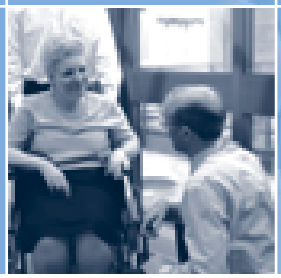
Leicestershire, Northamptonshire and Rutland
Strategic Health Authority

Consultation on new Primary Care Trust arrangements in Leicestershire, Northamptonshire and Rutland:

Ensuring a patient-led NHS



Current NHS organisations in Leicestershire, Northamptonshire and Rutland

(December 2005)

NHS hospital trusts provide services across PCT areas, as do the following:

- Leicestershire Partnership Trust
- Northamptonshire Healthcare NHS Trust
- Two Shires Ambulance Service NHS Trust (Northamptonshire)
- East Midlands Ambulance Service (Leicestershire and Rutland)

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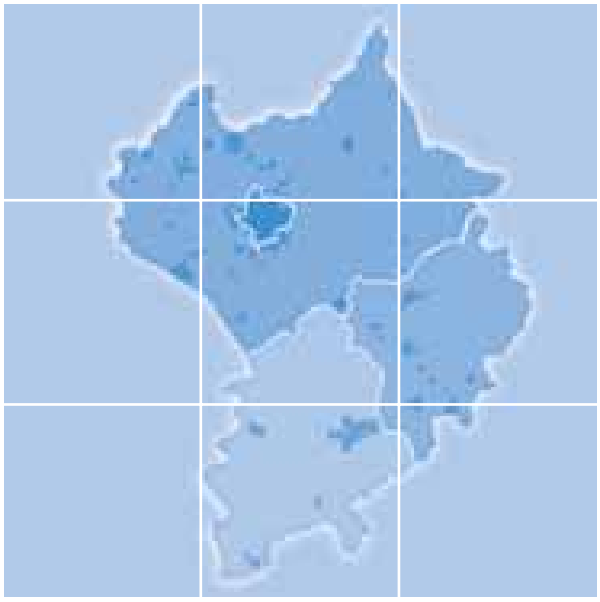


This public consultation runs from 14 December 2005 to 22 March 2006.

For details of how to respond to the consultation and how to obtain this document in alternative formats, please see Appendix 5 on page 27.

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, with improved accident and emergency services and more up-to-date buildings.

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

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

Alongside public health development, commissioning must place a real emphasis on safety and quality.

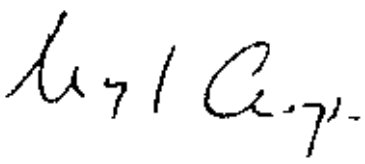
Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

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

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

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

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



Sir Nigel Crisp KCB Chief Executive,
Department of Health and NHS

Preface

This document sets out two proposals for the creation of a new structure of Primary Care Trusts within Leicestershire, Northamptonshire and Rutland, namely:

Proposal 1: to create

- One Primary Care Trust (PCT) for the city of Leicester
- One PCT for the counties of Leicestershire and Rutland, and
- One PCT for the county of Northamptonshire.

Proposal 2: to create

- One Primary Care Trust (PCT) for the city of Leicester
- One PCT for the counties of Leicestershire and Rutland, and
- Two PCTs for the county of Northamptonshire.

These proposals are the subject of a public consultation which commences on the 14th December 2005 and closes on 22nd March 2006.

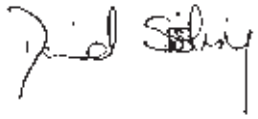
The consultation is being led by the Leicestershire, Northamptonshire and Rutland Strategic Health Authority (LNR SHA), and jointly delivered with the nine current Primary Care Trusts.

In consulting on these proposals, the SHA is seeking the views, opinions and advice of members of the public and those who work in or with the NHS (organisations and individuals). These will then be taken into account by the LNR SHA Board when it determines a recommendation to be put forward to the Secretary of State for Health with regard to the new structure. The Secretary of State will subsequently create the new organisations, dissolve the existing PCTs, and arrange the transfer of assets into the new NHS organisations. It is intended that this latter part of the process, with the new PCTs in place, will be completed by October 2006.

The LNR SHA Board will carefully weigh the views expressed by participants in this consultation. We have arrived at the proposals after an inclusive process of engagement with key stakeholders was undertaken by each of the current Primary Care Trusts. We are keen to maintain this inclusiveness. We will consider all of the views that are expressed. We have arranged, in conjunction with the PCTs, for an extensive range of consultation meetings to take place to assist this process. These meetings will be identified and written up on our website www.lnrsha.nhs.uk/consultations.
Written submissions are also invited: a reply sheet is provided as part of this document, and an electronic version is available on the SHA website.

During the engagement process a number of issues were raised that need to be addressed in creating the new PCTs. These are set out in this document and, in addition to the proposals, the SHA is keen to have your views and advice on these and any other related matters.

I do hope that you or your organisation will take the opportunity to participate in this consultation: the SHA is keen to have your views.



David Sissling, Chief Executive, Leicestershire, Northamptonshire and Rutland Strategic Health Authority.

1. Your NHS

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

1.02 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.

1.03 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.

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

Achieving a patient-led NHS

1.05 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?

1.06 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.

1.07 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.

1.08 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.

1.09 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.

1.10 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.

1.11 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.

1.12 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.

1.13 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'.

1.14 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.

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

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

1.16 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.

