Report to Cabinet

Subject Primary Care Trust Re-organisation

Date 2nd March 2006

Author Chief Executive

1. Reference has been made at previous Cabinet meetings to the government's proposal to reconfigure the Primary Care Trusts in Nottinghamshire and elsewhere in the country. Formal consultation on the reconfiguration options has now been received from the Strategic Health Authority and I attach as an appendix to this report a copy of the part of the consultation document which describes the background to the proposals and which describes the three options which are proposed for Nottinghamshire, including an analysis of how the options have been assessed against the seven criteria which have been stipulated by the Department of Health. Comments on the proposals are required by 22nd March 2006 in order that the Strategic Health Authority might select a preferred option for recommendation to the Secretary of State. The Secretary of State will make a final decision on the proposals some time in spring of this year.

2. Although the Council's view is being sought on the three options proposed, it would appear that it is open to the Council to propose an alternative PCT configuration, although we are told that any alternative proposal would have to satisfy the seven criteria which I have mentioned above. At a meeting held on Tuesday 7th February 2006, the Gedling Partnership agreed that a Primary Care Trust based on the Gedling, Rushcliffe, Broxtowe area should be proposed as a better option, particularly since this better reflects 'patient pathways' to care in the city hospitals. It is understood that Rushcliffe Borough Council is considering making a similar response.

3. Looking at the consultation document, I would offer the following observations:

   i) The introductory text and evaluation criteria put forward give very little if any weight to joint working between PCTs and Districts - the whole emphasis is on social services and the perceived need to enhance co-ordination with social services. This ignores the importance of the links with district housing, leisure, environmental health functions and the district based LSPs and CDRPs (at one point on page 16 in evaluating the application of criterion 6 to the two PCT option, the paper proceeds on the completely wrong assumption that there is a single CDRP in Nottinghamshire). None of these proposals will do anything to enhance those arrangements - indeed, they will all serve to undermine them.

   ii) The list of pros and cons in the option appraisal appears arbitrary and contradictory. For instance, the establishment of cross boundary arrangements is seen variously as a problem (criterion 1, option 3) and an

opportunity (criterion 2, option 2), whereas elsewhere there is simply an acknowledgment that "there are successful examples where organisations work across boundaries" (criterion 6, option 3). Looking at criterion 4 (improvement of public involvement), the two PCT option is considered to offer "greater transparency, sensitivity and engagement of local public", yet this assertion is not explained or justified. It is at least arguable that none of the options would allow for greater public engagement - they would create much larger, more remote and less responsive arrangements for the residents of Gedling. They would undermine rather than build on "existing structures (which) support public involvement within local authority and voluntary sector boundaries" – all of them would undermine the "strategic alliances" within the LSPs and the CDRPs (criterion 6, option 2).

iii) On page 26, the paper says that "the new PCTs will continue the strong relationships that already exist with local service providers". Again, this assertion is not explained or justified and given what is said above, I think we are entitled to doubt that this will be the case in Gedling - indeed, it has already been suggested to us in previous discussions and consultations about these proposals that the new PCTs will look to deal with the County Council rather than District Councils and the LSPs and district based organisations.

iv) The consultation paper itself offers the comment on page 10 that "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". Members might consider that a PCT based on the Gedling, Rushcliffe, Broxtowe area would better fit the local needs of the suburban area whilst still offering the efficiency savings demanded by criterion 7. It is suggested that this option would satisfy all of the evaluation criteria and would perform better under criteria 3 and 4 than any of the proposed larger PCT solutions.

4. <u>Recommendation</u>

It is recommended that the Cabinet agree to support the proposal for a Gedling/Rushcliffe/Broxtowe PCT and that this be communicated to the Strategic Health Authority accordingly.

Appendix 1

Your NHS

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

The proposals at the heart of this consultation will mean new geographical boundaries for strategic health authorities (SHAs) and primary care trusts (PCTs) across England. The solutions proposed in this document are unique to the Trent area and reflect the needs, preferences and health priorities of the local communities in Nottinghamshire, Derbyshire and Lincolnshire.

Why is this so important?

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

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

Achieving a patient-led NHS

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

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

- respect people for their knowledge and understanding of their own clinical condition and how it impacts on their life;
- support them in using this knowledge to manage their long-term illnesses better;
- provide people with the information and choices that allow them to feel in control and fit their care around their lives;
- treat people with dignity and respect, recognising them as human beings and as individuals, not just people to be processed;
- ensure people always feel valued by the health and care services and are treated with respect, dignity and compassion;
- understand that the best judge of an individual's experience is the individual;
- ensure that the way clinical care is booked, communicated and delivered is as trouble free as possible for the patient and minimises the disruption to their life; and
- explain what happens if things go wrong and why, and agree the way forward.

