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Our Ref: NS/PCTs
(Please quote in your reply)

20th March, 2006

David Nicholson CBE
Commissioning a Patient-Led NHS
West Midlands Consultation Office
PO Box 2675
Stafford ST16 9BW

Dear Mr Nicholson

Birmingham City Council's response to "Ensuring a Patient-led NHS" - Consultation on new Primary Care Trusts arrangements in Birmingham and the Black Country

I am pleased to submit the enclosed report from the Health Overview and Scrutiny Committee, in response to the above consultation. The response is supported by and incorporates the views of the Council's Executive.

A summary of our conclusions is as follows:

Overall, selecting between the two options for PCTs proved to be a very close call. Objective analysis was undertaken by the Health O&S Committee based on key criteria that was important for the Council and its performance. This showed that there are equally strong arguments for 3 PCTs and for having a single PCT in the City. From a Council and City wide perspective, a single PCT is desirable as it offers the ability to strategically plan, commission and deliver services, especially for vulnerable groups and those with complex needs. Greater efforts can be made on securing equity and equality of provision and more effective use of resources across the City.

From an NHS/ local perspective, 3 PCTs are desirable as they enable progress to be maintained around partnership working. PCTs are on a path of improvement and major organisational restructuring could prove to be disruptive. Relationships, co-operation and stability are important for the City Council and its performance. A Comprehensive Performance Assessment Inspection and Joint Area Review of Children's Services are expected in October 2006; this is the same time that changes to PCTs are to be implemented.

That said, current arrangements with PCTs are not perfect and changes will need to be made if the City is to benefit from a strong, unified commissioning function. Many of these issues are set out in this paper and will require ongoing dialogue and negotiation between key partners in order to ensure that the proposed restructuring delivers real benefits to improving health and the performance and quality of services in the City.

The Health O&S Committee concludes that neither of the proposed options offers a true choice or automatically appears to be the one that will work the best for Birmingham. However, our preference, only marginally and with conditions, is for Option 1: the merger of East and North PCTs and the retention of Heart of Birmingham Teaching PCT and South PCT to create three PCTs in the City. **The Committee's support is conditional based on the need for clear, solid commitments that the new structure (whether one PCT or three PCTs) will**

- Be part of robust strategic commissioning arrangements with the City Council;
- Will adopt a shared model for working together and establish common, consistent care pathways;
- Be able to create a framework for planning and achieving outcomes within local areas - aligning the delivery of Practice Based Commissioning with other agencies, close to the service user;
- Use evidence, not postcodes, to justify different needs and types of services.
- Be able to commit resources to agreed priorities across the City when required and/or support different patterns of investment to achieve equality of outcomes.
- Be able to work locally as well as strategically.
- Be able to respond and act quickly
- Be able to work with the Council constructively to deliver on a range of agendas and the achievement of targets to improve performance
- Be able to plan and invest funding in children's and adults services, particularly as regards low volume, high complexity needs, using open book approaches which recognize the co-dependent relationship between health and care .
- In the case of three PCTs, have one strategic lead to act on behalf of all three PCTs.

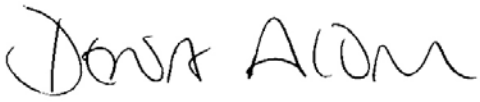
Regardless of the final outcome, we are certain that the views and information contained in our report will give a useful insight into what is needed for the City as a whole as well as for creating a “Patient-led NHS”. We believe this information has consequences beyond the consultation itself. It is important that the evidence we have received and the issues raised in the report are not overlooked once the consultation has ended.

The City Council is keen to engage with the Strategic Health Authority and our health partners in resolving these matters and issues.

We look forward to hearing from you once the consultation has concluded and the outcomes are known.

Please do not hesitate to get in touch, should the need arise.

