Configuration of NHS Ambulance Trusts in England

Consultation Document

Configuration of NHS Ambulance Trusts in England

Consultation Document

DH INFORMATION READER BOX

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Superseded Docs	**N/A**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

Your ambulance trust – your views

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

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

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

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

Process

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

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

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

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

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

Background

Progress to date

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

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

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

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

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

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

How ambulance services will continue to improve

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

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

10 This will have the following benefits:

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

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

Why changes to service organisation are necessary

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

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

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

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

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

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

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

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

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

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

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

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

The proposal

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

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

25 The benefits of this proposal are:

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

The proposed restructure

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

Size – would they be able to deliver?

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

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

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

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

Structure – how would they fit with other service providers?

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

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

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

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

Our recommendation

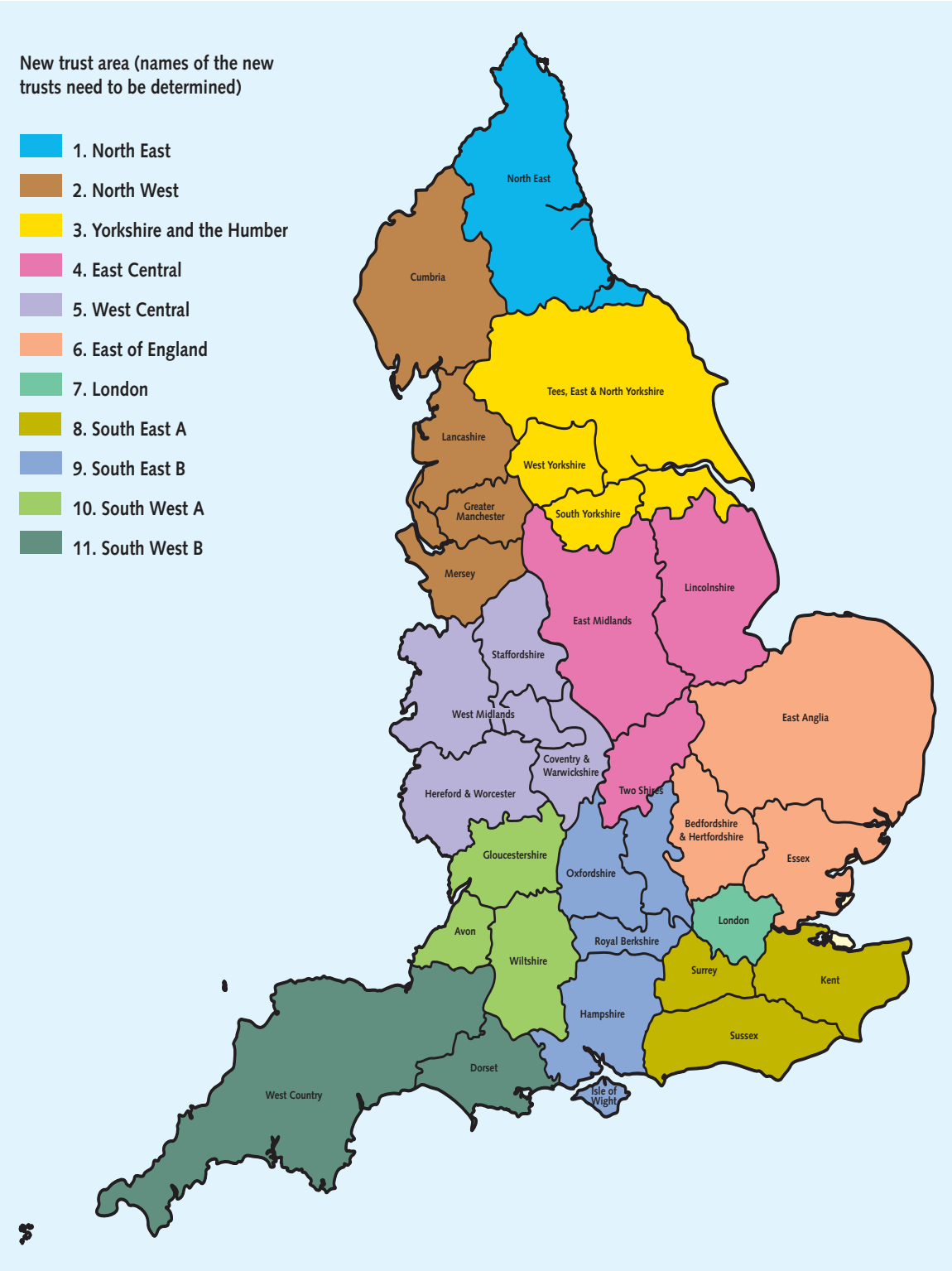
34 There should be 11 ambulance trusts organised around Government Office of the Region boundaries. For the most part, this has resulted in common boundaries with the Government Regional Offices. However, there are two areas which we have recommended splitting in two: the south east and the south west.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

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

Proposed ambulance trusts

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

Proposed ambulance trust configuration



The South East Government Region

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

The South West Government Region

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

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

Isle of Wight

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

London

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

Other areas

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

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

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

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

The benefits

Overall benefits

43 These proposals would provide:

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

Benefits for patients

Raising standards

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

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

More investment in front-line services

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

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

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

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

Responding quickly and effectively to local needs

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

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

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

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

  (a) the planning of the provision of those services

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

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

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

Support good performance

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

Benefits for staff

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

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

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

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

Savings for re-investment in front-line services

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

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

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

Reduced overheads

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

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

Re-investment

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

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

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

What happens next?

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

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

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

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

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

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

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

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

Produced by COI for the Department of Health

272302 1p 75k Dec 05 (CWP)

CHLORINE FREE PAPER

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

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

If you require further copies of this title quote *272302/Configuration of NHS Ambulance Trusts in England – Consultation Document* and contact:
DH Publications Orderline
PO Box 777
London SE1 6XH
Tel: 08701 555 455
Fax: 01623 724 524
Email: dh@prolog.uk.com

08700 102 870 – Textphone (for minicom users) for the hard of hearing 8am–6pm Monday to Friday

www.dh.gov.uk/publications