1.17 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.

1.18 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.

1.19 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.

1.20 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.

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

The wider picture

1.22 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.

1.23 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.

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

1.25 PCTs will play a crucial role in working with their practices to design, plan and develop better services for patients. They will conduct needs assessments of their local communities and work

closely with local authorities so that the wider health and care needs of local communities are addressed. There are lessons concerning commissioning that can be learnt from local authorities.

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

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

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

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

What does this mean for PCTs?

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

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

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

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

The PCT role in more detail

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

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

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

1.35 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.

1.36 The Department of Health has a significant programme of policy development work on the future regulation and management of the health system overall. Further guidance in 2006 will set out the implications of this work for SHAs, PCTs and other NHS bodies.

Protecting staff

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

1.38 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.

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

Next steps

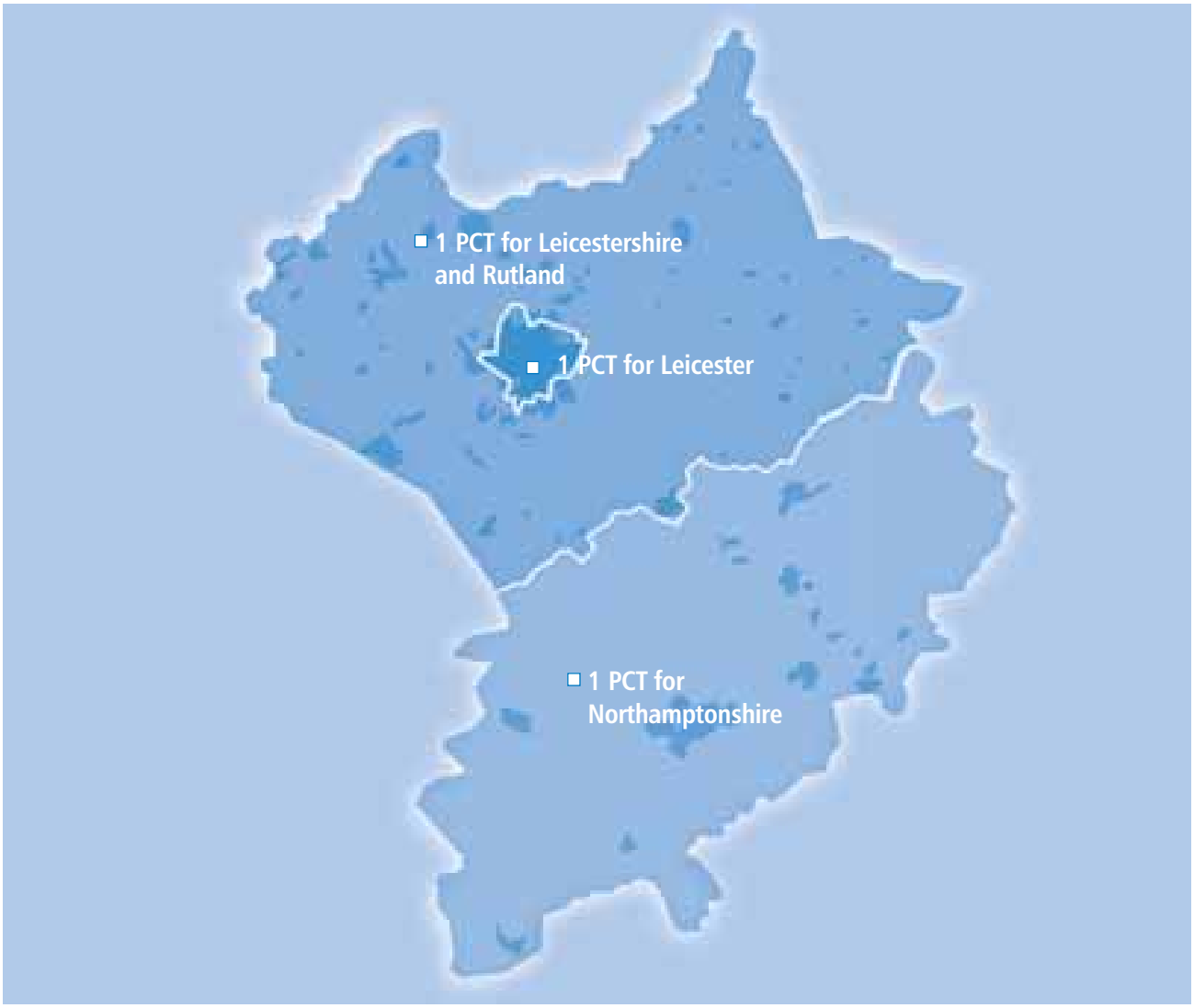
1.40 This document is one of a series of separate consultation exercises on the proposed boundaries and structures for each new PCT. Proposals for the new SHA boundaries are also being consulted on at local level in a similar way.

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

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

An explanation of how to comment and by when is set out in David Sissling's preface to this document and in full in Appendix 1 (see page 23). Arrangements for people with impaired vision, hearing or other special needs are also set out in Appendix 1.

