisation too large to relate to either its population or its GPs at a time when effective implementation of Practice-based Commissioning requires real clinical engagement. The performance management of an increasing range of providers could also prove a challenge for a single new organisation.

Significant disparities in health inequalities could be masked and it may be difficult for a large organisation to deal effectively with local performance and management issues across hundreds of providers in primary care. To avoid these potential risks, there would need to be significant investment in management on a locality basis.

In addition, there are the risks of disruption associated with any major organisational change, particularly in an area which has largely delivered its statutory duty to achieve financial balance and meet Government targets.

Preferred option

Although a minority of respondents to the pre-consultation document did express a preference for one PCT for Birmingham, the majority, including each of the existing four PCTs said that creating three PCTs for Birmingham was their preferred option. This in part reflects the fact that the boards of North Birmingham PCT and Eastern Birmingham PCT had already agreed to merge prior to the publication of "Commissioning a Patient-led NHS".

The preferred option of Birmingham and The Black Country Strategic Health Authority, based upon ability to deliver the criteria outlined in "Commissioning a Patient-led NHS" is Option 1.

Option 1: 8 PCTs

Create five coterminous PCTs in the Black Country, reduce Birmingham PCTs from four to three

- Merge two Dudley PCTs to create a single PCT for Dudley, merge three Sandwell PCTs (Oldbury and Smethwick, Wednesbury and West Bromwich and Roley Regis and Tipton) to create one PCT for Sandwell
- Leave Wolverhampton PCT, Walsall PCT and Solihull PCT as at present
- Merge North Birmingham PCT and East Birmingham PCT to create one PCT (Birmingham East and North PCT), leaving South Birmingham PCT and Heart of Birmingham PCT as at present

Preferred PCT configurations and linkages with local authorities

Current PCT	Population (000)	Future PCT	Population (000)	Local Authority
Birmingham and The Black Country	2,309		2,309	
Dudley Beacon and Castle	104	Dudley	302	Dudley MBC
Dudley South	198			
Solihull	199	Solihull	199	Solihull MBC
Walsall	245	Walsall	245	Walsall MBC
Wolverhampton	239	Wolverhampton	239	Wolverhampton City Council
Oldbury and Smethwick	102	Sandwell	298	Sandwell MBC
Rowley Regis and Tipton	82			
Wednesbury and West Bromwich	114			
North Birmingham	169	North Eastern Birmingham	400	Birmingham City Council
Eastern Birmingham	231			
South Birmingham	341	South Birmingham	341	
Heart of Birmingham	285	Heart of Birmingham	285	

Implications for staff

The preferred configuration, by creating slightly larger PCTs should enable recruitment and retention of the highest calibre staff through improvements in opportunities for staff training, continuing professional development, research and improved career paths. Larger PCTs may be better able to provide flexible employment policies and working practices, improving the quality of working life for staff.

Implications for patients

The preferred configuration:

- Will deliver real Choice for patients. By having a clearer responsibility for commissioning, PCTs in conjunction with SHAs will be able to develop the range and variety of provider options available for patients. Practice-based Commissioning will be a key element in the delivery of Choice. Focusing and developing commissioning capability and systems for supporting Practice-based Commissioning should be easier within the larger PCTs proposed in the Black Country, with sufficient local focus in the proposed three PCTs in Birmingham.

- Improves access to services and facilitate equitable, consistent, high quality and clinically-effective county-wide services, whilst retaining a locality focus for commissioning purposes.

- Will ensure that the NHS understands the needs and wants of local people. "Creating a Patient-led NHS" details a radical change for the NHS and for PCTs in particular, envisaging a new relationship with people in which the NHS supports people in improving their health rather than doing things to or for them. Ensuring that information on self help and healthy living are available will be critical and PCTs may also wish to work with partner organisations to develop capacity within the community for sustaining and strengthening healthy life styles. PCTs will be better able to focus its public health expertise on such initiatives and, by ensuring sufficient resource

to develop an appropriate focus, the PCTs will be better able to involve and work with users of services and their carers developing sophisticated ways of discovering consumer requirements, experiences and changing needs as well as assessing health needs.

Implications for NHS organisations and other partner organisations

The preferred configuration:

- Drives health improvement and reduces health inequalities in local communities by supporting the development of a whole systems approach to service development through multi-agency planning and integrated service delivery. Coterminosity with local authorities should enable consistent joint working on the reduction of health inequalities and allow joint appointments across health and social services and the development of shared services where appropriate. The proposed three Birmingham PCTs will reflect the operational division of management for social services, facilitating better planning and service delivery.

- Releases recurrent savings from economies of scale (including management cost savings) whilst ensuring appropriate and affordable management capacity, capability and structures to deliver the agenda and associated programme of change. The reduction of the number of statutory bodies, and a programme to increase the number of corporate services shared with other NHS bodies will release money for reinvestment in patient care. This is a key benefit of the changes envisaged.

- Improves the effectiveness of services which need to be commissioned jointly. The commissioning of a range of services should be possible in a more connected way, including services for mental health, learning disability, children and older people. Not all of these services will be commissioned jointly – for example those relating to in-patient care are more likely to be commissioned by a PCT possibly in collaboration with other PCTs. However there are substantial areas of Health and Social Care for which a single plan, single commissioning and single contracting are essential if people are to receive the kind of seamless unified services they need.

- The NHS as a local partner. As well as the benefits in terms of public health, improved links with local authorities should enable the NHS to play a more consistent part in the other issues of partnership for which the NHS has a duty including, for example, issues relating to community safety, environmental improvement, transport, housing etc.

- Developing effective and efficient commissioning of heath care. The proposed changes put commissioning at the heart of all that PCTs do. Their task is now clear: PCTs need to fully understand the needs of all their communities, and use their commissioning muscle to lever the very best patient care out of providers, on behalf of their populations. PCTs are now effectively the guardian of tax payers money, and have a clear duty to get the very best health care through effective commissioning and contracting. The proposed reconfiguration of PCTs will provide the necessary focus, capacity and skills to deliver real benefits to the patients and citizens of Birmingham, Solihull and the Black Country.