Yours faithfully



Councillor Deirdre Alden
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Our Ref: DW/DA
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20th March, 2006

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Commissioning a Patient-Led NHS
West Midlands Consultation Office
PO Box 2675
Stafford ST16 9BW

Dear Mr Nicholson

Birmingham City Council Health Overview and Scrutiny Committee
Response to the Proposed Reconfiguration of UK Ambulance Services

Introduction

This letter sets out the response from Birmingham City Council to the proposals by the Department of Health to reduce the number of Ambulance Trusts from thirty one to eleven.

The response has been produced by the Health Overview & Scrutiny Committee and incorporates the input of the Council's Executive Management Team and individual Elected Members.

Comments on the Consultation Process

The Birmingham City Council Health Overview and Scrutiny Committee have a number of concerns regarding the Consultation process for this reconfiguration. One such concern is that the process is not asking our opinion on how services should be configured to best serve the population. The question set out in the

consultation document merely asks if there should be eleven Ambulance Services in England. This clearly ignores local issues and any suggestions the Overview and Scrutiny may have regarding the configuration and delivery of services in the West Midlands and their implications for Birmingham.

In addition the Committee was not pleased to see that during the Consultation process adverts appeared in the press recruiting the Chairmen of the new Ambulance Organisations. More worryingly, on Friday 17th March, local newspapers carried articles reporting that Chief Executives of two current Ambulance Trusts had resigned following the appointment of a new Chief Executive for the Central West Region. If such an appointment has been made, then we feel this is unacceptable. It gives the impression that the outcomes have been pre-determined before the consultation itself has concluded. It also undermines the consultation process, undermines the views of patients and the public in influencing change in the NHS and goes against the principles of a 'Patient-led NHS'.

Large Organisational Benefits and Pitfalls

The Department of Health Consultation document states that the creation of a large region wide trust would allow the Ambulance service to deal with the increased demand for service delivery and provide an opportunity to address quality issues. The creation of a West Midlands wide Ambulance service will mean that the service will serve a population of around 5.5 million people and would cover an area of 5,766 square miles. This would result in an Ambulance organisation that has no worldwide precedent. Given the recent failure of mergers in both the East Midlands and East Anglia it is of particular concern that the proposal is likely to result in a service that is more expensive and may struggle to meet targets.

The consultation document also sets out that a large organisation would allow new methods of working, such as more community based care, to be utilised. Many of these new methods of working are currently being implemented by different Trusts across the region without the need for merger. The consultation document does not adequately explain why changes to work practices can only be achieved through merger or indeed what relevance the size of the organisation has in regard to methods of working.

It is also difficult to understand how a single Trust Board across such an area would be able to maintain a much needed local focus. The proposed area includes a great deal of diversity in terms of both urban and rural locations as well as extremely diverse populations. One Trust Board will find it extremely difficult to shape a single organisation to take account of the very different needs in localities.

The West Midlands currently contains Ambulance Services that have very different levels of performance. There is concern that merging these Trusts without adequate planning could result in an overall reduction of patient care. The Committee would recommend that before such a merger is embarked upon that each of the constituent Trust spends a significant amount of time addressing issues of best practice and performance. There needs to be a systematic approach to performance improvement that raises standards to the level of the highest and not to the lowest denominator. Hopefully a structured and considered approach to merger would prevent the problems that have occurred when other large Ambulance Services have been created.

Management Issues

One of the stated deficiencies of the current structure of Ambulance services is that management capacity is currently spread thinly across the region. As a result of the proposed restructure the number of boards will be cut and therefore will reduce further management capacity across the region. If Locality Delivery Units are maintained as at present with differing work practices then the new single board would have to have a day to day understanding of four different structures and working methodologies.

In terms of accountability and governance arrangements, we feel a higher level of expectation will be placed on Non Executive Directors. They will become responsible for a more diverse population base. We are not sure whether such a small number of individuals will be fully representative of the diverse population base and the particular needs of localities.

