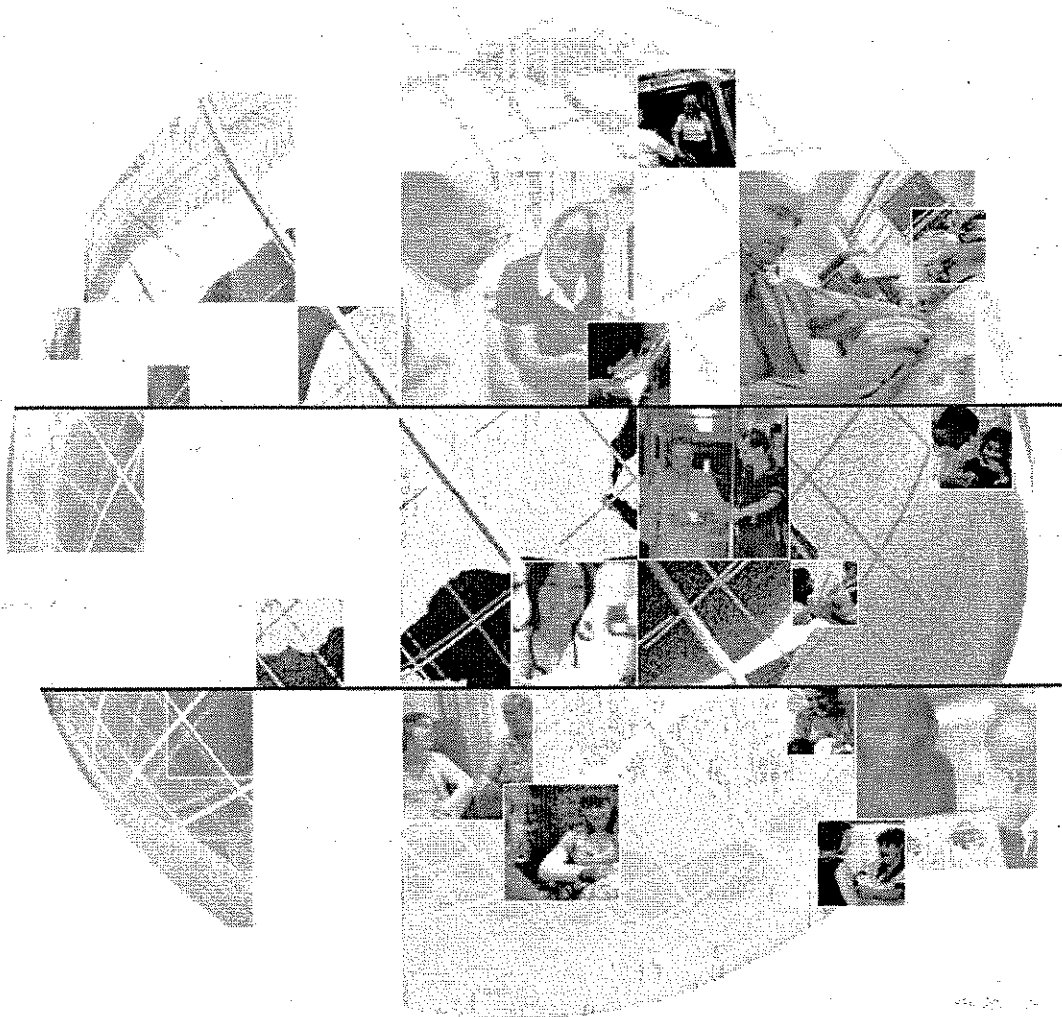
Annexe 1

Trent NHS
Strategic Health Authority



Consultation on new primary care trust arrangements in Trent: Ensuring a patient-led NHS

Consultation on new primary care trust arrangements in Trent: Ensuring a patient-led NHS

The consultation on proposals to establish new primary care trusts in England will take place on a nationwide basis for 14 weeks starting on 14 December 2005 and 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.

We can make arrangements to help those for whom English is not the preferred language. Please see the back page for details.

This document is also available on the internet at www.tsha.nhs.uk

Executive summary

This document details the proposals for reconfiguration of primary care trusts in Trent in response to the publication of *A patient-led NHS* and the subsequent document *Commissioning a patient-led NHS*.

The document sets out the options for reconfiguration and details the relevant factors to be considered for each.

It is not possible within this document to summarise all the results of discussions that have led to this consultation and it should be noted that these discussions have been recognised as informal, acknowledging that there will now be a period of consultation.

It is also important to note that **the document does not propose any direct changes to the services patients receive.** This document is proposing a change to the organisations that manage and administer the health services across Trent.

The proposals include the reconfiguration of the existing 19 primary care trusts to create new commissioning organisations: one in Lincolnshire, and either one or two in each of Nottinghamshire and Derbyshire, all working to a new East Midlands Strategic Health Authority, amalgamating the two strategic health authorities of Trent and Leicestershire, Northamptonshire and Rutland.

The timetable for the whole process is included within the document.