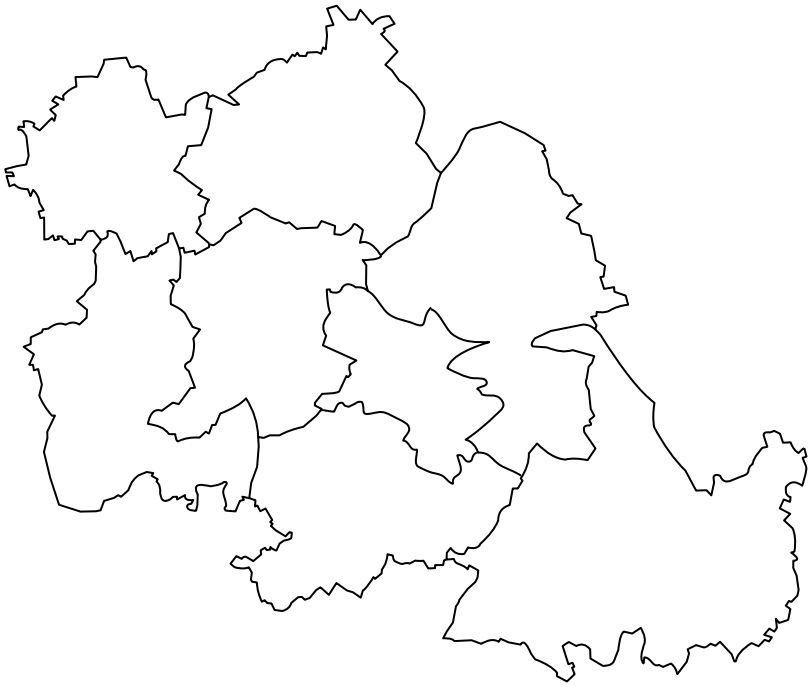
Appendices

1 Map - existing SHAs, England

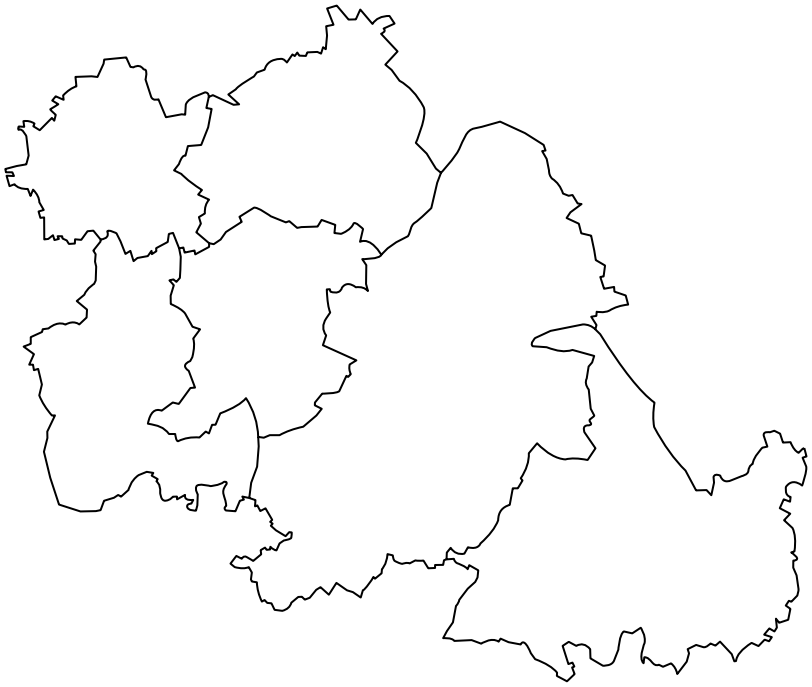
2 Map - existing PCTs, Region

3 Map – proposed PCTs Region

Option 1



Option 2



4. Consultees

Members of the public

City Councils
Metropolitan Borough Councils

Health Overview and Scrutiny Committees
Public and Patient Involvement Forums
Forum Support Organisations

Members of Parliament

Primary Care Trusts
NHS Trusts
PEC Chairs of PCTs

Staff side representatives

Public and Patient Involvement Leads of PCTs and NHS Trusts
Race Equality Councils

Local Medical Committees
Local Dental Committees
Local Ophthalmic Committees
Local Pharmaceutical Committees

Government Office of the West Midlands
Regional Director of Public Health
Health Protection Agency
Advantage West Midlands

Police Services
Fire Services

5. Cabinet Office Code of Practice on Written Consultation

All UK national public consultations should follow the criteria set out in this Code of Practice.

The Code requires that the criteria should be reproduced and they are set out below:

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage

2. It should be clear who is being consulted, about what questions, in what timescale and for what purpose

3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain

4. Documents should be made widely available, with the fullest use of electronic means (though not to the exclusion of others), and effectively drawn to the attention of all interested groups and individuals

5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation

6. Responses should be carefully and open-mindedly analysed, and the results made widely available, with an account of the views expressed and reasons for decisions finally taken

7. Departments should monitor and evaluate consultations, designating a consultation coordinator who will ensure the lessons are disseminated

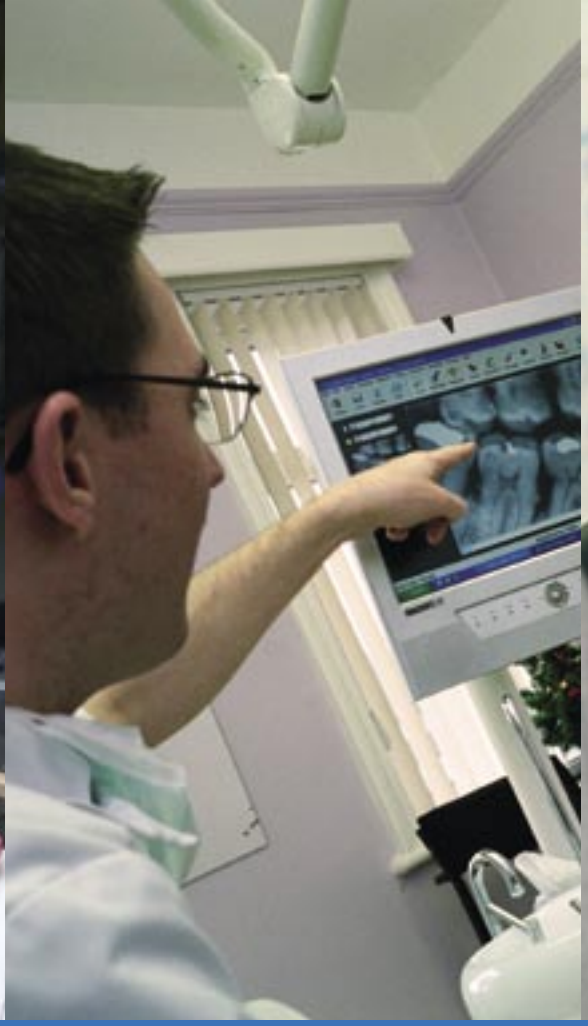
There are no obvious significant departures from this Code of Practice.

Notes

Design and production:

Multi Communications

www.multicomms.co.uk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14 December 2005

Dear Colleague

STRATEGIC HEALTH AUTHORITY CONFIGURATION

Enclosed with this letter is a consultation document on the new boundaries for Strategic Health Authorities (SHAs) in the West Midlands. Consultation will take place on a nationwide basis from 14 December until 22 March 2006.

