Hampshire and Isle of Wight NHS
Strategic Health Authority

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

ENSURING A PATIENT-LED NHS

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Foreword

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

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

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

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

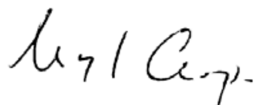
Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

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

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

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

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



Sir Nigel Crisp KCB

Chief Executive, Department of Health and NHS

Preface

Commissioning a Patient–led NHS

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

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

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

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

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

Professor Jonathan Montgomery
Chairman

Sir Ian Carruthers OBE
Chief Executive

Hampshire and Isle of Wight Strategic Health Authority

SECTION ONE

BACKGROUND TO COMMISSIONING A PATIENT-LED NHS

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

1 YOUR NHS

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

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

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

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

2 ACHIEVING A PATIENT-LED NHS

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

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

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

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

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

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

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

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

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

- a wider range of services in convenient community settings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 THE WIDER PICTURE

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

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

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

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

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

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

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

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

5 WHAT DOES THIS MEAN FOR PRIMARY CARE TRUSTS?

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

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

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

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

6 THE PRIMARY CARE TRUST ROLE IN MORE DETAIL

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

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

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

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

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

7 PROTECTING STAFF

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

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

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

8 NEXT STEPS

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

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

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

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

SECTION TWO

PROPOSALS FOR THE CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

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

1 THE PRESENT CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

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

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

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

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

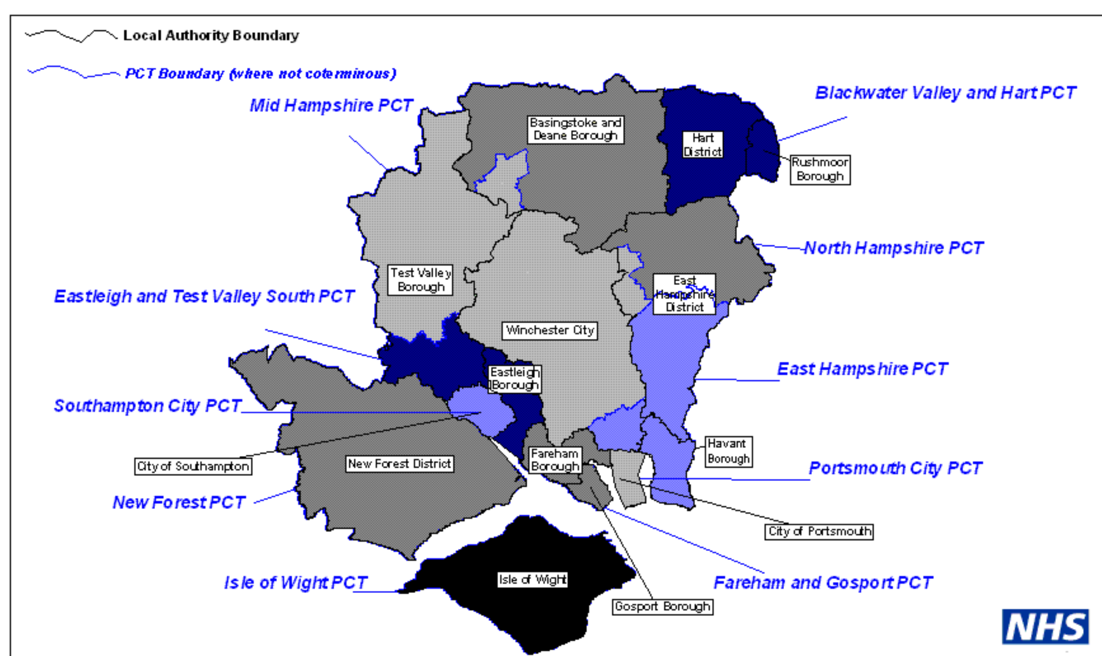
TABLE 1: EXISTING PRIMARY CARE TRUSTS AND LOCAL AUTHORITIES IN HAMPSHIRE

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

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

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

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



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

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