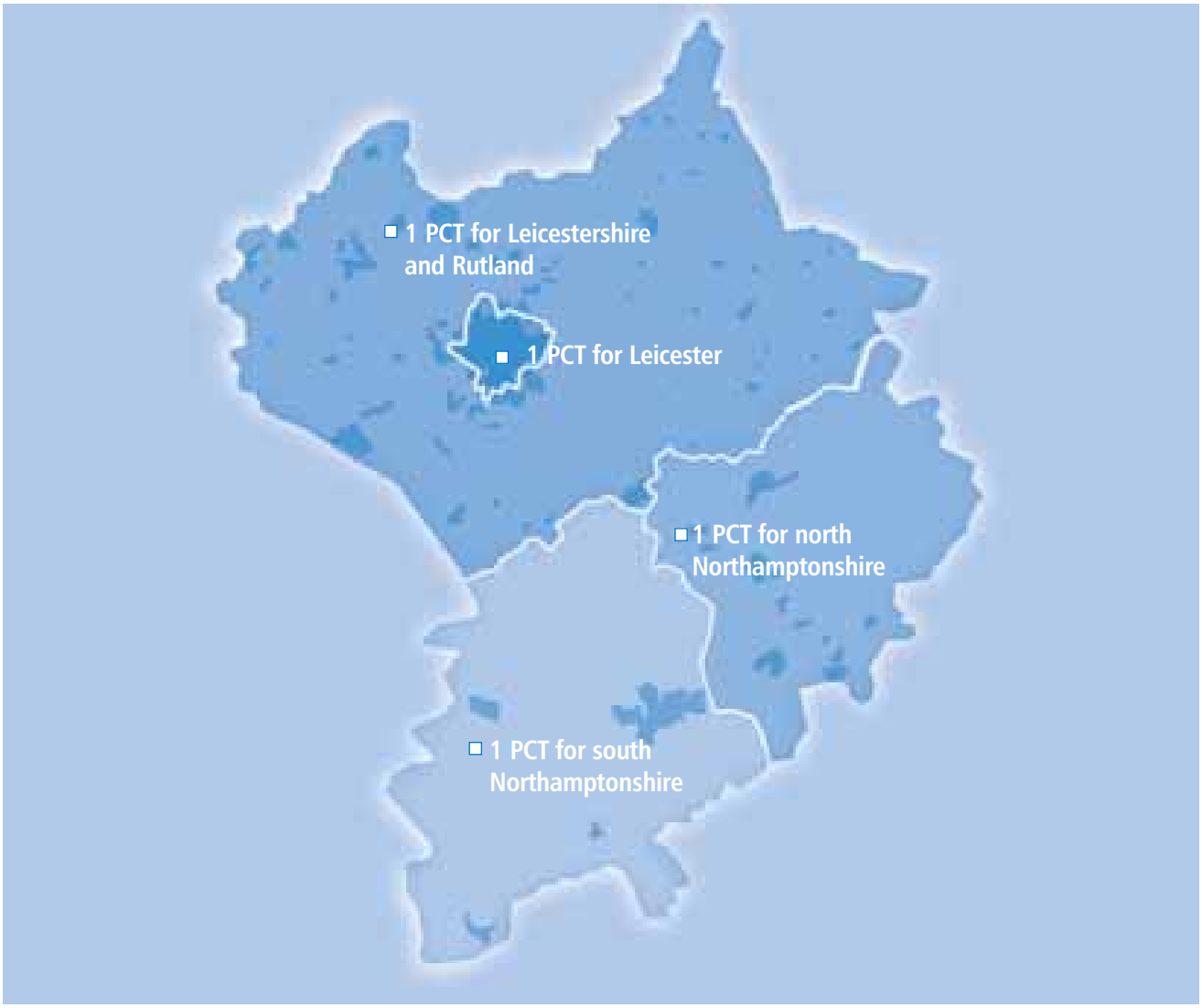
2. The proposals for Leicestershire, Northamptonshire and Rutland



2.01 This public consultation seeks opinions on two proposals for the implementation of *Creating a Patient-led NHS* in Leicestershire, Northamptonshire and Rutland. These are:

Proposal 1: to create

- One Primary Care Trust (PCT) for the city of Leicester
- One PCT for the counties of Leicestershire and Rutland, and
- One PCT for the county of Northamptonshire.



Proposal 2: to create

- One Primary Care Trust (PCT) for the city of Leicester
- One PCT for the counties of Leicestershire and Rutland, and
- Two PCTs for the county of Northamptonshire.

2.02 In either instance, any agreed reconfiguration of organisations would be implemented by October 2006.

2.03 These proposals have been arrived at by the Strategic Health Authority following a process of extensive engagement with key stakeholders, both within and beyond the NHS. The engagement process included groups such as NHS staff, Patient and Public Involvement Forums, MPs, voluntary organisations, local authorities and NHS trusts.

2.04 The engagement process was always seen as the forerunner to the current process of public consultation.

Background to the Leicestershire, Northamptonshire and Rutland proposals

2.05 Within the Leicestershire, Northamptonshire and Rutland Strategic Health Authority area there are currently nine Primary Care Trusts (PCTs). These are as follows:

PCT	Registered Population[2]	2005/06 Budgets £000's
Leicester City West	135,700	162,768
Eastern Leicester	166,000	189,030
Charnwood and North West Leicestershire	227,300	235,903
Hinckley and Bosworth	100,600	94,406
Melton Rutland and Harborough	138,600	132,588
South Leicestershire	148,600	143,990
Northampton	207,700	225,426
Northamptonshire Heartlands	272,800	291,522
Daventry and South Northamptonshire	98,500	93,378

2.06 An option appraisal process was carried out by each of the nine PCTs, with some PCTs having worked together on this piece of work. A consistent approach was taken by using an option appraisal framework.