Contents

Foreword	5
Preface	6
Your NHS	7
Achieving a patient-led NHS	7
What do we mean when we talk about 'commissioning?'	9
The wider picture	9
What does this mean for PCTs?	10
The PCT role in more detail	10
Protecting staff	11
Next steps	11
The NHS in Trent	12
Criteria for assessment	12
Commissioning a patient-led NHS in Nottinghamshire	14
Commissioning a patient-led NHS in Derbyshire	18
Commissioning a patient-led NHS in Lincolnshire	24
Your questions answered	26
How you can have your say	28
Appendices:	
Map 1: Existing SHAs in England	30
Map 2: Existing Trent SHA and PCT boundaries	31
Map 3: Proposed new single East Midlands SHA boundary with proposed new PCT boundaries	31
List of consultees	32
Jargon and acronym buster	33
Code of practice on consultation	35

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, improving accident and emergency services and updating 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.

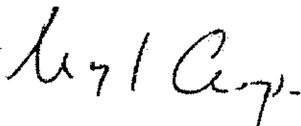
Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

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

Many of you will have already been involved in our earlier discussions on the shape of the NHS for this region and will have commented on the proposal for the primary care trusts (PCTs). However, this next consultation phase is important as it provides a real opportunity for you to engage in the discussions on the future of your NHS. We want your views, we want to listen to the issues you raise, we want you to be part of the final decision.

Much has improved in the NHS over recent years - reduced waiting times, improved treatments and better hospitals, due in part to additional resources, but also due to the dedication and professionalism of our staff. But there is still more to do if we are to address inequalities, reduce waiting still further and increase patient choice.

90 per cent of the people that come into contact with the NHS do so in primary and community services (GPs, walk-in centres, clinics). We therefore need to focus on making that experience responsive to patient needs by ensuring services are in the right place and available at the right time. We also need to make sure that we encourage people to stay healthy and that we manage long-term conditions such as diabetes and heart disease at a local level - often in people's own homes where it is safe to do so.

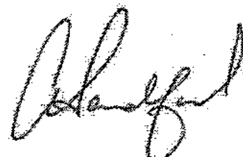
One of the biggest challenges facing us all is the fact that we are living longer. For health and social care, this means considerable resources will need to be invested to care for an ever increasing and ageing population. The proposed changes contained in this document are not directly about how and where services are provided; they are about reducing administration and management costs so we can re-invest the money where it is needed most – on the front-line. Every pound saved on management costs can be a pound invested in improving healthcare.

In order to get the most out of the money available, PCTs need to become stronger organisations with the leverage to influence the market and negotiate the best possible deal when commissioning effective services, working more closely with local partners to improve public health, reduce inequalities and ensure best value for money.

The proposals discussed in this document for fewer, larger primary care trusts across Trent provide the level of resources for reinvestment that we feel can make a real difference to health services in the area.

Running in parallel to this are consultation exercises on the reconfiguration of Trent and Leicestershire, Northamptonshire and Rutland strategic health authorities, and the ambulance services across the area.

We thank you in advance for taking the time to engage with us in this debate and we look forward to your comments and further discussions.



Alan Burns
Chief Executive
Trent Strategic Health Authority

Arthur Sandford
Chairman
Trent Strategic Health Authority

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 are unique to the Trent area and reflect the needs, preferences and health priorities of the local communities in Nottinghamshire, Derbyshire and Lincolnshire.

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

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

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, called '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 the practice based commissioning approach described above. 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[1]) which offer high quality, choice, and value for money.
- Reduce health inequalities and ensure that the role of individuals is recognised and utilised at local level.
- Develop and sustain strong relationships with GPs and their practices and implement a system of practice based commissioning.
- Work closely with local authority partners and other commissioners to ensure integrated commissioning of health and social care, including emergency planning.
- Ensure that nurses, midwives and allied health professionals play a key role in improving the health of local populations.
- Stimulate the development of a range of nursing, midwifery and allied health professional providers.
- Provide appropriate clinical leadership in a system of diverse providers.
- Develop robust communication and involvement systems to manage relationships and engage with their local residents and communities.
- Ensure that a range of services are provided for their communities in ways that most appropriately meet their local needs.

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

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 19 in Trent 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 page 28.

The NHS in Trent

Trent Strategic Health Authority (Trent SHA) serves the three East Midland counties of Derbyshire, Lincolnshire and Nottinghamshire with a combined population of 2.7 million people and a total NHS budget of £2.5 billion.

The Trent health community consists of 19 primary care trusts, four NHS hospital trusts, two ambulance trusts, three mental health trusts and two foundation trusts.

Trent is diverse and covers the rural areas of the Peak District National Park in Derbyshire and the sparsely populated communities in Lincolnshire, together with the more densely populated, multi-cultural cities of Nottingham and Derby.

The strategic health authority is accountable to the Secretary of State for Health for the performance of NHS organisations in the three counties.

The Trent Strategic Framework 2005-2010[2] describes the expected demographic shifts and trends which will shape the future of health and healthcare within the Trent SHA area for the next 20 years. It highlights that people are expected to live longer, obesity is predicted to increase and population growth will be slow. The NHS will need to ensure that service models reflect the culturally and ethnically diverse population of the region.