This consultation relates a change to organisational boundaries and does not include any proposals for service change. The proposal we are consulting on is to bring together Birmingham and The Black Country SHA, Shropshire and Staffordshire SHA and West Midlands South SHA to establish one SHA for the West Midlands which is coterminous with the Government Office of the Region.

I can assure you all comments received on or before 22 March will be included in the consultation process.

Please send your comments to:

Mr David Nicholson CBE
Commissioning a Patient-led NHS
West Midlands Consultation Office
PO Box 2675
Stafford
ST16 9BW

Or by e mailing wmconsultation@sasha.nhs.uk

Further copies of the document can be obtained by writing to the address above, by telephoning 0845 257 7045, by e mailing wmconsultation@sasha.nhs.uk or on line at www.nhswestmidlands.org.uk

We can make arrangements to help those for whom English is not the preferred language. Please contact us by one of the above methods.

I look forward to receiving your comments.

The deadline for all responses is 22 March 2006

Yours faithfully,

David Nicholson CBE
Chief Executive

Birmingham and The Black Country Strategic Health Authority
Shropshire and Staffordshire Strategic Health Authority
West Midlands South Strategic Health Authority


Consultation on new Strategic Health Authority arrangements in the West Midlands:

Ensuring a Patient-led NHS

Strategic Health Authority Consultation

The consultation on the new boundaries for Strategic Health Authorities in England will take place on a nationwide basis for 14 weeks ending on 22 March 2006. Please let us have your comments. We guarantee comments received on or before this date will be included in the consultation process.

You should send your responses to:

Mr David Nicholson CBE
Commissioning a Patient-led NHS
West Midlands Consultation Office
PO Box 2675
Stafford
ST16 9BW

Or by emailing wmconsultation@sasha.nhs.uk

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We can make arrangements to help those for whom English is not the preferred language, or require this document in braille or large print. Please write to the address above or call **0845 257 7045.**

إذا لم تكن الإنجليزية هي لغتك الأولى أو كنت ترغب في أن يكون هذا المستند مكتوباً بطريقة برايل أو مكتوباً بخط كبير ، فالرجاء الاتصال بالرقم الموجود أدناه.

यदि हिंदीभाषी व्यक्तियों के लिए अंग्रेज़ी भाषा में तैयार किए जाने वाले दस्तावेज़ों के अलावा आपको ब्रेल लिपि या बड़े अक्षरों में छपे दस्तावेज़ों की आवश्यकता है, तो कृपया ऊपर दिए गए पते पर लिखें या 0845 257 7045 पर फ़ोन करें।

ਜੇ ਤੁਹਾਡੀ ਪਹਿਲੀ ਭਾਸ਼ਾ ਅੰਗਰੇਜ਼ੀ ਨਾ ਹੋਵੇ ਅਥਵਾ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਬ੍ਰੇਲ ਜਾਂ ਮੋਟੀ ਛਪਾਈ ਵਿਚ ਚਾਹੀਦੀ ਹੋਵੇ, ਤਾਂ ਕਪਾ ਕਰੀਕੇ ਉਪਰ ਲਿਖੇ ਪਤੇ ਉਪਰ ਲਿਖੋ ਜਾਂ 0845 257 7045 ਉਪਰ ਫੋਨ ਕਰੋ।

જો તમારી પ્રથમ ભાષા અંગ્રેજી નથી કે તમારા માટે આ દસ્તાવેજ બ્રેઇલમાં કે મોટી છાપામાં જોઇતી હોય, તો કૃપા કરીને ઉપર આપેલા સરનામે લખો અથવા 0845 257 7045 પર ફોન કરો.

اگر آپ کی اصل زبان انگریزی نہیں ہے یا آپ یہ دستاویز بریل یا بڑے حروف میں چاہتے ہیں تو براہ کرم مندرجہ ذیل نمبر پر رابطہ کریں۔

Consultation on new Strategic Health Authority arrangements in the West Midlands:

Ensuring a Patient-led NHS

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.

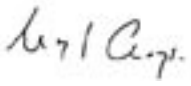
Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

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

The paper entitled "Commissioning a Patient Led NHS" published on 28 July 2005 by Sir Nigel Crisp, Chief Executive of the NHS, focused on creating a step change in the way services are commissioned by front line staff, to reflect patient choices.

Creating a Patient led NHS and improving the health of the whole population requires:

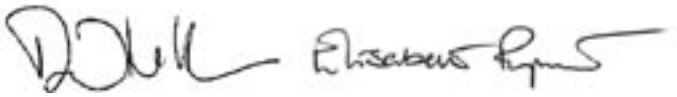
- better engagement with local clinicians in the design and commissioning of services;
- a rapid and universal roll out of General Practice-based commissioning (PbC);
- Primary Care Trusts (PCT) support for PbC and performance management, through contracts, of all Trust Providers;
- a review of the functions of Strategic Health Authorities (SHAs) to support commissioning and contract management.

These changes complement the major national policies of Choice of Provider, Payment by Results and the development of the NHS Foundation Trusts Programme and Practice-based Commissioning.

This document outlines in detail the future role of Strategic Health Authorities nationally to support commissioning, commissioners and contract management.

At present there are three SHAs which cover Shropshire and Staffordshire, Birmingham and The Black Country, and West Midlands South. Commissioning a Patient-led NHS makes it clear there should be considerably less than the current number of SHAs, and that where sensible alignment with Government Offices of the Region should be considered. We are therefore consulting upon a preferred option which would replace the three SHAs with one Strategic Health Authority covering the whole of the West Midlands. This reflects the direction of "Commissioning a Patient-led NHS" and would align the NHS with the West Midlands Health Protection Agency. We are confident the reduction of three SHAs to one SHA covering the West Midlands would be able to deliver a significant reduction in management and administrative costs.

Having considered the future role Strategic Health Authorities will be required to undertake as outlined within this document we would be keen to hear your views on whether the preferred option best meets these criteria.



David Nicholson
Chief Executive

Elisabeth Buggins
Chairman, Birmingham
and The Black Country SHA

Mike Brereton
Chairman, Shropshire
and Staffordshire SHA

Charles Goody
Chairman,
West Midlands South SHA

Your NHS

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

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.

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.

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.

Achieving a patient-led NHS

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?

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.

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.

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.

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.

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.

In the eight 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 2004-05 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.

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.

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'.

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.

We need stronger PCTs 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.

What do we mean when we talk about 'commissioning'?

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.

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.

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.

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.

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.

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

The wider picture

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.

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.

PCTs 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.

PCTs 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.

The PCT 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.

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

SHAs 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.

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

What does this mean for SHAs?

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 SHAs and PCTs.

SHAs 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 PCTs, and a smaller number of NHS Trusts as more gain Foundation status. (Foundation Trusts are not accountable to SHAs.)

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

- **Role:** The focus for SHAs 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.

The SHA role in more detail

As we continue to develop the health reform policies there may be additional roles and functions identified for SHAs. An initial view of the new SHA 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 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.