Financial Implications

The consultation document sets out that this merger will result in a saving across the West Midlands of approximately £3 million. It is of concern that the disruption caused by this merger is only going to achieve such limited savings. The proposal also sets out that the main implication of the merger will be to devolve to one board structure whilst leaving the locality units in place. The Committee would challenge the assumption that reducing four boards to one would provide these savings, especially in the short term where additional redundancy costs will be incurred.

At present each of the Ambulance Trusts use different IT and communication systems and it seems logical that a single trust would need to harmonise these systems as a matter of urgency. In discussions with the Ambulance Trusts it appears that they are aware of this issue however no costs have been identified on how much this process would cost and how long it would take. In the meantime, this may exacerbate inconsistencies in service provision.

The Committee is very concerned that if the savings are not achieved through reduction in management costs then there will be a move to reduce control centres which will result in a loss of local focus whilst also resulting in a reduction of patient care.

Consistency of Service

Even though the consultation document states that the proposed merger will not result in any changes to frontline services, we feel it is inevitable that this will happen, due to inconsistencies in current practice and provision. One such inconsistency is that Staffordshire Ambulance Service provides pre-hospital Thrombolysis treatment to some of its patients whilst some other Trusts do not. They claim that that early Thrombolysis treatment, pre- hospital, results in lower death rates. It is not clear whether such a practice would be rolled out across the region by a single organisation. The inconsistencies are exacerbated by the relationships a single organisation would have with different PCTs across the region. At this stage the working groups set up to align work practices cannot illustrate how the new single organisation would work.

It seems entirely premature to consult on the creation of an organisation when there is no evidence to support that it is either financially or clinically viable.

Patient Transport Services

The issue regarding contracts for Patient Transport Services has also been raised with Health Overview and Scrutiny Committee. There is concern that by merging all Trusts in the region will mean an effective monopoly situation with regard to contracts for Patient Transport Services. If such a monopoly were to arise then any benefits conferred by competition would be lost which could result in a reduction in quality of patient care.

Survey Responses

In considering and evaluating the proposals, we are aware that the West Midlands Ambulance Service NHS Trust PPI Forum has carried out its own survey to ascertain what members of the public think about the proposed merger. The outcomes of this survey are summarised below

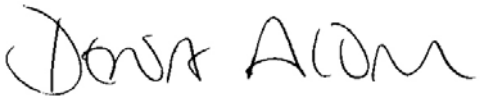
The PPI Forum interviewed 438 people and asked them whether supported the proposed merger of West Midlands Ambulance Service NHS Trust into a wider regional Trust. Of those surveyed 381 (87%) said they were against the proposal, 30 (7%) people said they did not know enough about the proposal and 26 (6%) people supported the proposal. This demonstrates that the proposed merger is not supported by the local population.

Conclusions

In conclusion the Birmingham City Council Health Overview and Scrutiny Committee does not support the proposal to create eleven Ambulance Trusts in England. At present there is insufficient evidence that patients will benefit or why changes in work practices can only occur as a result of a merger. The anticipated financial savings do not appear to be significant, and as the work is still in progress to plan for how a merged trust would work, there is no guarantee that this is the best way forward.

This consultation is driven by the need to make efficiency savings of £3 million. We feel it is a drastic step to merge 4 separate bodies into a single organisation when it might be easier to for the Department of Health to consider asking each of the current Ambulance Trusts to identify efficiency savings of £750,000 and to develop financial plans to recover this money.

Yours faithfully



Councillor Deirdre Alden
Chairman – Health Overview and Scrutiny Committee

Contact officers

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Specific contributions included in this draft

Health O&S Committee
(Committee deliberations February 8th)
Councillor Deidre Alden (Chairman)
Councillor Abdul Aziz
Councillor Keith Barton
Councillor Rev. Richard Bashford
Councillor Steve Bedser

Councillor Paulette Hamilton
Councillor Ray Hassall
Councillor Talib Hussain
Councillor Jane James
Councillor Ayoub Khan (Vice Chairman)
Councillor Yvonne Mosquito
Councillor Margaret Sutton

Birmingham City Council's response to "Ensuring a Patient-led NHS" - Consultation on new Primary Care Trusts arrangements in Birmingham and the Black Country

Introduction

1. This paper sets out the response from Birmingham City Council to the above document and has been facilitated by the Health Overview and Scrutiny Committee. It is supported by and incorporates the views of the Council's Executive. Therefore in this paper the Council is speaking both on behalf of the Birmingham public and health users and also as a partner in achieving improved health and well being for all.