2.07 The framework was based on national criteria whereby any new organisation should have the ability to:

- Secure high quality service
- Improve health
- Improve public involvement
- Improve commissioning and the effective use of resources
- Manage financial balance and risk
- Improve co-ordination with social services through greater congruence of PCT and local government boundaries
- Deliver at least a 15% reduction in management and administrative costs.
- Improve the engagement of General Practitioners and the rollout of Practice Based Commissioning, with demonstrable practice support

2.08 These criteria are expanded upon in Appendix 3 which sets out how they were used within the engagement process.

2.09 The results of those option appraisals, which were undertaken in August to September 2005, were as follows:

2.10 For the city of Leicester, strong support was received for the option of Leicester City West PCT and Eastern Leicester PCT combining to form one new PCT which would be coterminous with Leicester City Council, a unitary local authority.

2.11 For the counties of Leicestershire and Rutland, there was strong support for the option of combining the current four PCTs to create one new organisation. The current PCTs are Charnwood and North West Leicestershire; Melton, Rutland and Harborough; Hinckley and Bosworth; and South Leicestershire. The new PCT would be coterminous with Leicestershire County Council and Rutland County Council, and would incorporate all seven borough and district councils in Leicestershire.

2.12 Two favoured options arose from the option appraisal exercise in Northamptonshire. These were:

- Northampton, Northamptonshire Heartlands and Daventry and South Northamptonshire PCTs combine to form one new organisation, coterminous with Northamptonshire County

2 - PCT populations: 2003 ADS Populations

Council and incorporating all seven borough and district councils, and

- the establishment of two PCTs for Northamptonshire - one for the north of the county and one for the south. The north Northamptonshire PCT would be coterminous with Corby Borough Council, East Northamptonshire Council, Kettering Borough Council, and the Borough Council of Wellingborough. The south Northamptonshire PCT would be coterminous with Daventry District Council, Northampton Borough Council, and South Northamptonshire Council.

2.13 The Strategic Health Authority considered the option appraisals at its Board meeting of 29 September 2005. In making its decision, the SHA Board carefully considered each proposal against the national criteria (2.07 above), and in particular focussed on the need to:

- strengthen the future commissioning function of the new organisations, particularly in relation to practice based commissioning
- achieve congruence with local authority boundaries
- achieve the required cost savings
- ensure capacity for partnership working.

2.14 The SHA Board carefully considered the two options that were put forward from Northamptonshire. It was recognised that both had received support during the initial engagement process. Whilst the Board came to the view at that time that one PCT was its preferred option for Northamptonshire, our approach within this public consultation is one of neutrality. The Strategic Health Authority therefore particularly welcomes views on whether a one-PCT or a two-PCT structure is most suitable for Northamptonshire, taking into account the national criteria (2.07).

The functions of the new Primary Care Trusts in Leicestershire, Northamptonshire and Rutland

2.15 The new organisations will:

- Improve the health of the community
- Reduce health inequalities
- Secure the provision of services
- Engage with local people and other local service providers to ensure that patients' views are properly heard and that coherent access to integrated health and social care services is provided
- Undertake emergency and resilience planning
- Oversee and manage Practice Based Commissioning.

The benefits and the disadvantages of having fewer Primary Care Trusts in Leicestershire, Northamptonshire and Rutland

2.16 The option appraisal process identified significant potential benefits that could be realised through a reduction in the number of PCTs. These are as follows:

- A greater opportunity to develop stronger commissioning functions
- The ability to increase the amount of support that could be given to General Practices in relation to Practice Based Commissioning
- Coterminosity with those local authorities providing social services, with increased opportunity for joint working (especially in relation to Local Strategic Partnerships and Local Area Agreements)
- The opportunity to develop a stronger and more effective public health function with greater capacity to address health inequalities and to improve health
- The opportunity to align health and social care agendas
- Enhanced opportunities to achieve 15% cost savings
- The minimisation of financial risk.

2.17 The option appraisal also identified a number of potential disadvantages associated with the creation of fewer PCTs, and these are as follows:

- A potential risk in terms of the equitable application of funding was also raised, particularly in the context of ensuring that appropriate investment is made in those areas experiencing the greatest public health challenges.
- The most significant issue related to the potential loss of 'localness', which could have an adverse impact upon the new organisations' ability to understand and to respond to the needs of distinctive communities, their capacity to engage effectively with patients and the public, and the capability to forge local partnerships
- A potential risk to clinical engagement was identified, specifically the degree to which a large PCT might experience difficulty in establishing efficient lines of communication and engagement with all clinical groups.

Views of stakeholders invited

2.18 Participants in the current public consultation are invited to contribute their views and advice on the potential benefits and disadvantages outlined above (as well as any others) in the context of Proposals 1 and 2. The Strategic Health Authority is committed to listening to all views and to weighing these carefully against the national criteria. Within this, the SHA's listening approach acknowledges the divergence of views expressed in the initial engagement process in Northamptonshire, where options were not locally agreed in the way that they were in Leicestershire and Rutland and in the city of Leicester.

2.19 The Strategic Health Authority is also keen to gain stakeholders' views on important issues which emerged as part of the initial engagement process undertaken by the current PCTs, namely

- the need for the new PCTs to establish effective locality arrangements
- maintaining active public and patient involvement processes
- ensuring effective clinical engagement, and
- ensuring the equitable application of funds within PCTs.