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.

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 SHAs, PCTs and other NHS bodies.

Protecting staff

The proposals set out in this document mean important changes for staff working in the current SHAs and PCTs. 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.

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.

The Department of Health has recently published a human resources framework to outline the relevant appointment processes for the new SHAs and PCTs, and to support staff through these changes.

Next steps

This document is one of a series of separate consultation exercises on the proposed boundaries for each local SHA. Proposals for the new PCT boundaries are also being consulted on at local level in a similar way.

The proposals, which follow, outline plans to create a new West Midlands SHA from the present three in the region. They describe the important implications of these changes for staff, local people, the NHS and its partner organisations such as the voluntary sector.

The three SHAs are consulting jointly via the West Midlands Consultation Office hosted by Shropshire and Staffordshire Strategic Health Authority.

A national consultation is also taking place on a proposed reconfiguration of Ambulance Trusts. Shropshire and Staffordshire Strategic Health Authority is co-ordinating the consultation in this area on behalf of the Secretary of State and therefore if you would like to know more about the proposals please use the contact details on the inside cover to request a copy of the consultation document or alternatively it can be found on the Department of Health website.

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.

A full explanation of how to comment and by when is set out on the inside cover including arrangements for people with impaired vision, hearing or other special needs.

Proposals for the West Midlands

Against the background of these changed roles and functions, and their requirements we propose that in the West Midlands, covering the counties of Staffordshire, Shropshire, Herefordshire, Worcestershire, Warwickshire, the Metropolitan Boroughs of Dudley, Walsall, Solihull and Sandwell and the City Council areas of Birmingham, Wolverhampton and Coventry and coterminous with the Government Office of the West Midlands, there should be one new West Midlands SHA. This would replace the existing three SHAs of Birmingham and The Black Country, Shropshire and Staffordshire and West Midlands South.

Birmingham and The Black Country SHA

Covers the geographic area made up of the City Council areas of Birmingham and Wolverhampton and the Metropolitan Boroughs of Dudley, Walsall, Solihull and Sandwell.

The SHA covers a population of 2.4 million that is rich and diverse in nature, with over 15 per cent from black and ethnic minority groups. Race inequality is closely correlated with health inequality and economic deprivation. The population is also economically diverse. It ranges from some of the most socio-economically deprived wards in the UK to areas of relative affluence in places such as Sutton Coldfield and Solihull.

Overall, the area is relatively deprived, with four of the six local authorities being in the 20 per cent most deprived authorities nationally due to high rates of unemployment, poor housing, and poverty.

There are currently twelve PCTs in Birmingham and the Black Country, two specialist mental health NHS trusts (of which one is a care trust),

one ambulance trust, eight acute hospital NHS trusts and two Foundation Trusts.

Shropshire and Staffordshire SHA

Covers the geographic area of the counties of Shropshire and Staffordshire which includes the areas served by Stoke-on-Trent City Council, Staffordshire County Council, Shropshire County Council and Telford & Wrekin Borough Council.

The SHA covers a population of 1.5 million people. Although South Staffordshire and the majority of Shropshire are less deprived than other counties in England, North Staffordshire and the Borough of Telford and Wrekin have significant levels of urban deprivation. North Staffordshire is multi-cultural, with significant Asian and African-Caribbean communities, and was designated a Health Action Zone in 1999.

There are currently ten PCTs within Shropshire and Staffordshire, two specialist mental health NHS trusts, one ambulance trust and five acute hospital NHS trusts.

West Midlands South SHA

Covers the geographically large and diverse area of the counties of Warwickshire, Herefordshire, Worcestershire and the City Council area of Coventry.

The SHA covers a population of 1.5 million people. The area surrounding Coventry has a diverse mix of ethnic groups and high levels of deprivation. Warwickshire contains the local authorities of Nuneaton and Bedworth which still employ many in traditional manufacturing industries and also the areas in the north and the south of the county which are largely rural. Within Herefordshire , Warwickshire and Worcestershire there are pockets of deprivation, but these areas are generally more affluent than the national average. Rugby has a diverse population and benefits from a collaborative primary care infrastructure.

There are currently eight PCTs within West Midlands South, one specialist mental health NHS trust, two ambulance service trusts and five acute hospital NHS trusts.

The key characteristics of the proposed new SHA

The proposed new SHA would be coterminous with the Government Office of the West Midlands. The population covered would be 5.3 million covering a geographical area of 5,021 square miles (13,004 square km).

We have considered whether the current configuration of three separate SHAs could successfully deliver the functions required by Commissioning a Patient-Led NHS. It is our view that only the proposed new single SHA for the West Midlands would meet the national criteria and achieve 15 per cent management cost savings. Therefore no other option is being proposed.

The three SHAs within the West Midlands have, since establishment, worked together on a range of issues such as specialised commissioning, emergency planning, procurement of services from the independent sector and on the National Programme for Information Technology.

Local authorities across the West Midlands work collectively as part of the West Midlands Regional Assembly in many areas which include transport, the environment, planning and public health. The Regional Assembly brings together local authorities in relation to health matters through the Regional Public Health Partnership.

Given the long history of the West Midlands as a Regional Government area and the coherence with the links made across local authorities, police and fire services there were no other new options raised by neighbouring SHAs or considered as viable options.

The single proposal is therefore to merge the three SHAs within the West Midlands - Birmingham and The Black Country SHA, Shropshire and Staffordshire SHA and West Midlands South SHA – and establish one strategic health authority covering the whole of the West Midlands.

The case for change

The criteria for new SHAs are based upon their ability to deliver their key roles. The key roles and the criteria for assessment of the proposed option in delivering those roles are:

1. **Develop service and manpower strategies, and exercise oversight of major investment or service reconfigurations across a coherent socio-geographical area**

The West Midlands is a coherent socio-geographic area recognised widely by the resident population. In health planning terms the majority of healthcare delivered to the population of the West Midlands is undertaken within the boundaries of the West Midlands.

As health reform policies are implemented there will increasingly be circumstances where sensible, structured development of the local health community and it's patterns of commissioning and provision will require consideration of a larger population base than that currently occupied by SHAs i.e. to conduct the core future role the SHA needs a broader population base, but one which is coherent in service planning terms. A West Midlands wide perspective is the optimum configuration to achieve this.

There is existing evidence of this. Major investment decisions currently taken within health services across the West Midlands involve West Midlands commissioners. Specialised services such as cardiac and forensic psychiatric services are commissioned within a West Midlands wide framework. The move to a single West Midlands SHA will improve the ability to achieve a coherent plan across the area.

The change is required because currently major investment and specialised service commissioning decisions involve three separate organisations collaborating to ensure an optimum outcome. This could be achieved by delegating responsibility for decision making to one of the three SHAs, but would not give the coherence of a single West Midlands wide response.