2. It was always anticipated that any change to PCTs, whether structural or involving adjustments to their roles and responsibilities, would be thought-provoking and involve challenging debate. Developing a response to this consultation has resulted in just that.

3. From the outset, the Health O&S Committee recognised that the task of deciding between the two proposals for restructuring PCTs in Birmingham was not going to be clear-cut or straightforward. For this reason, we decided to carry out our own objective analysis to ascertain whether 3 PCTs or a single PCT would be best for the City.

4. Given that "Ensuring a patient-led NHS" promotes the need for closer working between PCTs and local authorities, the Committee developed criteria that enabled us to test the two proposals against key themes and issues that were of importance to us as a Council. This criteria included

    - **Health improvement** (e.g. reducing health inequalities, development of Practice Based Commissioning, consistency and equity of service provision, delivery of public health targets, and engagement of primary care at local level)
    - **Partnership working** (improved connectivity with District, City and regional structures, provision of integrated care, multi-agency working, capacity and resources for partnership working)
    - **Improved Performance** (Local Area Agreements, Emergency Planning, joint and city-wide targets and impact on CPA scoring)
    - **Effective use of finances** (approaches to funding for priority neighbourhoods and city-wide targets, investment in commissioning plans for vulnerable groups, unified commissioning)

5. Verbal and written contributions were invited from senior managers and service practitioners from the NHS, the City Council and the Voluntary Sector against the above themes. A mini survey was conducted via a questionnaire

and the results analysed. Additionally, evidence was submitted about the potential risks to the Council of the two options. A copy of the questionnaire and a brief analysis of the responses are attached at appendix 1.

6. This paper reflects the outcome of the Committee's debate and careful deliberations of all the evidence gathered.

Overall conclusions

7. The proposed changes have come at a time when PCTs are at an important stage in their development. They are on a path of improvement and are working hard to drive and transform health services so that they respond to local needs. A lot of energy and effort has gone into building relationships and trust with partners, particularly the City Council. We recognise that this partnership working has come a long way but that there is still further work to be done. We also recognise that these relationships are sensitive and must be sustained. It is important that the progress, commitment and good-will built through recent partnership working are not lost.

8. Change can be disruptive, but it can also be constructive as it creates opportunities for further growth and refinement. Whilst the restructuring of PCTs is nationally driven and relates to the need to strengthen their commissioning role, there are equally valid drivers at local level which must be taken into account in determining the final composition of PCTs in Birmingham.

9. At the heart of the consultation lies the principle of creating a "Patient-led NHS", but the changes are in essence nationally driven and underpinned by the need to make cost savings. We are concerned that the change is being imposed and that its timing is premature given the current phase of development of PCTs and the relationships developed with the City Council.

10. The consultation document appears to simplify the debate by purely focusing on the number of PCTs in Birmingham. Given the previous history of NHS reorganisations, it is evident that there are no perfect structures. We believe the fundamental issues are not about the number of PCTs but about infrastructures, relationships and ways of working. It is only by defining and agreeing the latter that we can begin to identify how many PCTs we need in the City. We are concerned that the consultation process has allowed little scope for this fundamental debate.

11. Overall, selecting between the two options for PCTs proved to be a very close call. Objective analysis was undertaken by the Health O&S Committee based on key criteria that was important for the Council and its performance. This showed that there are equally strong arguments for 3 PCTs and for having a single PCT in the City. From a Council and City wide perspective, a single

PCT is desirable as it offers the ability to strategically plan, commission and deliver services, especially for vulnerable groups and those with complex needs. Greater efforts can be made on securing equity and equality of provision and more effective use of resources across the City.