2 THE FUTURE CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

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

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

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

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

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

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

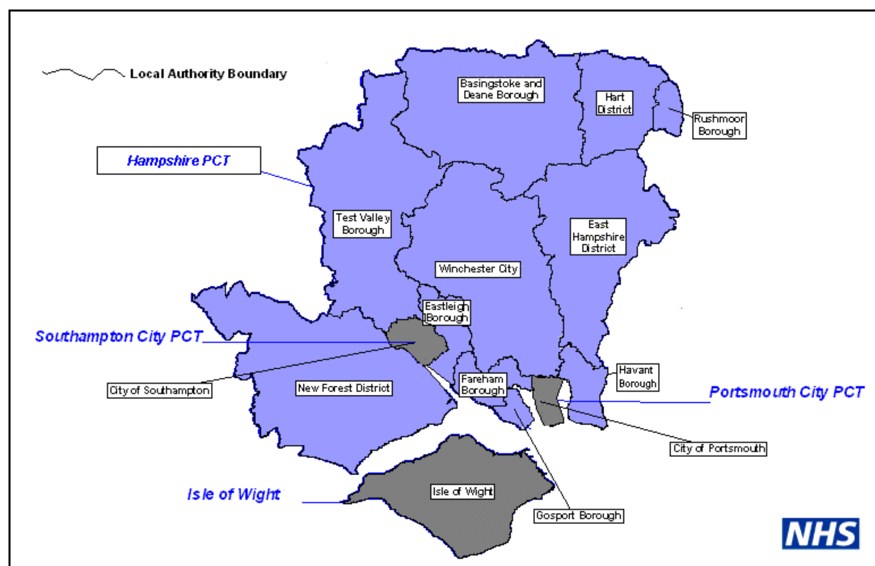
- Option B: three Primary Care Trusts replacing the existing seven Primary Care Trusts.

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

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

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

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

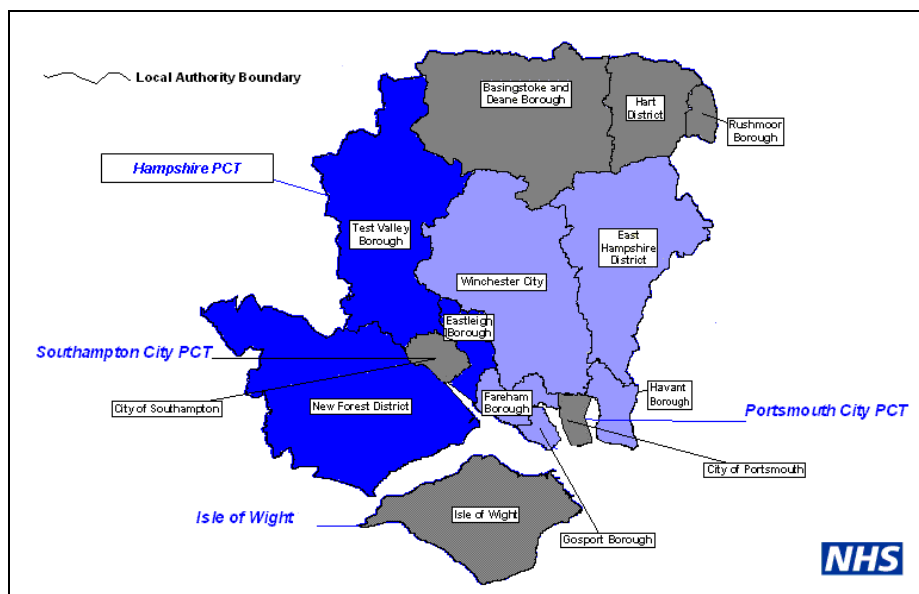


2.6 Table 3 shows the population served by these proposed new organisations and their relationships with Local Authorities under Option B (three Primary Care Trusts for Hampshire). Figure 3 is a map which illustrates Option B.

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

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

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



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

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

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

3 THE PROPOSED CONFIGURATION OF PRIMARY CARE TRUSTS IN HAMPSHIRE

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

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

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

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

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

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

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

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

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

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

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

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

SECTION THREE

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

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

1 THE SPECIAL CIRCUMSTANCES OF THE ISLE OF WIGHT

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

2 THE PRESENT CONFIGURATION ON THE ISLE OF WIGHT

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

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

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

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

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

3 THE FUTURE CONFIGURATION ON THE ISLE OF WIGHT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 4

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

4 THE PROPOSED CONFIGURATION ON THE ISLE OF WIGHT

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

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

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

SECTION FOUR

CONSULTATION PROPOSALS

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

1 CONSULTATION PROPOSALS

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

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

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

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

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

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

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

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

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

2 LOCAL CONSULTATION

Timetable for Local Consultation

2.1 The following table sets out the timetable for consultation.

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

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

Copies of the Consultation Document

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

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

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

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

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

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

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

Making Your Views Known

2.6 Views and comments on these proposals should be sent:

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

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

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

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

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