There is a fear that a single organisation could be perceived as making decisions which are Birmingham centric and do not recognise the rurality of substantial areas of Shropshire and Staffordshire and West Midlands South SHAs. The new SHA will work to ensure that local relationships are maintained.

2. **Manage the performance of and develop capacity and capability in the new PCTs and, for as long as necessary, NHS Trusts with appropriate levels of local knowledge and judgement**

As SHAs succeed in guiding trusts to be in a position to apply for Foundation Trust status by 2008/09, the responsibility for performance management of those new organisations will move to PCTs and be conducted by them through their contracts, i.e. performance management of provider trusts will cease to be an SHA role. There is therefore no longer the need for the current number of SHAs.

In developing the capacity of PCTs to be able to deliver for their populations in a world of Practice-based Commissioning, Payment by Results, Choice and plurality of provision, it is likely that PCTs will, in some cases, merge with others to form larger organisations of greater capability.

Subject to consultation on the future configuration of PCTs and all NHS Trusts becoming being in a position to apply for Foundation Trust status by 2008/09, the SHA will be responsible for performance management of a total of 16 organisations across the West Midlands. Currently there is significant variation in the performance of PCTs and NHS Trusts across the West Midlands. A single organisation would ensure delivery of consistent performance standards across the West Midlands.

The current variation in delivery against targets would be sustained if three separate organisations remain responsible for ensuring delivery.

With the proposed reduction in numbers of organisations by 2008 if the proposed change were not implemented two of the current SHAs could be responsible for performance management of only four organisations.

3. Exercise oversight of the system as a whole in their area, in partnership with Monitor and the Healthcare Commission

The partnership relationship with the Healthcare Commission will be further enhanced by a single West Midlands SHA as this will be coterminous with the Healthcare Commission team.

There would be considerable duplication of effort within three separate SHAs in ensuring partnership with Monitor and the Healthcare Commission. However the new SHA will work to ensure that local relationships are maintained.

A local focus and local knowledge may be seen to be more beneficial in the relationship with Monitor and Healthcare Commission.

4. Enhance key partnerships, including those with Regional and Local Government and Higher Education Institutions

Working with the region's Offices of Government, Regional Development Agencies and Assemblies to promote better health and ensure that the economic muscle/footprint of the NHS is recognised and utilised at regional level to influence regional economic, labour market and other investment strategies are three of the key partnerships necessary for a successful SHA of the future. Coterminosity with these bodies offers significant advantages in influencing and decision making to enhance health improvement of the population and reduce inequalities.

Local Authorities remain a significant partner. Currently the Association of Directors of Social Services is configured on a West Midlands basis. Coterminosity again offers significant gains in ensuring strategic alliances are developed to deliver health improvement across the West Midlands.

Coterminosity with all of the bodies outlined will enable the new SHA to develop a single agreed strategy for the West Midlands.

There is currently considerable duplication of effort within three separate SHAs in ensuring partnership with Government Offices of the Region, Regional Development Agencies and Assemblies.

There is a risk that a coherent strategic partnership to deliver health improvement across the West Midlands does not achieve the necessary consensus when involving three separate organisations.

5. Take account of existing or planned structures in other parts of the NHS and related organisations

Pros and cons as per criteria 2.

6. Achieve a significant reduction in management costs so as to contribute to the Government's savings target

The current core budgets of three SHAs is £14.12 million.

The changed functions and reduction to a single SHA for the West Midlands is estimated to save 53 per cent of core budget resulting in £7.5m savings which will be available for frontline clinical services in 2008.

Retention of three Boards would reduce the financial savings released.

There is a duplication of functions within the three separate organisations which reduces the ability to release savings.

Implications for Staff:

The proposed configuration:

- Focuses the SHA on delivering the new agenda. This should offer significant opportunities for the development by staff of new skills, new opportunities for personal and professional development, leading to improved career satisfaction. The smaller focused SHA should also be better able to provide flexible employment policies and working practices, improving the quality of working life for staff.

- It is anticipated that the proposed organisation would require significantly fewer staff and that those staff may be required to have a different set of skills to enable them to fulfil the new role. Any changes for staff will be undertaken following the national HR guidance. Support for staff through this period of change to develop skills and plan their future career will be available.

Implications for patients

The proposed configuration:

- Will deliver real Choice for patients. By having a clearer responsibility for performance managing and working with PCTs to develop commissioning capability and systems for supporting Practice-based Commissioning, SHAs will performance manage PCTs to develop a range and variety of provider options for patients to ensure that all populations are supported to obtain maximum opportunity to take advantage of available choice options. This will improve access to services for patients and ensure equitable, consistent, high quality and clinically-effective services, whilst retaining a locality focus through the PCTs for commissioning purposes.

- Releases recurrent savings from economies of scale (including management cost savings) whilst ensuring appropriate and affordable management capacity, capability and structures to deliver the agenda and associated programme of change. The reduction of the number of statutory bodies will release money for reinvestment in patient care. This is a key benefit of the changes envisaged.

Implications for NHS organisations and other partner organisations:

The proposed configuration:

- Drives health improvement and reduces health inequalities in local communities by ensuring that a single SHA supports the development of a whole systems approach to service development through multi-agency planning and integrated service delivery on a consistent basis within the region.

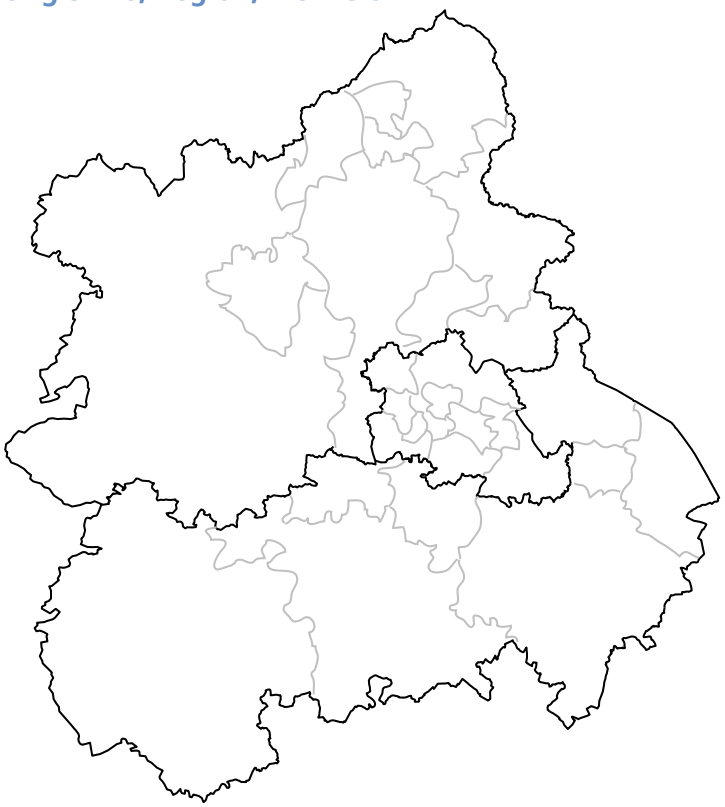
- The NHS as a local partner. Coterminosity with Regional Agencies will simplify relationships, and should better enable a consistent and more streamlined approach within all health economies. These improved links should also enable the NHS to play a greater role in other issues of partnership for which the NHS has a duty including, for example, emergency planning and management, and issues relating to community safety, environmental improvement, transport, housing etc.