12. From an NHS/ local perspective, 3 PCTs are desirable as they enable progress to be maintained around partnership working. PCTs are on a path of improvement and major organisational restructuring could prove to be disruptive. Relationships, co-operation and stability are important for the City Council and its performance. A Comprehensive Performance Assessment Inspection and Joint Area Review of Children's Services are expected in October 2006; this is the same time that changes to PCTs are to be implemented.

13. That said, current arrangements with PCTs are not perfect and changes will need to be made if the City is to benefit from a strong, unified commissioning function. Many of these issues are set out in this paper and will require ongoing dialogue and negotiation between key partners in order to ensure that the proposed restructuring delivers real benefits to improving health and the performance and quality of services in the City.

14. The Health O&S Committee concludes that neither of the proposed options offers a true choice or automatically appears to be the one that will work the best for Birmingham. However, our preference, only marginally and with conditions, is for Option 1: the merger of East and North PCTs and the retention of Heart of Birmingham Teaching PCT and South PCT to create three PCTs in the City. **The Committee's support is conditional based on the need for clear, solid commitments that the new structure (whether one PCT or three PCTs) will**

    - Be part of robust strategic commissioning arrangements with the City Council;
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- Be able to plan and invest funding in children's and adults services, particularly as regards low volume, high complexity needs, using open book approaches which recognize the co-dependent relationship between health and care .
- In the case of three PCTs, have one strategic lead to act on behalf of all three PCTs.

15. Regardless of the final outcome, we are certain that the views and information contained in this paper will give a useful insight into what is needed for the City as a whole as well as for creating a "Patient-led NHS". We believe this information has consequences beyond the consultation itself. It is important that the evidence we have received and the issues raised in this paper are not overlooked once the consultation has ended. The City Council is keen to engage with the Strategic Health Authority and our health partners in resolving these matters and issues.

MAIN FINDINGS - 1 PCT or 3?

16. At the outset of the Committee's work, there was a general assumption that many people favoured having 3 PCTs as this would allow for business continuity, cause minimal disruption and retain a local focus on the diverse needs of local communities. The Health O&S Committee was surprised to find this was not fully corroborated in the evidence submitted to us. Alongside support for 3 PCTs, compelling arguments also exist for having a single PCT. These arguments cannot be ignored and must be addressed, regardless of the final outcome.

17. Another assumption was that opting for 3 PCTs would be the next best thing to maintaining the status quo. Many people expressed the view that Option 1 (establishing 3 PCTs) should be supported because it offered the minimum level of disruption. However, there is widely held view that moving to 3 PCTs is a short term solution and a stage in the journey to eventually have a single PCT in the City. Given that North and Eastern Birmingham PCTs are already working under "shadow" arrangements ahead of a potential merger, the Committee believes that a status quo or "no change" is not viable even in relation to the model for 3 PCTs.

18. We heard evidence that the current structure of PCTs has strengths as well as weaknesses; experience of service practitioners shows that the present configuration is not always compatible with ways of working on city-wide issues and the strategic aims and priorities for the City as a whole. These issues are described in more detail in the subsequent sections of this paper and would need to be addressed if the final decision was for the retention of 3 PCTs. Furthermore, many people stated that if a single PCT was inevitable

at some point then they would prefer to move to this now rather than face incremental change and further disruption.

19. A third assumption was that 3 PCTs would be coterminous with the area structures for the Social Care and Health Directorate. However, this is not the case. In light of the requirements of the Children's Act 2004, the Social Care and Health Directorate has recently reviewed its own structures resulting in the establishment of city-wide arrangements for commissioning of Children's and Adults services. Although some operational management structures may exist locally, the intention is to strengthen links at district level. Services to children such as support to schools will be configured into six areas, again networked to the 10 Districts. Joint services to people with Learning Disabilities and Mental Health have always been joined at City-wide level and there are no proposals to change this. Three PCTs would therefore not offer coterminosity with these developments and would need to be strengthened both in terms of capacity and structures for successful working at a strategic city-wide level and at localised level with District Strategic Partnerships.