2.20 The reply sheet contained within this consultation document contains space for stakeholders to submit their views on these and other topics.

Boundary issues

2.21 When PCTs were created, several General Practices located close to county boundaries aligned themselves with neighbouring county PCTs rather than with the PCT that they were geographically a part of. As *Commissioning a Patient-led NHS* seeks to ensure that wherever possible the new PCTs will be coterminous with local authority social service boundaries, it is proposed that these practices rejoin their respective county PCTs. Specifically, this affects the following areas:

i) in Northamptonshire :

- Brackley and Byfield
- Oundle and Wansford

ii) in Leicestershire:

- Bottesford
- Croxton
- Kegworth.

The impact on stakeholders of creating new Primary Care Trusts in Leicestershire, Northamptonshire and Rutland

2.22 Patients will not see an immediate difference in the way that services are delivered to them - rather, they will see the continued development of services. As the benefits of stronger commissioning are achieved, patients will experience greater choice and shorter waiting times - a more responsive NHS led by their needs. In addition management cost savings will be spent on patient services, particularly cancer and palliative care.

2.23 It is important to emphasise that the current public consultation is exclusively about organisational change. Any future service change will be for the new Primary Care Trusts to consult upon at the appropriate time.

2.24 If, following consultation, it is decided that PCTs are to be reconfigured, then PCT staff will initially transfer to the successor organisation i.e. the new PCT. However, some very senior staff may be required to apply for posts before the date of the transfer.

2.25 Each of the two proposals will require additional and advanced capabilities from any new PCTs. These have been identified within *Commissioning a Patient-led* NHS (e.g. analytical and modelling expertise; performance monitoring and management skills). These requirements are likely to result in opportunities for continuous professional development for staff, as new PCTs will require staff with these capabilities and suitable aptitudes if they are to operate successfully.

2.26 NHS and partner organisations will benefit from a streamlined commissioning process if either proposal for Leicestershire, Northamptonshire and Rutland goes ahead. Acute trusts, mental health trusts and ambulance service trusts will negotiate with fewer PCTs. At the same time, these trusts must prepare for a commissioning process which is going to be more robust than hitherto as a result of strengthened commissioning with a 'critical mass'.

2.27 Local authority partners providing social care services will benefit from any streamlining which arises as a result of the establishment of new boundaries amongst the proposed new PCTs. District and borough councils may see the strengthening of formal strategic partnerships (e.g. Local Strategic Partnerships, Local Area Agreements)

as arrangements to ensure 'localness' within the larger PCTs are put into place. Any new headquarters arrangements for a smaller number of PCTs will mean that some geographical proximity to some district or borough councils will alter.

2.28 The larger voluntary organisations, which operate at county or city level, will benefit from having fewer PCTs with which to maintain relationships, if either proposal proceeds. The necessity of replicating agreements and working arrangements across the current series of PCTs has been identified as absorbing scarce management resources by some voluntary organisations. New PCTs must take care to ensure that the relationships built with smaller voluntary and community groups (i.e. those with a district, borough or neighbourhood focus, or patients' groups) are maintained and built upon: a strengthened public health function and commissioning based on the needs of local populations each require a partnership approach with local groups. In addition, the choice agenda and local decision making may result in new activities relating to the delivery of services being considered by the voluntary and community sector.

Realising the benefits

2.29 The proposals being consulted upon are designed to bring benefits in the following areas:

- Strengthened commissioning of services
- The introduction of Practice Based Commissioning
- A stronger public health function, and
- The development of partnerships.

Each of these is addressed as follows.

Strengthening the commissioning function

2.30 Commissioning is the process by which the health needs of the local population are defined, priorities are determined, and appropriate services are purchased and monitored. It encompasses the following areas:

- The assessment of the health needs of local communities
- The analysis of information
- Establishing evidence of the effectiveness of clinical and non-clinical interventions
- Service specification and procurement
- Contracting
- Demand management
- Performance management
- Monitoring and evaluation
- Financial management.

2.31 Effective commissioning requires a step change in the capability, capacity and expertise currently available within PCTs. To achieve this change requires sustained attention in a range of interconnected areas, namely:

- The enhancement of information and analytical systems
- The increased involvement of public health in commissioning systems
- Engagement in national diagnostic and development programmes
- Learning from the private sector and local authorities
- Developing appropriate skills within the PCT workforce
- The development of a more businesslike and commercial culture within PCTs.

This work will be critical to the success of the new organisations. The existing SHA and the proposed new East Midlands body, if accepted, will oversee and coordinate necessary work programmes.

Practice Based Commissioning

2.32 Practice Based Commissioning (PBC) will enable the devolution of budgets to frontline clinicians in order for them to commission appropriate healthcare on behalf of their patients. This will require the provision of enhanced support to GP practices, which may form themselves into groups or clusters for these purposes.

2.33 It also provides an important opportunity to strengthen clinical engagement in strategic planning to improve health and to reduce health inequalities.

2.34 *Commissioning a Patient-Led NHS* requires all GP practices to have the opportunity to realise the benefits of PBC by December 2006.