- Developing effective and efficient commissioning of heath care. By supporting PCTs in their focus on commissioning responsibilities, the NHS should, in the future, be better able to strengthen provider arrangements locally for example, by encouraging the development of innovative and alternative services or service providers.

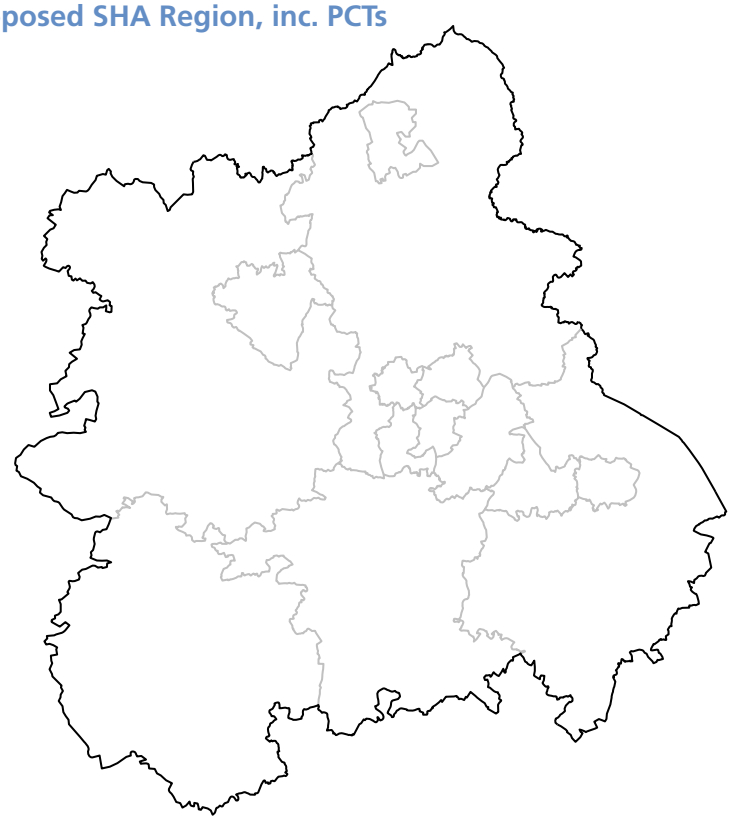
Appendices:

1 Map – existing SHAs, England, also showing Government Office of the West Midlands boundary

2 Map - existing SHAs, Region, inc. PCTs



3 Map – proposed SHA Region, inc. PCTs



4. Consultees

Members of the public

City Councils
County Councils
Borough Councils
District Councils
Metropolitan Borough Councils

Health Overview and Scrutiny Committees
Community Health Councils (Wales)
Public and Patient Involvement Forums
Forum Support Organisations

Members of Parliament

Primary Care Trusts
NHS Trusts
Local Health Boards (Wales)
PEC Chairs of PCTs
Medical Directors of NHS Trusts

Staff side representatives

Public and Patient Involvement Leads of PCTs and NHS Trusts
Race Equality Councils

Local Medical Committees
Local Dental Committees
Local Ophthalmic Committees
Local Pharmaceutical Committees

Government Office of the West Midlands
Regional Director of Public Health
Health Protection Agency
Advantage West Midlands

Police Services
Fire Services

5. Cabinet Office Code of Practice on Written Consultation

All UK national public consultations should follow the criteria set out in this Code of Practice.

The Code requires that the criteria should be reproduced and they are set out below:

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage

2. It should be clear who is being consulted, about what questions, in what timescale and for what purpose

3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain

4. Documents should be made widely available, with the fullest use of electronic means (though not to the exclusion of others), and effectively drawn to the attention of all interested groups and individuals

5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation

6. Responses should be carefully and open-mindedly analysed, and the results made widely available, with an account of the views expressed and reasons for decisions finally taken

7. Departments should monitor and evaluate consultations, designating a consultation coordinator who will ensure the lessons are disseminated

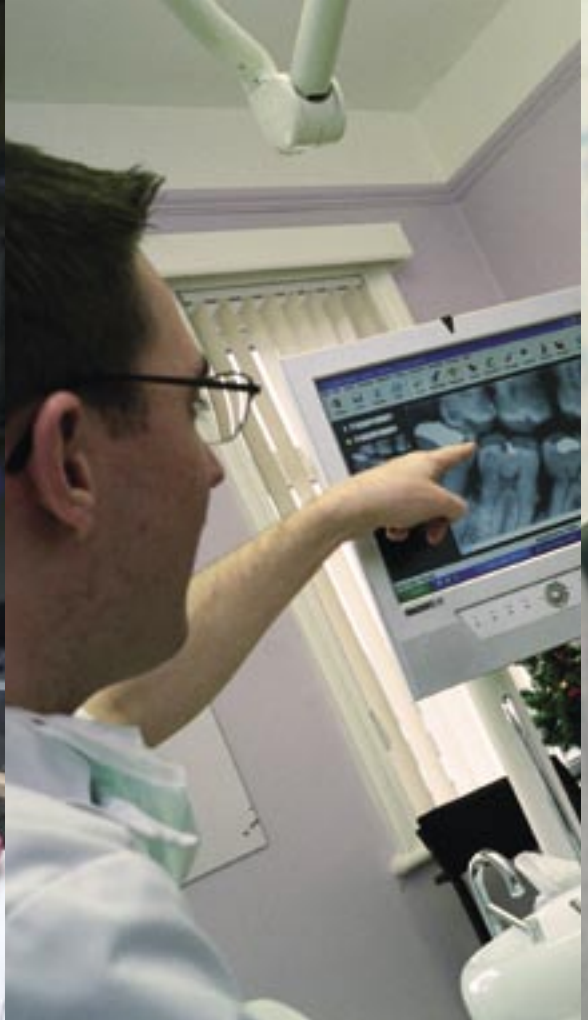
There are no obvious significant departures from this Code of Practice.