The strategic framework also explores the impact that the present NHS system reform initiatives will deliver by 2008. The shift from a healthcare system characterised by public service monopoly, hierarchy and top-down attitudes to one having diverse providers, networks and consumer power will continue to reform healthcare in Trent.

Currently the 19 PCTs in Trent both provide and commission services. **This document is not proposing any changes to the direct delivery of the services patients receive.** This document is, however, proposing that the two responsibilities, commissioning and providing, are separated and more clearly defined.

Creating strong organisations that can devote time, energy and resources to commissioning is important if the NHS is to develop the capacity to rise to the future challenge and deliver high quality healthcare.

Criteria for assessment

The Trent SHA Board considered a number of options for reconfiguration of each county against the criteria described in the document *Commissioning a patient led NHS*, and followed the principle indicating that the Department of Health will be looking to the reconfigured PCTs to have a clear relationship with local authority social service boundaries.

The criteria were used to assess the configuration of PCTs, described as the new organisation's ability to:

- Secure high quality, safe services: By being large enough to be a powerful commissioner with the right expertise and critical mass to secure local services. Larger, more robust organisations are likely to be more effective and benefit from a pooling of commissioning expertise, which in turn will allow some specialisation (e.g. commissioning primary care services) as well as the development of new skills in market management and practice based commissioning.
- Improve health and reduce inequalities: This requires both specific health service interventions (particularly to reduce inequalities in access to services), and joint working with

[2] Download from www.tsha.nhs.uk or telephone 0115 9684468 or email communications@tsha.nhs.uk for a hard copy.

local authorities and other agencies. Local area agreements will be a powerful vehicle to secure delivery.

- Improve the engagement of GPs and roll out practice based commissioning: With the advent of practice based commissioning with a strong local focus, the new PCTs will have a performance management and strategic commissioning role – expertise and capacity will be required to support this.
- Improve public involvement: The new organisations will need to make sure they build on the good but disparate range of work already achieved across the counties including the relationships developed with local communities through local strategic partnerships and work with the voluntary sector.
- Manage financial balance and risk: As guardians of the public purse the new PCTs must be able to operate effective mechanisms to manage the financial risks in any one year. Bigger organisations will allow concentration of expertise and smoothing of risk.
- Improve co-ordination with social services: Through greater congruence of PCT and local government boundaries. This will also be further developed in the light of an impending white paper on out of hospital care.
- Deliver at least 15% reduction in management and administrative costs: New PCTs will need to exploit economies of scale, ensuring that money spent on management costs is reduced and investment directed to front line services evident at local level.

The SHA Board then submitted the preferred options to the Secretary of State in a document titled *Creating a patient-led NHS in Trent*[3]. This document discusses all the options initially put forward for each county. The Secretary of State then decided which options should be included in this consultation document.

The PCTs, supported by the strategic health authority, have tried at all times to propose options that are strategically sound but which will allow local sensitivity.

After extensive consideration by the PCTs, SHA and Department of Health, three options are now being considered for Nottinghamshire, one option for Lincolnshire, and four options for Derbyshire. These options are discussed in more detail below.

Whilst all the options radically change the current structures in place, they will NOT affect service provision, which will remain locally sensitive and locally delivered. It is however emphasised that whilst the options create large commissioning bodies, sufficient local focus will be built into the structure to enable local sensitivity.

All options will allow economies of scale and reduce management and administrative costs to be reinvested in direct patient care.

[3] Download from www.tsha.nhs.uk or telephone 0115 9684468 or email communications@tsha.nhs.uk for a hard copy.

Commissioning a patient-led NHS in Nottinghamshire

There are currently eight PCTs operating in Nottinghamshire. These are detailed in the table below.

The PCTs operate in a climate of collaboration and work closely with one another within health and social care economies/communities, which currently focus on north and south Notts. Bassetlaw PCT also work closely with the South Yorkshire PCTs through clinical networks, which recognise their patient flows to South Yorkshire Providers

The PCTs work together across the county (with the exception of Bassetlaw) as part of the Nottinghamshire Teaching PCT, which is hosted by Mansfield District PCT.

PCT	Registered population
Ashfield	81,733
Bassetlaw	107,000
Broxtowe and Hucknall	139,000
Gedling	93,300
Mansfield District	90,775
Newark and Sherwood	126,295
Nottingham City	317,080
Rushcliffe	118,070

With the exception of Broxtowe and Hucknall and Ashfield PCTs, each of the PCTs are coterminous with their district local authority, or in the case of Nottingham City, the unitary authority. The district of Hucknall, whilst part of the Ashfield district in terms of local authority boundary, sits in the Broxtowe and Hucknall PCT rather than Ashfield PCT.

With the exception of Nottingham City PCT, all other PCTs are within the boundary of Nottinghamshire County Council.

Ashfield and Mansfield District PCTs, whilst separate statutory bodies with their own boards, professional executive committees and resource allocation, work under one integrated set of management arrangements led by a single chief executive and senior management team.