Strengthening the public health function

2.35 The changes signalled within *Commissioning a Patient-led NHS* provide an opportunity to create Primary Care Trust public health teams with a critical mass, in order to better support health improvement and other public health contributions. Such expertise is currently spread too thinly. A critical mass will enable sub-specialisation and more effective delivery, in particular:

- Strengthened commissioning of health improvement at a local level with the capability to ensure its delivery
- Enhanced capacity to commission and deliver health protection and emergency planning
- Enhanced ability to support the commissioning of modernised and efficient NHS services
- Enhanced ability to work in partnership with local authorities and other statutory and non-statutory organisations including the voluntary sector.

Each new PCT will have an Executive Director of Public Health leading a team with sufficient capacity to carry out its health improvement, health protection and service quality functions.

Developing Partnerships

2.36 In order to address the broad determinants of health, the new PCTs must be structured in such a way as to enable continued engagement with both statutory and non-statutory bodies at a community level (including the voluntary sector and patients' groups). This might be achieved, for example, through Local Strategic Partnerships, Local Area Agreements and Community Safety Partnerships.

2.37 The new PCTs must ensure that they sustain strong relationships with distinctive local populations, local communities and bodies such as Patient and Public Involvement Forums, irrespective of the actual number of new organisations created.

2.38 Importance is attached to maintaining and building upon the local partnerships which are already in place as a result of the work of the current PCTs and their predecessor Primary Care Groups.

2.39 In order to continue to improve the health of the local population and to reduce health inequalities, the opportunity to link Practice Based Commissioning with public health and the wider commissioning agenda will need to be realised. Thus the development of new partnerships within the NHS is also of crucial importance.

2.40 Integrated performance management systems will be introduced across the NHS and local government wherever this is appropriate and

practicable. This will ensure that the new PCT organisations will maximise opportunities for developing shared understanding of local health and social care needs and avoid unnecessary duplication.

2.41 Joint public health appointments between the NHS and local authorities will also be the norm as this will aid partnership working significantly.

Management Costs Savings

2.42 *Commissioning a Patient-led NHS* has identified that its reforms will generate savings of £250million per annum across England, to be reinvested in frontline clinical services. The SHA has been tasked with securing at least a 15% reduction in management and administration costs within the proposed reconfiguration of PCTs and the SHA itself. These savings will be re-invested in designated local clinical services

Conclusion

2.43 The proposals outlined in this document have been developed through an extensive process of engagement with staff and stakeholders. This has been helpful not only in confirming the scale of the opportunities to be secured but also in highlighting the importance of securing 'localness' and local responsiveness.

2.44 Risks to performance and business continuity, arising from the resultant process of change should either proposal be adopted, have been identified. Detailed responsive plans are being devised and will be carefully managed to ensure that the real achievements and gains of recent years are not compromised.

2.45 The proposals for reconfiguration for Leicestershire, Northamptonshire and Rutland must be seen as a part of the wider set of interconnected reforms set out in Section 1 of this document. Taken together they will deliver choice, enhanced patient experience and value for money throughout the local health community.

2.46 Please make your views on the proposals known by participating in this consultation opportunity. Please complete and return the freepost reply form in this document or use the online version, or attend one of the many stakeholder meetings taking place across Leicestershire, Northamptonshire and Rutland in the period to 22 March 2006 when the consultation closes (please see details in local press, or view at www.lnrsha.nhs.uk/consultations).

Consultation reply sheet

(Please attach additional sheets if you wish)

Section 1	
Do you favour Proposal 1 or Proposal 2? Please tick your choice in the box to the right.	
Proposal 1: to create • One Primary Care Trust (PCT) for the city of Leicester • One PCT for the counties of Leicestershire and Rutland, and • One PCT for the county of Northamptonshire.	☐
Proposal 2: to create • One Primary Care Trust (PCT) for the city of Leicester • One PCT for the counties of Leicestershire and Rutland, and • Two PCTs for the county of Northamptonshire.	☐

Section 2	
Please use this section as appropriate to indicate how your preferred option is stronger than the alternative in terms of the national criteria for the new PCTs. (Please see Appendix 3 on page 26 for a fuller wording of the national criteria, plus the local considerations relating to these criteria as used in the earlier engagement process.)	
National criteria: i) the securing of high quality services, and ii) improving health	**Your comments:**
iii) improving the engagement of GPs iv) improving commissioning and the effective use of resources v) managing financial balance and risk	**Your comments:**
vi) improving public involvement, and vii) improving coordination with social services	**Your comments:**
viii) delivering at least 15% reduction in management and administration costs.	**Your comments:**

Please cut along here

Section 3

Please use this section to address the topics which emerged within the local engagement process
(see section 2.19 on page 15)

i) the need for the new PCTs to establish effective locality arrangements, and ii) maintaining active public and patient involvement processes	**Your comments:**
iii) ensuring effective clinical engagement, and iv) ensuring the equitable application of funds within PCTs.	**Your comments:**

Section 4

Additional comments

If you are replying as an individual, please complete 1 and 4 below.
If you are replying on behalf of an organisation (e.g. local authority, voluntary organisation, professional group) please complete 1, 2, 3 and 4 below.

1. Your name	
2. Your organisation	
3. Your position within the organisation	
4. Your address	

Please return this form, by 22 March 2006, in an envelope - no stamp required - to:

Freepost RLYT-SSSZ-CLSK,
LNRSHA, Lakeside House, 4 Smith Way,
Grove Park, Enderby, Leicester LE19 1SS.

Appendices

Appendix 1. Responding to the consultation, and the process of decision-making

The Strategic Health Authority is committed to listening to all views contributed as part of this public consultation.