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

- patient and client choice - not just in hospitals but in primary and social care too;
- better, more integrated support and care for people with long-term illnesses;
- a wider range of services in convenient community settings;
- faster, more responsive emergency and out-of-hours services; and
- more support to help people improve and protect their own health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Since April 2005 GPs have been able to become more involved with commissioning through the practice based commissioning approach described above. The aim is to have universal coverage of practice based commissioning by the end of 2006.

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

The wider picture

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

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

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

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

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

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

SHAs will continue to provide leadership and performance management to the NHS. They will be responsible for ensuring that key national objectives are delivered and that services are high

quality, safe and fair. Taking forward this agenda will need good leadership, within both the NHS as well as other local services.

Over time, as we move towards all **NHS** trusts achieving foundation status, performance management will increasingly be focused on the commissioners of services.

What does this mean for PCTs?

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

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

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

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

The PCT role in more detail

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

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

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

The overall management of the health system will continue to develop as we fully implement 'payment by results' and patient choice and move towards greater plurality of provision through NHS foundation trusts and greater independent sector involvement.

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

Protecting staff

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

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

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

Next steps

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

The proposals which follow outline plans to create a number of new PCTs from the present 19 in Trent SHA. They describe the implications of these changes for staff, local people, the NHS and its partner organisations.

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

A full explanation of how to comment and by when is set out on page 28.

The NHS in Trent

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

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

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

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

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

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

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

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

Criteria for assessment

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

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

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

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

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

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

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

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

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

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

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

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

Commissioning a patient-led NHS in Nottinghamshire

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

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

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

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

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

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

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

The three options being considered for Nottinghamshire are:

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

Assessing the options against the criteria

See page 12 for a fuller explanation of each criterion.

Criterion 1: Secure high quality, safe services

Option 1: One Nottinghamshire PCT

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

Option 2: Nottingham City and Nottinghamshire County PCTs

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

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

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

Criterion 2: Improve health and reduce inequalities

Option 1: One Nottinghamshire PCT

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

Option 2: Nottingham City and Nottinghamshire County PCTs

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

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

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

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

Option 1: One Nottinghamshire PCT

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

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

Option 2: Nottingham City and Nottinghamshire County PCTs

- Established locality working arrangements already in place in parts of the county
- Current health community planning/commissioning structure is not based around the city boundary

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

- Potential to build on existing patient flows and effective working relationships between primary and secondary care
- Inconsistent with current local professional committee boundaries

Criterion 4: Improve public involvement

Option 1: One Nottinghamshire PCT

- Potential to develop county-wide approaches to public involvement
- Risk of disengagement of local population with organisation that is not seen as locally responsive

Option 2: Nottingham City and Nottinghamshire County PCTs

- Existing structures support local public involvement within local authority and voluntary sector boundaries
- Greater transparency, sensitivity and engagement of local public

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

- Existing structures support local public involvement within local authority and voluntary sector boundaries
- Inconsistent with Nottinghamshire and south Yorkshire organised voluntary sector bodies and local authorities

Criterion 5: Manage financial balance and risk

Option 1: **One Nottinghamshire PCT**

- Potential to redirect resource and maximise investment in infrastructure to support services
- Larger organisation has greater capacity to manage financial risks

Option 2: Nottingham City and Nottinghamshire County PCTs

- More responsive to local financial planning
- Greater flexibility in allocation of resource based on local needs based assessment

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

- More responsive to local financial planning
- Greater flexibility in allocation of resource based on local needs-based assessment
- Bassetlaw would share resource allocation with another challenged community (Doncaster)

Criterion 6: Improve co-ordination with Social Services

Option 1: One Nottinghamshire PCT

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

Option 2: Nottingham City and Nottinghamshire County PCTs

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

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

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

- Inconsistent with local authority boundary and existing strategic alliances will make relationships more complex.
- There are successful examples where organisations work across boundaries

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

Option 1: One Nottinghamshire PCT

- Easier to deliver in the larger organisation
- Maximum savings from reconfiguration directed to front line services such as cancer screening and palliative care

Option 2: Nottingham City and Nottinghamshire County PCTs

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

Option 3: Nottingham City and Nottinghamshire County PCTs without Bassetlaw

- PCTs will deliver at least a 15% reduction, but the level of reduction in management costs will pose significant challenge for Nottingham City and Bassetlaw/Doncaster PCTs

Your questions answered

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

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

What really are the benefits for staff?

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

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

What really are the benefits for patients?

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

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

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

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

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

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

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

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

What happens next?

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

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