The three options being considered for Nottinghamshire are:

- Option one: One PCT for Nottinghamshire (including City and Bassetlaw)
- Option two: Two PCTs: Nottingham City and Nottingham County organisations coterminous with both city and county councils
- Option three: Two PCTS: Nottingham City and Nottingham County minus Bassetlaw, which would be linked to Doncaster.

Assessing the options against the criteria

See page 12 for a fuller explanation of each criterion.

Criterion 1: Secure high quality, safe services

Option 1: One Nottinghamshire PCT

- Reduced potential for cross boundary inequalities in access to services
- Consistent strategic goals through a single local delivery plan for health
- Confidence that emergency planning is more effectively coordinated on a large scale
- Critical mass of expertise in Nottinghamshire PCTs will improve quality commissioning and development of providers/choice for patients by having the capability to exert real influence and leverage with providers
- Critical mass of public health experience

Option 2: Nottingham City and Nottinghamshire County PCTs

- Established locality working arrangements already in place in parts of the county
- Focus on different cultures and needs across the county and of an inner city population
- Concern over the longer term sustainability of separate city and county organisations due to the size of the city PCT and reliance on collaboration with a county PCT
- Sustainability for the complete range of public health and commissioning functions will be a risk

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

- Consistent with existing clinical networks
- Consistency for the Bassetlaw population with the catchment areas for the South Yorkshire acute trusts
- Structures needed which work across local authority boundaries in relation to emergency planning, integrated health and social care delivery etc.

Criterion 2: Improve health and reduce inequalities

Option 1: One Nottinghamshire PCT

- Potential to deliver an integrated countywide approach to address health improvements.
- Improved coordination with the Government Office for East Midlands.
- Potential to dilute focus on the significant health inequalities of the city unless public health can be directed at areas of greatest need such as City; Ashfield; Mansfield.

Option 2: Nottingham City and Nottinghamshire County PCTs

- Better joint working with local authorities in order to deliver health improvement, a reduction in health inequalities and integrated services for patients and their carers.
- Opportunity for Nottingham City PCT to focus on its own complex and challenging health inequalities.
- Opportunities for joint arrangements for public health leadership.

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

- Enhanced strong public health similarities with South Yorkshire population.
- Inconsistent with local authority and government office boundaries.

Criterion 3: Improve the engagement of GPs and roll out of practice based commissioning

Option 1: One Nottinghamshire PCT

- Consistent approach across all general practices, strengthening development of patient pathways and clinical engagement.
- Coterminosity with local medical committee and other professional committees.

- Potential not to recognise the different cultures and needs of urban and rural populations and does not reflect natural clinical communities.

Option 2: Nottingham City and Nottinghamshire County PCTs
- Established locality working arrangements already in place in parts of the county
- Current health community planning/commissioning structure is not based around the city boundary

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw
- Potential to build on existing patient flows and effective working relationships between primary and secondary care
- Inconsistent with current local professional committee boundaries

Criterion 4: Improve public involvement

Option 1: One Nottinghamshire PCT
- Potential to develop county-wide approaches to public involvement
- Risk of disengagement of local population with organisation that is not seen as locally responsive

Option 2: Nottingham City and Nottinghamshire County PCTs
- Existing structures support local public involvement within local authority and voluntary sector boundaries
- Greater transparency, sensitivity and engagement of local public

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw
- Existing structures support local public involvement within local authority and voluntary sector boundaries
- Inconsistent with Nottinghamshire and south Yorkshire organised voluntary sector bodies and local authorities

Criterion 5: Manage financial balance and risk

Option 1: One Nottinghamshire PCT
- Potential to redirect resource and maximise investment in infrastructure to support services.
- Larger organisation has greater capacity to manage financial risks

Option 2: Nottingham City and Nottinghamshire County PCTs
- More responsive to local financial planning
- Greater flexibility in allocation of resource based on local needs based assessment

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw
- More responsive to local financial planning
- Greater flexibility in allocation of resource based on local needs-based assessment
- Bassetlaw would share resource allocation with another challenged community (Doncaster)

Criterion 6: Improve co-ordination with Social Services

Option 1: One Nottinghamshire PCT
- Improved coordination for Department of Health, Government Office for East Midlands and the strategic health authority
- Potential to improve cross boundary working arrangements

Option 2: Nottingham City and Nottinghamshire County PCTs
- Coterminosity of NHS and local authority (Social Services) boundaries to support more integrated health and social care from both commissioning and provision perspective
- Builds on existing strategic alliances with organisations such as the Drug and Alcohol Action Team (DAAT) and the Crime and Disorder Partnership

- Effective balance to reduce complexity in relationships with fewer organisations, enabling easier communication, speedier decision making and implementation whilst maintaining a local focus

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw
- Inconsistent with local authority boundary and existing strategic alliances will make relationships more complex.
- There are successful examples where organisations work across boundaries

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

Option 1: One Nottinghamshire PCT
- Easier to deliver in the larger organisation
- Maximum savings from reconfiguration directed to front line services such as cancer screening and palliative care

Option 2: Nottingham City and Nottinghamshire County PCTs
- PCTs will deliver at least a 15% reduction, but the level of reduction in management costs will pose a significant challenge for Nottingham City PCT whilst ensuring skills and capacity to deliver

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw
- PCTs will deliver at least a 15% reduction, but the level of reduction in management costs will pose significant challenge for Nottingham City and Bassetlaw/Doncaster PCTs

Commissioning a patient-led NHS in Derbyshire

There are currently eight PCTs operating wholly in Derbyshire. These are detailed in the table below. The Glossop population is within the Derbyshire County Council boundary, but currently forms part of Tameside and Glossop PCT. The population of each PCT is defined by the number of patients registered with each GP practice within the PCT boundary.