This document can be made available upon request in different formats for people with impaired vision, hearing or other special needs.
Please telephone **0116 295 5801**.

There are three ways in which you can make your views known:

1 Please complete the consultation reply sheet which is printed within this document.

Cut out the sheet and return it to the Strategic Health Authority using the Freepost address on the sheet (no stamp needed).

2 You can complete the equivalent sheet electronically when you visit the Strategic Health Authority's website. Please go to: www.lnrsha.nhs.uk/consultations

3 You can attend and contribute at one of the series of consultation meetings which have been organised by the Strategic Health Authority and the current Primary Care Trusts. These meetings are targeted to the needs of specific stakeholder groups, including staff, the public, voluntary and community groups, local authorities and MPs. Meetings for the public will be advertised in the local press and on the SHA website www.lnrsha.nhs.uk/consultations

All responses must be received by the Strategic Health Authority by 22 March 2006.

After this date, the SHA will

- collate and analyse views for consideration by SHA Board members before final decision-making at a formal and public Board meeting, and
- within 21 days from the end of the consultation period, report on the results of the consultation and make recommendations for change to the Secretary of State for Health.

The Secretary of State will then make decisions on any orders which should be made to dissolve existing Primary Care Trusts and establish new ones and provide for transfers of staff and property etc.

Appendix 2. Glossary of terms

Acute services
Services provided for the treatment of disease or illness which is usually of short duration.

Alternative Provider Medical Services (APMS)
A form of contract which PCTs can use with a range of service providers (e.g. independent sector, voluntary sector, NHS trust, other PCTs, GPs) so that services can be restructured to offer greater patient choice, improved access and greater responsiveness to the specific needs of the community.

Commissioning
This is the process by which the health needs of the population are defined, priorities determined and appropriate services purchased and monitored.

Community care
Services which are provided outside of a hospital, within the community that is served, eg in health centres, individual clinics, or in people's homes.

Continuity of care
Organising health care so that the patient does not notice a break in the care that is being provided when the transfer takes place, usually between hospital.

Department of Health
This is the department within central government which is responsible for health and social services within England, including the central management of the NHS.

Economies of scale
The financial savings and efficiencies which can be achieved by larger organisations.

Emergency care
Care for patients whose admission to hospital is unplanned.

Emergency planning
The process of planning how to deal with a serious or major incident such as a rail crash, terrorist incident or chemical spill. Each part of the NHS has an emergency plan which must relate to the emergency plans of other responding agencies, e.g. local authorities, police and fire services.

General Medical Services (GMS)
These are the services provided by NHS general practitioners (family doctors).

Governance
Governance arrangements are the 'rules' that govern the internal conduct and external accountabilities of an organisation.

Health Advisory Committees
Parliamentary committees with independent experts in relevant fields in membership, their purpose is to advise Government.

Health community
The various organisations that work together in a local area to plan and provide health care services.

Healthcare Commission
The Healthcare Commission was established to help improve the quality of healthcare. It provides an independent assessment of the standards of services, whether provided by the NHS, the private sector or voluntary organisations.

Human resources
People who work for the organisation, whether directly employed or contracted to work through a separate organisation or agency.

Local Area Agreement (LAA)
Part of the developing agenda in local government, LAAs cover the area of one or more local authorities and focus on a collection of goals across a range of services, and these can relate to either local or national priorities. They focus on quality of life and well-being and are closely linked to Local Startegic Partnerships (see below).

Local Strategic Partnerships
Formal arrangements which bring together different parts of the public sector (e.g. local government, NHS organisations, education) as well as private, community and voluntary organisations so that services work together and support each other.

Patient and Public Involvement Forum (PPIF)
Made up of volunteers, there is a Forum in each PCT and NHS trust. Each Forum's purpose is to monitor and review health services from the patient's perspective, to seek the public's views about health services and to make recommendations to the NHS based on those views.

NHS trusts
These are the NHS organisations which provide hospital, mental health and ambulance and special services to patients.

Patient-centred care
The approach t treatment specified in the NHS Plan. Care and treatment is designed around the needs of the patient, and their convenience, and patients and users are fully consulted on the performance of health services and their future development.

Patient pathway
This is an NHS term used to capture the route followed by the patient into, through and out of NHS services including in some circumstances, social care services. Often, for example, the patient pathway commences with a referral from a GP to a hospital department or speciality.

Personal Medical Services (PMS)
New arrangements which allow primary care trust and providers such as GPs and nurses greater flexibility and the opportunity to innovate in their provision of services to patients.

Primary care trusts (PCTs)
NHS organisations which take the lead in assessing health needs of local populations, planning and securing all health services and improving health for the local population.

Public Service Agreement (PSA)
An agreement on key, 'must-do' targets to which the Secretary of State has committed the Department of Health.

Regulatory Impact Assessment (Code of Practice)
A Regulatory Impact Assessment is a short document which is published with regulatory proposals and new legislation. It briefly describes the issue which has led to a need for regulation and compares various possible options for dealing with that issue.

Resilience planning
The aspect of emergency planning (see above) that relates to responding to disruptive challenges through anticipation, preparation, prevention and resolution.

Risk management
This activity in the NHS involves identifying, analysing and controlling the risks from untoward occurrences in clinical and non-clinical areas within individual NHS organisations.