Notes

Design and production:

Multi Communications

www.multicomms.co.uk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14 December 2005

Dear Colleague

AMBULANCE SERVICE CONFIGURATION

Enclosed with this letter is a Consultation Document on the Configuration of Ambulance Services in England I am forwarding to you on behalf of the Department of Health. This document sets out a proposal to establish eleven ambulance trusts across England in order to deliver organisations that are operationally fit for future challenges. These proposals are not about changes to service provision, but will enable the implementation of the support functions and structures necessary to improve patient care in the way set out in *Taking Healthcare to the Patient,* and support local provision of services tailored to patient need.

For the West Midlands it is considered that the optimum configuration to achieve this national proposal would be for the current four ambulance trusts (Staffordshire; Coventry and Warwickshire; West Midlands and Shropshire; Hereford and Worcester) to be replaced by one ambulance trust covering the whole of the West Midlands.

We currently have four highly performing organisations all of which have different strengths and weaknesses. In addition our pre-consultation with stakeholders identified a number of concerns regarding this proposal. I therefore felt it would be helpful to set out discussions we have had with the four ambulance trusts to ensure locally we address the concerns people have raised and to enable the ambulance trusts to come together whilst mitigating any risk to service delivery, continue to deliver high levels of performance and clinical outcomes with an explicit aim to improve standards across the four to achieve the best in the world.

The principles agreed by all four ambulance service trusts and the SHA's would bring together a single Trust, which will set out the strategic direction of travel and governance arrangements. However, we agree that the Trust will need clear local management and operational structures that reflect the different communities they serve. In order to achieve this we would propose to establish within the overall strategic management locally managed operational "delivery units".

Options

During pre consultation many stakeholders asked why the current ambulance configuration would not be able to deliver the range of services envisaged in the future.

At best staying as we are would have a neutral impact upon the performance responses in the individual services.

However, in considering the capacity and capability of our ambulance services to meet the challenges described, it is clear that doing nothing is not an option. Over the last 30 years, the number of Ambulance Trusts has reduced steadily as a result of mergers and amalgamations. Currently there are 31 Ambulance NHS Trusts in England, of which 8 are urban Trusts. There is considerable diversity in terms of size and income. As part of the national review a principle of Ambulance Trusts to be coterminous with SHA boundaries was considered to be the best option.

Very small health service organisations rely upon a few key individuals and have little managerial, clinical or financial flexibility. This makes them vulnerable to turnover and absence of staff, and vulnerable in the face of unforeseen financial costs. Succession planning is extremely difficult. Small services are often very dependent on key individuals which provides for limited resilience.

Regional planning is often compromised because regional organisations have to deal on a range of issues with four organisations, which could potentially compromise progress on a range of emergency planning issues particularly when each service has different technologies, plans and protocols.

This is a real issue given the level of potential terrorist threat to big urban conurbations.

Management capability and capacity is spread thinly potentially compromising the pace of change, whilst the lack of “critical mass” within these small organisations compromises the management of financial risk. This is further compromised by the costs associated with retaining four Trust Boards which limits the money available to invest in the staff development required and to develop front line staff, managers and leaders to enable the Ambulance Service to fulfil its potential.

Establishing a single ambulance trust across the Region creates a structure which has the potential to truly deliver the strategic and operational capacity and capability needed to meet the challenges of the future and which remains sustainable into the future.

There are concerns that creating a new organisation will have a detrimental impact upon the performance standards of current high performing organisations. This is a risk in any reorganisation. However, the four ambulance trusts are working together to ensure plans are in place to ensure current standards and ways of working are sustained through the change and that all services then begin to move to the standard of the best. It is not anticipated that this new regional ambulance service will operate on a centralised command and control model. Instead, it is anticipated

that the service will balance the need for a small, strategically focused centre, with a distinct and strong local focus, based on existing local ambulance service boundaries and free to act within the parameters of defined policies and standards.

Clearly, such a proposal is also coterminous with both anticipated strategic health authority boundaries and other regional planning boundaries. Thus, such an organisation would reduce the routine administrative burden and consequent duplication currently experienced by each of the services, allowing local operations to maintain and indeed strengthen their existing links with their local communities, becoming more responsive to local needs and enabling them to focus on the development of local services to meet local needs. Within such a proposal, the need to maintain several resilient ambulance control/call centres is considered important.

A single Ambulance Trust would also have far greater capacity and capability to become a high-profile organisation that influences and directs strategy within the wider NHS. This does not happen at present.

Whilst making initial savings for reinvestment by removing the costs of existing Trust Boards and some management and administrative costs, it is anticipated that this proposal would have significant future impact in terms of reducing unnecessary hospital admissions through the use of the ambulance service to provide some primary care services and to develop services which enable patients to remain in their own homes. In addition economies of scale with regard to procurement standardisation over time will help to deliver additional savings.

Benefits of a Single Service for the West Midlands

Whilst there is no doubt the existing four ambulance services deliver high performance, a single ambulance service for the 5 million people of the West Midlands gives a structure capable of delivery of a world class service to patients. This would be based upon local management and operational structures to ensure current high standards in specific areas were not reduced.

A single service will release the costs of bureaucracies and free up resources, an estimated £3 million pounds in the short term, for additional and better trained and equipped front line staff. Further savings, as a result of size, would further be reinvested into clinical services.

A single service would have the stature to influence the forthcoming complex NHS agenda and through more efficient resource usage give greater flexibility in how the resources are deployed into the front line.

The benefits of a single service are considerable and will only be fully realised if a large degree of the locality focussed drive, management and pride is maintained and locked into robust local delivery units.

The intention is to benefit from an efficient region wide Trust with services focussed and delivered locally.

What would a single Trust and its Local Delivery Units Do?

In broad terms, the Ambulance Trust board would be responsible for setting the strategic direction and ensuring local governance. The Local Delivery Units would work closely with local NHS Trusts and deliver the broader range of quality services. In a little more detail:-

The Trust Board

Leadership and management development
Sets strategic direction and business plans
Sets the capital investments programme
Develops good clinical and corporate governance arrangements
Contributes to national policy development
Provides core business support services
Develops the capacities for Foundation Trust status
Performance Management to delivery standards

The Local Delivery Units

Day to day delivery of clinically high quality safe services
Focus on greater partnership and integration with the local NHS
Development of a greater range of services
Influence and develop with commissioners an emergency and urgent care pathway
Improve performance and clinical outcomes
Build upon the local reputations for excellence

Benefits to Patients

A single ambulance service structure across the region provides the best platform to deliver more joined up services across the individual counties with greater flexibility to deploy resources:-

Better access to specialist services previously unavailable locally
Improved co-ordination across the region
Greater capacity to further drive up standards and get better, more consistent clinical outcomes
Provide a broader range of local services for the PCT commissioners so maintaining local service delivery
Reduce the numbers of Boards and Executive Teams, auditor costs and duplication of support services allowing savings to be reinvested into the front line
Patients across the region would benefit from the best practice standards from each of the current services being implemented consistently
Paramedics and support staff would be better trained, better equipped and more confident to deliver extended range of care to patients in their homes
In the event of natural or terrorist disasters a single service will have planned and trained their responses to deliver a fast, seamless service across the West Midlands

Benefits to Staff

A single ambulance service structure across the region offers staff the best opportunity to expand and improve their range of skills through professional education and training. The eventual broader range of services will not only allow for greater job satisfaction but also for rotation within other organisations allowing for future, more diverse work opportunities. Staff will benefit from:

Better training, education, experience and equipment
Participation in a broader range of services with a broader range of organisations
Development of a wider range of competences with a greater autonomy of decision making
Opportunities for career development

Value for Money Benefits

This proposal is about saving money but saving money to invest in the ambulance service being proposed.