PCT	Registered population
Amber Valley	132,078
Central Derby	124,603
Chesterfield	110,000
Derbyshire Dales and South Derbyshire	92,596
Erewash	102,119
Greater Derby	155,505
High Peak and Dales	106,000
North Eastern Derbyshire	158,289

Note: The registered population of Glossop (as part of Tameside and Glossop PCT) is 30,511.

The four options now being considered for Derbyshire are:

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

Each of the options has benefits over the current arrangements, and all will improve the ability of the PCT to commission services.

Assessing the options against the criteria

See page 12 for a fuller explanation of each criterion.

Criterion 1: Secure high quality, safe services

All options

- Improve the ability of the PCT to commission high quality, safe services.
- Increased focus on monitoring and performance management by reducing duplication of effort.

Option 1: One Derbyshire PCT excluding Glossop

- Greater specialisation and economies of scale in commissioning; increases the PCT's leverage and influence.
- A commissioning arrangement covering mental health services for Derbyshire (excluding Glossop) has been in place successfully since 2003 for mental health services supported by a local mental health forum in each locality.
- The PCT will continue to need to participate in commissioning networks outside of Derbyshire as some patients will continue to be treated outside the county

Option 2: Derby City and Derbyshire County PCTs excluding Glossop

- Some planning structures already work on a city/county basis, although in some instances the translation from planning into commissioning happens across a wider population.
- This would require the establishment of a commissioning network between the PCTs, as neither clinical networks nor patient flows are determined by the city boundary.
- Level of duplication of commissioning activity, reducing the ability of both PCTs to develop the more specialist functions required.
- The smaller Derby PCT may not be able to exert sufficient leverage and influence in commissioning healthcare.

Option 3: One Derbyshire PCT including Glossop

- Greater specialisation and economies of scale in commissioning; increases the PCT's leverage and influence.
- A commissioning arrangement covering mental health services for Derbyshire (excluding Glossop) has been in place successfully since 2003 for mental health services supported by a local mental health forum in each locality.
- The PCT will continue to need to participate in commissioning networks outside of Derbyshire as some patients will continue to be treated outside the county
- Further specialisation and economies of scale in commissioning
- Many clinical networks and protocols between primary and secondary care (for example the Manchester Commissioning Collaborative and the Manchester Cancer Network); are the same for the existing High Peak and Dales PCT and the population of Glossop. This would strengthen the leverage of the PCT in commissioning discussions.
- This would require the establishment by the PCT of an additional agreement with Tameside Acute Trust to meet the needs of Glossop patients.

Option 4: Derby City and Derbyshire County PCTs including Glossop

- Some planning structures already work on a city/county basis – although in some instances the translation from planning into commissioning happens across a wider population.
- This would require the establishment of a commissioning network between the PCTs, as neither clinical networks nor patient flows are determined by the city boundary.
- Level of duplication of commissioning activity, reducing the ability of both PCTs to develop the more specialist functions required.

- The smaller Derby PCT may not be able to exert sufficient leverage and influence in commissioning healthcare.
- Further specialisation and economies of scale in commissioning for the county PCT
- Many clinical networks and protocols between primary and secondary care (for example the Manchester Commissioning Collaborative and the Manchester Cancer Network); are the same for the existing High Peak and Dales PCT and the population of Glossop. This would strengthen the leverage of the county PCT in commissioning discussions.
- This would require the establishment by the county PCT of an additional agreement with Tameside Acute Trust to meet the needs of Glossop patients.

Criterion 2: Improve health and reduce inequalities

Option 1: One Derbyshire PCT excluding Glossop
- Allows health inequalities to be addressed across the whole of Derbyshire (except Glossop).
- Provides the potential to equalise access to services across Derbyshire (except Glossop)
- Allows the pooling of public health expertise
- Working with local strategic partnerships and local authorities at local levels may become too far removed from decision-making for a county PCT.

Option 2: Derby City and Derbyshire County PCTs excluding Glossop
- Recognises the particular needs of the Derby city population
- Enables closer working with the Derby city local strategic partnership and allows continuation of current joint work with Derby City Council.
- Both organisations may be less able to invest in public health infrastructure to support core functions and support to locality working.