Stakeholders
Groups of people or organisations, both within and outside the NHS, who are influenced by the NHS, and/or have an influence upon the NHS. This inscludes patients, the public, NHS staff, GPs, local authorities, universities, voluntary and community groups, patients' groups, MPs.

Standards for Better Health
These new key standards provide a means of measuring the quality of health care, with the aim of achieving common standards across the NHS.

Strategic Health Authority (SHA)
The body which performance manages the local NHS system in its area - ensuring the delivery of improvements in health and health services locally by Primary Care Trusts and NHS trusts. Accountable to the Secretary of State for Health.

Appendix 3. The national criteria

Set out below are the local considerations of the national criteria that were used in the option appraisal work undertaken by LNR's Primary Care Trusts. This was the basis of the initial engagement process.

The analysis of responses to the public consultation will also use the national criteria and these local considerations. This will ensure a sound basis, consistency and continuity in the local work on implementing Commissioning a Patient-led NHS.

National criteria	Local considerations
• Secure high quality services	• Provision of clear/consistent patient pathways; compliance with Standards for Better Health; clinical governance; clinical networks; and integration opportunities.
• Improve the engagement of General Practitioners and the rollout of Practice Based Commissioning, with demonstrable practice support	• Relationship maintenance; improved clinical engagement; Professional Executive Committee considerations. Working in partnership to create community-based services.
• Improve health	• Public health capacity; congruence with local authority/social services boundaries; Local Strategic Partnerships; opportunities for joint working/joint posts. Long Term Conditions management; Children's Trust plans; mental health services; alignment of health needs and access to services.
• Improve public involvement	• Zone/patch/neighbourhood arrangements. Management capacity/critical mass. Managing the local 'face' of the NHS/sense of identity that the public can understand. PPIF (Patient and Public Involvement Forum) relationships.
• Improve commissioning and the effective use of resources	• Management capacity/critical mass. Commissioning and public health expertise; Local Area Agreements and LSPs, joint working opportunities. Potential for pooled or aligned budgets with key partners.
• Manage financial balance and risk	• Management capacity. Scale of budget; risk management arrangements.
• Improve co-ordination with social services through greater congruence of PCT and local government boundaries	• Boundary/geographical considerations of new organisations.
• Deliver at least a 15% reduction in management and administrative costs.	

Appendix 4. Consultees

The Strategic Health Authority is involving the following in this public consultation:

Primary Care Trust Boards

Primary Care Trust staff

Primary Care Trust Professional Executive Committees

NHS Trust Boards

Primary care contractors

Members of the public

Members of Parliament

Local Medical Committees

Local Optometrists Committees

Local Dental Committees

Local Pharmacy Committees

Patients' groups

Patient and Public Involvement Forums of PCTs

Local authorities

Local authority Health Overview and Scrutiny Committees

Trade Unions and professional bodies

Voluntary and community organisations with an interest in healthcare

Local prisons.

Appendix 5. Distribution and availability of this document

This document is being widely distributed locally by the SHA and PCTs. It is being sent directly to the stakeholder groups identified above. For members of the public, printed copies are available in public libraries and newspaper advertisements will state that copies can be obtained from the Strategic Health Authority.

In addition the document is available electronically on the Strategic Health Authority website www.lnrsha.nhs.uk and on the websites of current PCTs.

This document can be made available upon request in different formats for people with impaired vision, hearing or other special needs. Please telephone 0116 295 5801.

This document can also be made available upon request in different formats for people with a first language other than English. Please telephone 0116 295 5801.

Appendix 6. Code of practice on consultation

This consultation document has been produced in accordance with the Cabinet Office 'Code of Practice on Consultation' which sets out six criteria against which public consultation should be conducted.

The Code of Practice says that organisations should:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.

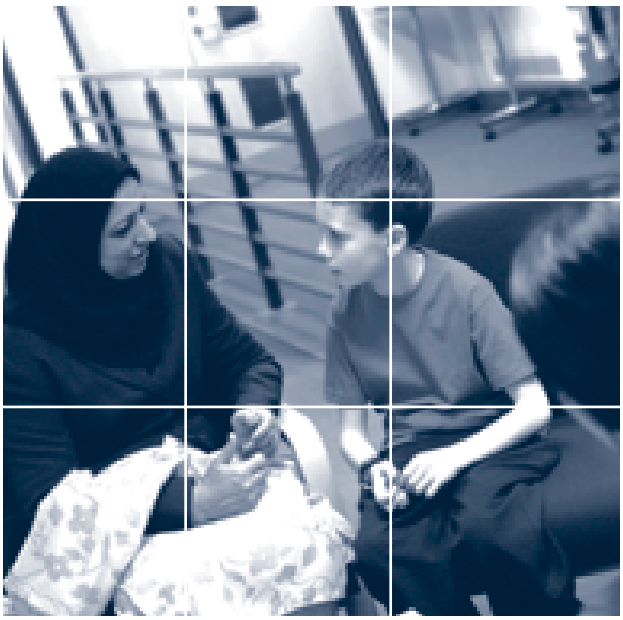
2. Be clear about what their proposals are, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced policy.

5. Monitor their effectiveness at consultation, including through the use of a designated consultation co-ordinator.

6. Ensure that consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment, if appropriate.



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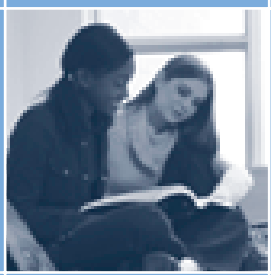


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