The more resources that can be saved through efficiency and bureaucratic cost savings, the more resources, year on year, there will be for the development of front line services.

Any organisation has to spend a minimum amount of funds just to exist and to comply with relevant regulations. Establishing one organisation rather than maintaining four will allow for significant savings to be made. These savings will be reinvested into the Local Delivery Unit capabilities and front line services through:-

Moving to one Trust means less Boards, less Executives and Non Executive Directors and reductions in some support services to senior management.
Services will come together more efficiently such as procurement, human resources, finance and payroll, information technology
A single headquarters obviously reduces the rent and rates costs as well as utility and insurance costs

Not all costs would be reduced immediately because of transitional requirements but a single Trust gives very good potential for real savings year on year.

Summary and What Happens Next

Summary

The consultation document enclosed is seeking your views on:

a proposal to establish eleven ambulance trusts across England in order to deliver organisations that are operationally fit for future challenges.

I have outlined within this letter our vision for how this could be implemented within the Region and I would be keen to hear your views on the local proposals. I would also be keen to hear your views about the name of the proposed new service. This is important because, if the proposal is accepted, then all four existing ambulance service Trusts would be dissolved and the rights, staff, liabilities and properties would be transferred to a newly established service.

Next Steps

This document will now be shared with the groups identified in the introduction.

A series of public meetings will be held across the West Midlands to present these proposals, take questions and receive views. Representatives from the Strategic Health Authorities, the Ambulance Services and the Primary Care Trust Commissioners will be in attendance.

You should send responses to:

Mr David Nicholson CBE
Commissioning a Patient Led NHS
West Midlands Consultation Office
PO Box 2675
STAFFORD
ST16 9BW

Alternatively you can fax to 0845 257 7046 or
email wmconsultation@sasha.nhs.uk

Yours faithfully,

David Nicholson CBE
Chief Executive

Birmingham and The Black Country Strategic Health Authority
Shropshire and Staffordshire Strategic Health Authority
West Midlands South Strategic Health Authority

The deadline for all responses is 22 March 2006

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**
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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 http://www.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 http://www.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

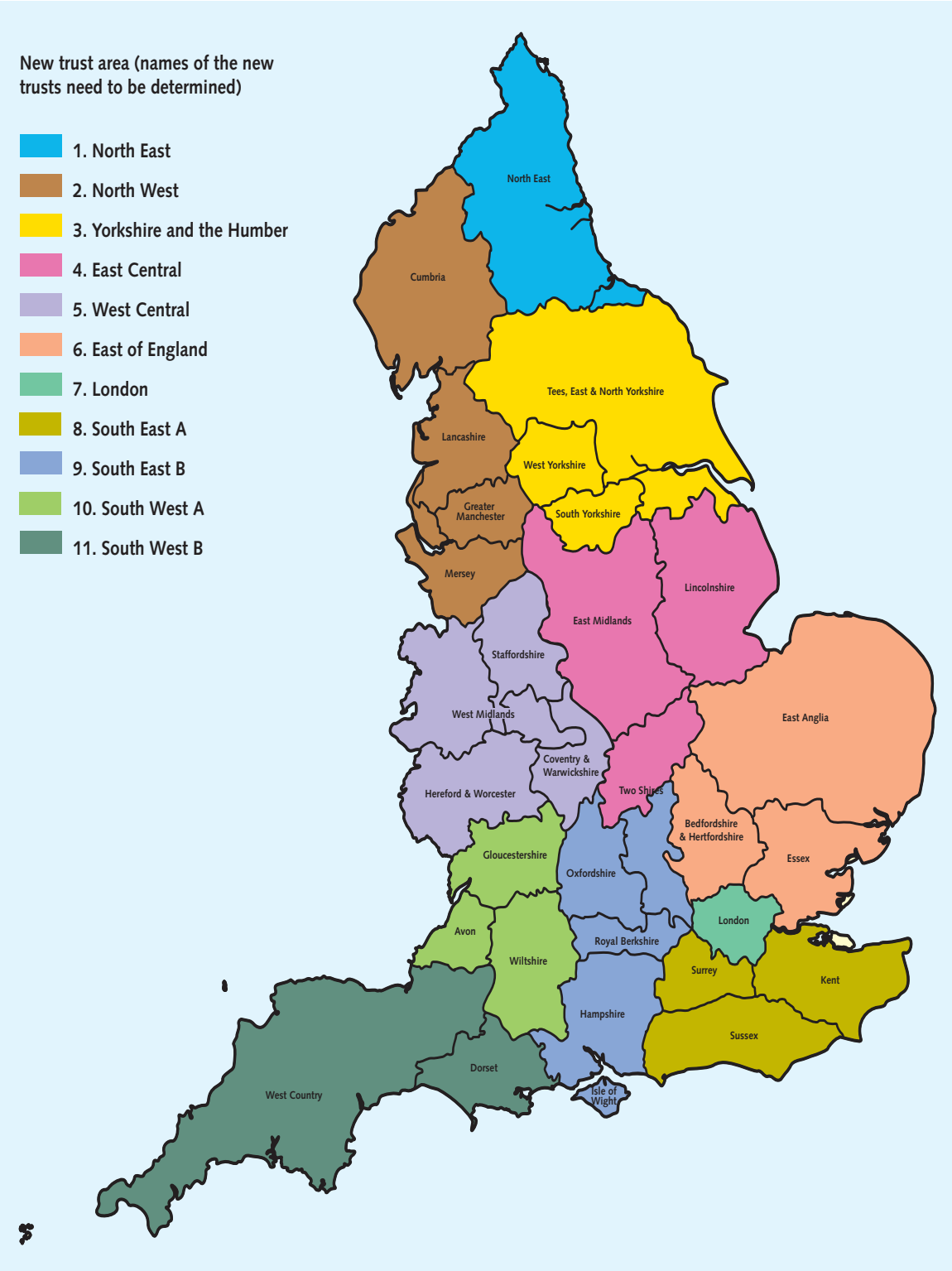
34 There should be 11 ambulance trusts organised around Government Office of the Region boundaries. For the most part, this has resulted in common boundaries with the Government Regional Offices. However, there are two areas which we have recommended splitting in two: the south east and the south west.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