Option 3: One Derbyshire PCT including Glossop
- Allows health inequalities to be addressed across the whole of Derbyshire.
- Provides the potential to equalise access to services across Derbyshire.
- Allows the pooling of public health expertise.
- Working with local strategic partnerships and local authorities at local levels may become too far removed from decision-making for a county PCT.
- Allows health inequalities to be addressed across the whole of Derbyshire
- Provides the potential to equalise access to services across the whole of Derbyshire
- There is already joint working between public health clinicians in High Peak and Dales and Tameside and Glossop PCTs, particularly on the local strategic pPartnership

Option 4: Derby City and Derbyshire County PCTs including Glossop
- Recognises the particular needs of the Derby city population
- Enables closer working with the Derby city local strategic partnership and allows continuation of current joint work with Derby City Council.
- Allows health inequalities in the county PCT to be addressed across the whole of Derbyshire
- Provides the potential to equalise access to services across the whole of the county PCT.
- There is already joint working for the county PCT between Public Health clinicians in High Peak and Dales and Tameside and Glossop PCTs, particularly on the Local Strategic Partnership.
- Both organisations may be less able to invest in public health infrastructure to support core functions and support to locality working.

Criterion 3: Improve the engagement of GPs and roll out of practice based commissioning

Option 1: One Derbyshire PCT excluding Glossop
- Less duplication of effort, with one PCT providing support (except to Glossop practices), plus the ability to increase resources devolved for support.

- Would enable maximum flexibility in design of practice groupings, which may cross over the city/county border.
- Ensures consistency of approach across all Derbyshire practices (except Glossop).

Option 2: Derby City and Derbyshire County PCTs excluding Glossop

- The higher overhead costs of maintaining two PCTs would reduce the ability to devolve resources to support practice based commissioning.
- Could result in differing approaches emerging between the two PCTs.

Option 3: One Derbyshire PCT including Glossop

- Less duplication of effort, with one PCT providing support, plus the ability to increase resources devolved for support.
- Would enable maximum flexibility in design of practice groupings, which may cross over the city/county border.
- Ensures consistency of approach across all Derbyshire practices.
- The professional and clinical networks for GPs in Glossop extend in to Manchester. There is little history of joint working between GPs in Glossop and GPs in the rest of Derbyshire

Option 4: Derby City and Derbyshire County PCTs including Glossop

- The higher overhead costs of maintaining two PCTs would reduce the ability to devolve resources to support practice based commissioning.
- Could result in differing approaches emerging between the two PCTs.
- No duplication of effort for the county PCT, with one PCT providing support, plus the ability to maximise resources devolved to support.
- Ensures consistency of approach across all Derbyshire practices for the county PCT.
- The professional and clinical networks for GPs in Glossop extend in to Manchester. There is little history of joint working between GPs in Glossop and GPs in the rest of Derbyshire.

Criterion 4: Improve public involvement

Option 1: One Derbyshire PCT excluding Glossop

- Provides a simpler communication pathway for patients, public and other organisations who are often confused by the current boundaries within the NHS.
- Would provide better opportunities to develop meaningful partnerships with some hard to reach groups e.g. the deaf community, black and minority ethnic communities.

Option 2: Derby City and Derbyshire County PCTs excluding Glossop

- Arrangements for public involvement more consistent with existing local authority arrangements.
- Greater local sensitivity and engagement.
- Less opportunity to develop a combined infrastructure to support patient and public involvement.
- Some voluntary organisations cover the whole of Derbyshire.

Option 3: One Derbyshire PCT including Glossop

- Provides a simpler communication pathway for patients, public and other organisations who are often confused by the current boundaries within the NHS.
- Would provide better opportunities to develop meaningful partnerships with some hard to reach groups e.g. the deaf community, black and minority ethnic communities
- Improved co-terminosity for Derbyshire-wide voluntary organisations
- Some Glossop-based voluntary organisations have developed links with Tameside and Glossop PCT.

Option 4: Derby City and Derbyshire County PCTs including Glossop

- Arrangements for public involvement more consistent with existing local authority arrangements.

- Greater local sensitivity and engagement.
- Less opportunity to develop a combined infrastructure to support patient and public involvement
- Some voluntary organisations cover the whole of Derbyshire.
- Some Glossop-based voluntary organisations have developed links with Tameside and Glossop PCT.

Criterion 5: Manage financial balance and risk

Option 1: One Derbyshire PCT excluding Glossop
- Larger organisation is more able to manage financial risks and fluctuations in income and/or costs.

Option 2: Derby City and Derbyshire County PCTs excluding Glossop
- The Derby PCT would have limited ability to manage financial risks and fluctuations in income and/or costs.

Option 3: One Derbyshire PCT including Glossop
- Larger organisation is more able to manage financial risks and fluctuations in income and/or costs.
- Further opportunities for a larger organisation to manage financial risks and fluctuations in income and/or costs.

Option 4: Derby City and Derbyshire County PCTs including Glossop
- The Derby PCT would have limited ability to manage financial risks and fluctuations in income and/or costs.
- Further opportunities for the county PCT to manage financial risks and fluctuations in income and/or costs.

Criterion 6: Improve co-ordination with Social Services

All options
- More effective joint working with the county council.

Option 1: One Derbyshire PCT excluding Glossop
- Potential for health organisations to develop a Derbyshire-wide (excluding Glossop) approach to joint commissioning.
- Less duplication in working on some county-wide responsibilities and working with county-wide organisations, such as Police and local representative committees.
- The PCT would need to work with two separate Social Services departments and tier 1 local authorities.

