Hampshire and Isle of Wight NHS
Strategic Health Authority

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

ENSURING A PATIENT-LED NHS

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Foreword

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

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

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

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

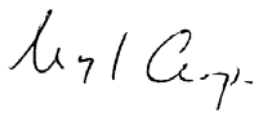
Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

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

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

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

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



Sir Nigel Crisp KCB

Chief Executive, Department of Health and NHS

Preface

Commissioning a Patient-led NHS

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

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

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

or

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

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

Professor Jonathan Montgomery
Chairman

Sir Ian Carruthers OBE
Chief Executive

Hampshire and Isle of Wight Strategic Health Authority

SECTION 1

BACKGROUND TO
'COMMISSIONING A PATIENT-LED NHS'

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

1 YOUR NHS

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

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

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

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

2 ACHIEVING A PATIENT-LED NHS

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

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

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

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

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

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

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

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

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

- a wider range of services in convenient community settings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 THE WIDER PICTURE

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

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

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

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

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

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

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

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

5 WHAT DOES THIS MEAN FOR STRATEGIC HEALTH AUTHORITIES?

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

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

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

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

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

6 THE STRATEGIC HEALTH AUTHORITY ROLE IN MORE DETAIL

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

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

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

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

7 PROTECTING STAFF

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

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

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

8 NEXT STEPS

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

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

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

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

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

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

SECTION 2

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

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

1 PROPOSED NEW STRATEGIC HEALTH AUTHORITY ARRANGEMENTS

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

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

2 THE LOCAL AREA AND ITS PEOPLE

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

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

3 HEALTH AND HEALTH CARE

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

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

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

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

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

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

4 PROPOSALS FOR THE FUTURE CONFIGURATION OF STRATEGIC HEALTH AUTHORITIES

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

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

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

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

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

    - size and diversity of the area and population served;

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

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

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

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

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

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

4.4 The criteria are considered in the Table 2.

TABLE 2: CRITERIA FOR STRATEGIC HEALTH AUTHORITY CONFIGURATION

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

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

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

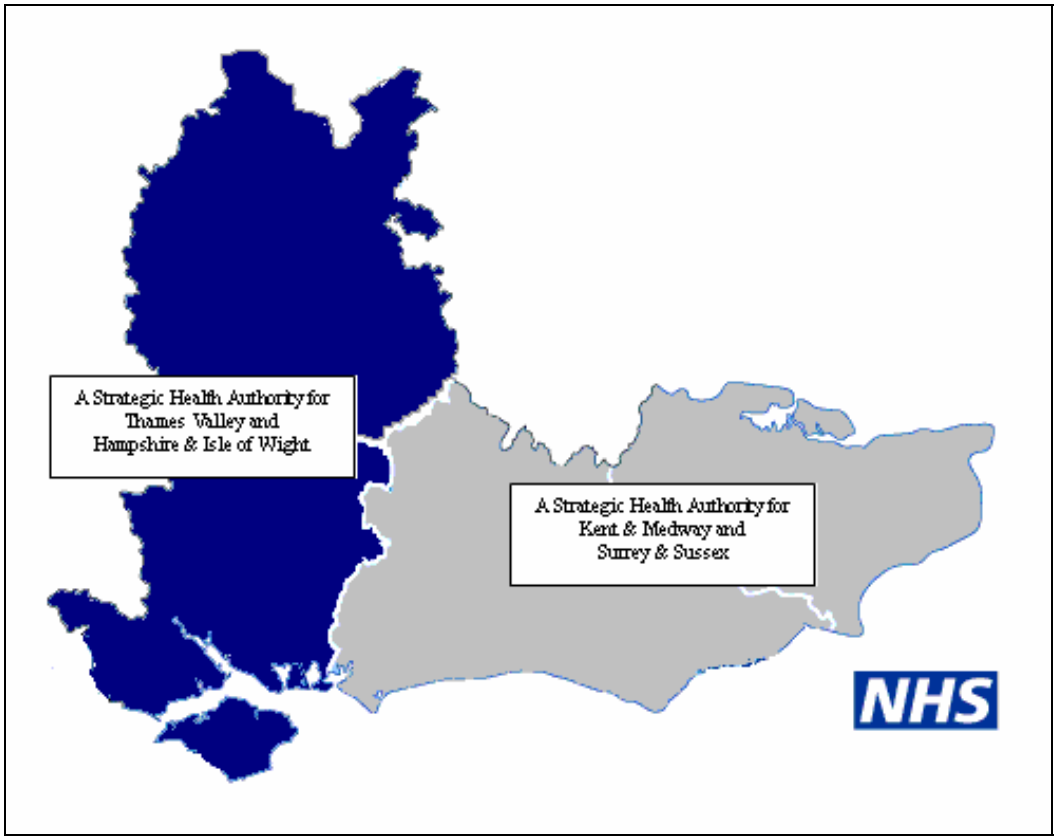
- **scale -** the south east government office area is the highest and most densely populated of the Government Office Regions - and is set to undergo further significant growth;
- **population profile** - the socio economic and demographic mix creates significant health challenges;
- **complexity -**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

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

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

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

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



5 LOCAL CONSULTATION

Timetable for Local Consultation

5.1 The following table sets out the timetable for consultation.

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

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

Copies of the Consultation Document

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

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

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

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

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

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

Making Your Views Known

5.6 Views and comments on these proposals should be sent:

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

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

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

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

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