Option 2: Derby City and Derbyshire County PCTs excluding Glossop
- Co-terminosity with the city council and greater co-terminosity with the county council allows for greater integration of planning and some service provision.
- Consistent with some existing programmes of work e.g. local area agreements and drug action teams.
- Maintaining two PCTs may hinder the development of services that would naturally cross the city/county boundary.

Option 3: One Derbyshire PCT including Glossop
- Potential for health organisations to develop a Derbyshire-wide approach to joint commissioning.
- Less duplication in working on some county-wide responsibilities and with county-wide organisations, such as Police and local representative committees.
- The PCT would need to work with two separate Social Services departments and tier 1 local authorities.

- Complete co-terminosity with the county council would allow for further integration of planning and commissioning e.g. children's trusts.

Option 4: Derby City and Derbyshire County PCTs including Glossop

- Co-terminosity with the city council and greater co-terminosity with the county council allows for greater integration of planning and some service provision.
- Consistent with some existing programmes of work e.g. local area agreements and drug action teams.
- Maintaining two PCTs may hinder the development of services that would naturally cross the city/county boundary.
- Complete co-terminosity with the county council would allow for further integration of planning and commissioning in the county PCT e.g. for children's trusts.

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

Option 1: One Derbyshire PCT excluding Glossop

- More opportunity to realise efficiencies and economies of scale, particularly by only having one Board and one set of governance arrangements.

Option 2: Derby City and Derbyshire County PCTs excluding Glossop

- As a smaller PCT there is the potential for the Derby PCT to have a relatively high operating cost, which may make it difficult to deliver fully the minimum required 15% reduction in management and administrative costs.
- The smaller PCT may be unable to adequately build capacity and capability in commissioning, market intelligence, and practice based commissioning infrastructure support whilst operating with a reduced management overhead resource.

Option 3: One Derbyshire PCT including Glossop

- More opportunity to realise efficiencies and economies of scale, particularly by only having one board and one set of governance arrangements.

Option 4: Derby City and Derbyshire County PCTs including Glossop

- As a smaller PCT there is the potential for the Derby PCT to have a relatively high operating cost, which may make it difficult to deliver fully the minimum required 15% reduction in management/admin costs.
- The smaller PCT may be unable to adequately build capacity and capability in commissioning, market intelligence, and Practice Based Commissioning infrastructure support whilst operating with a reduced management overhead resource.
- Further opportunities for the county PCT to realise efficiencies and economies of scale

Commissioning a patient-led NHS in Lincolnshire

There are currently three PCTs operating in Lincolnshire. These are detailed in the table below.

PCT	Registered population
East Lincolnshire	287,570
Lincolnshire South West teaching	192,591
West Lincolnshire	223,134

A small number of practices are physically located outside Lincolnshire but have a number of patients resident within Lincolnshire. It was proposed that these practices will transfer to the respective PCT in the county in which they are physically located.

This document is seeking your views only on the option of creating a single PCT for Lincolnshire. The strengths of this option assessed against the criteria are detailed below.

Assessing the options against the criteria

See page 12 for a fuller explanation of each criterion.

Criterion 1: Secure high quality, safe services

- Sufficient size, covering the population of 703,295, to be a strong purchaser of services from a wide range of providers and influence market conditions between practice based commissioning units and providers of services within an evolving environment of choice and contestability of service provision.

Criterion 2: Improve health and reduce inequalities

- Plans to formally bring together the specialist public health function in Lincolnshire currently delivered across the three PCTs, and appoint a joint director of public health with the county council to strengthen joint working.
- Plans to pursue joint posts with district councils to strengthen the joint working of local strategic partnerships.
- Better able to develop the necessary relationships at different levels of local government and best placed to address health inequalities across the whole of Lincolnshire.
- Well placed to balance investment across the county and ensure services are provided in such a way as to improve the health of the population and reduce identified health inequalities and inequities in healthcare provision.

Criterion 3: Improve the engagement of GPs and roll out of practice based commissioning

- Able to bring a consistent approach to engaging primary care contractors such as general practitioners, pharmacists and dentists, so avoiding possible confusion and inequity.
- Able to provide a consistent approach to investment decisions, apportionment of resources and development of incentives, which will be crucial to the success of developing practice based commissioning.

Criterion 4: Improve public involvement

- Consistency of approach. Engaging the public across the whole county in the planning and development of services will be a key role of the new PCT and being able to discuss issues across all the localities will bring a richer perspective to the debate.

Criterion 5: Manage financial balance and risk

- Able to balance resources and investment across the whole county.
- Greater ability to manage the fluctuations in activity and finance that might occur if patients choose to have treatment with out of county providers.

Criterion 6: Improve co-ordination with Social Services

- Enhanced coordination and quality of services by having geographical boundaries that match the boundaries of Lincolnshire County Council.
- Joint post with the county council in public health and increased joint working will enable more integrated commissioning of health and social care services, which will help improve the health of the population.
- Lack of coordination and poor communication may emerge if boundaries are not coterminous.

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

- Able to deliver at least a 15% reduction in management and administrative costs due to reduced overheads associated with having a single organisation.

Your questions answered

Will the new PCTs be 'local' enough to understand the health needs of local communities?

One of the key successes of existing PCTs has been their ability to work at a very local level. The new PCTs will continue the strong relationships that already exist with local service providers. In addition, in Lincolnshire the county council is currently undergoing a period of change and management reorganisation, which represents a significant opportunity for the health community to develop joint working with the new structure at the county council.

What really are the benefits for staff?

The movement to larger organisations should present better career structures, more opportunities for personal development, and opportunities to develop specialist roles. It will enable opportunities for shared learning activities and consistent working practices to be applied across our new geographic boundaries, with greater opportunities to learn from good practice within the organisation.

Additionally, staff in provider organisations will have to deal with far fewer commissioning organisations, which will streamline planning and decision making.

What really are the benefits for patients?

Money saved from management and administrative costs will be put into patient care. The PCTs will become stronger commissioners of services with greater leverage and a key role in managing the local health economy and ensuring greater equity of services across larger geographical areas.

Reducing the number of separate health organisations in Trent should make it easier for patients to understand the health system and offer a simpler communication channel, and the proposed new configurations will present greater opportunity to develop meaningful partnership with hard to reach groups.

You want to reduce the number of NHS organisations; will this mean job losses – and which kind of jobs - management and administrative and/or nurses and other care professionals?

The movement to fewer and larger organisations will mean that there will be economies of scale arising from duplication of current roles. As a consequence there will be fewer management and administrative posts required. This will mean that a number of staff will need to be declared "at risk" of redundancy.

We will work with affected individuals and trade unions to identify ways of trying to ensure minimum redundancies. We will also work in line with a national human resources framework that will be based on best practice and will negotiate with staff side representatives at a national level.

There will not be a reduction in the number of clinical staff and services, and patients will not be affected by these proposals.

How will these changes affect partner organisations such as the voluntary sector?

These changes should make it easier to engage with partner organisations and the voluntary sector by streamlining the number of commissioning organisations. This will particularly help in the opportunities for joint working between health commissioning bodies and other organisations. The exception will be out of county providers, who will lose the local focus and relationship currently possible with smaller, locally based PCTs.

What happens next?

The consultation on PCT reconfiguration will run until 22 March 2006. When the local consultations have finished, strategic health authorities will prepare and submit the results of the consultations, along with their recommendations, to the Secretary of State by 12 April 2006. The external panel will review the recommendations, and then the Secretary of State will consider them. Where recommendations are accepted, the administrative process to disestablish current organisations and establish new PCTs will take place in the latter part of 2006.

The Department of Health has set a deadline of October 2006 for all changes to PCT configuration to be complete.

How you can have your say

Your views form a vital part of the proposal to create a new PCT configuration in Trent, and we would encourage you to send us your comments about the proposals.

The 14-week consultation period begins on 14 December 2005 and ends on 22 March 2006. Trent Strategic Health Authority is actively inviting responses from individuals and organisations during this time and will be contacting staff, patients, patient representative groups, GPs, healthcare organisations, local authorities, universities, health charities, MPs and the media, among others, to seek their views.

We will also be holding public meetings which you are welcome to attend. Details of these are available on the strategic health authority's website at www.tsha.nhs.uk or in your local library.

There are several ways you can have your say and find out more:

Meetings
Attend one of the public meetings mentioned above.

Email
Send your comments to PCTconsultation@tsha.nhs.uk

Online
Visit the Trent SHA website at www.tsha.nhs.uk

Post
Use the form opposite to write to us at:
FREEPOST RLYT-HCXH-ZEZA
PCT consultation
Trent SHA
Nottingham
NG10 5QG

A summary of all responses received will be compiled after consultation ends, and subsequently published. Details of individual responses can be requested and must be disclosed under the Freedom of Information Act 2000, unless confidentiality is specifically requested. Please make it clear if you wish your comments to remain confidential.

All comments must be received by Wednesday 22 March 2006.

Thank you for taking part in this consultation.

Have your say on the proposed reconfiguration of primary care trusts in Trent

Are you commenting on (please tick all that apply):

☐ Lincolnshire ☐ Nottinghamshire ☐ Derbyshire ☐ All

Which proposals do you think would be best for your local NHS?

Why do you think this?

What suggestions would you make to improve it further?

Any other comments?

Please indicate which option you **support** by ticking the appropriate box(es):

Lincolnshire	- option 1 ☐
Nottinghamshire	- option 1 ☐ option 2 ☐ option 3 ☐
Derbyshire	- option 1 ☐ option 2 ☐ option 3 ☐ option 4 ☐

If you **do not** support any of the above options, please indicate what your alternative would be.

Name (optional):

Address (optional):

Email (optional):

Phone number (optional):

Are you responding as a member of staff, member of the public, or part of an organisation (if yes, please state which)?

If you wish for your comments to remain confidential, please tick the box ☐

Please return this form to the freepost address on the opposite page no later than 22 March 2006.