20. A further issue raised with us about coterminosity relates to the Perry Barr and Sparkbrook Districts. Councillors and officers working in these wards are concerned that the creation of 3 PCTs in the City would leave these wards straddling between the boundaries of 2 or 3 PCT areas. This would cause problems and complexities for partnership working and equity of provision and health services in those Districts. The Committee is of the view that some re-working of the PCTs boundaries would be necessary to ensure that such Districts were within the catchment areas of one PCT and not two or three.

21. The Committee raised concerns about the size of the proposed PCTs under the two options. The Strategic Health Authority confirmed that if a single PCT was created in the City, it would not be the largest in the Country (the largest PCT was expected to cover a population of approximately 1.75 million). However the benefits of coterminosity and enhanced partnership working needed to be weighed up against the risk of creating an organisation too large to relate its populations or its primary providers and GPs. There was need for PCTs to have sufficient focus to deliver Practice Based Commissioning, tackle inequalities and have the ability to drive strategic change through local providers. The Chief Executives of the current PCTs expressed the view that the size of the three proposed PCTs was just right as they would be big enough to take action, yet small enough to make a difference. They did not feel that Heart of Birmingham would be disadvantaged in any way or that there were any plans to merge Heart Of Birmingham Teaching PCT with Sandwell PCT due to the integrated approaches being worked up through the "Towards 2010" Programme.

22. Officers from the Council were of the view that, regardless of size and irrespective of the final choice of option, the important factors were to build

and maintain strong working relationships. Each option needed to be workable both at local level with District Strategic Partnerships and at a City wide level as this was a requirement of the performance framework outlined in Government's White Paper, Our Health, Our Care, Our Say.

3 PCTs – advantages and disadvantages

23. The Committee heard evidence that the current configuration of PCTs has advantages and disadvantages. Staff from the NHS informed us that PCTs are working hard to bring a focus to health inequalities at local level. Partnership working and relationships are much stronger now than in the past allowing PCTs to plan, design and develop better services in line with the needs of their local populations. Commissioning decisions can be focussed on local needs and have the potential for greater impact when appropriately aligned across local primary care, acute care and with City Council services. By using data and micro-management of service provision, PCTs are able to influence performance, monitor quality and drive-up standards. This local focus provides a good base for PCTs to launch Practice Based Commissioning and align it to the diversity of need in their areas and the plurality of contractors.

24. We were also informed that the role and functions of PCTs are expanding and that there is a greater focus on relationships with the local authorities. Throughout the Government's White paper "Our Health, Our Care, Our Say", there is a sustained emphasis on the need for effective commissioning and a clear expectation for increased coterminosity between PCTs and local authorities. This will facilitate an increase in joint commissioning, closer integration of health and social care services and joint workforce planning to create multi-skilled, community-based teams to support people to maintain their health and independence. Both PCTs and local authorities will be expected to have robust monitoring systems, which will speedily identify providers which do not provide equal access to high quality, cost-effective services. Competence in commissioning and contract management will become a more important component of performance assessment.

25. There is also an expectation that the use of Health Act flexibilities will be greatly increased and that this will happen in parallel with a growth in Practice Based Commissioning, enabling practices to direct resources to community-based and integrated services. PCTs will be expected to increase resources for preventative services and health promotion to an extent they have not been able to do before.

26. The Committee is aware that the needs of local communities have benefited from the local focus provided by the 4 PCTs. It was reported that there is a history of partnership working with the City Council which has led to some

service improvements and the pooling of budgets. However, it has also exposed real difficulties in the ability of the PCTs to work city wide and create consistency of approaches.

27. Each PCT has adopted different models of working and different processes and structures. For those looking from the outside in, it appears there are wide variations between the PCTs and for all intents and purposes they are 4 distinctly separate organisations with their own cultures, boundaries and power bases. This has been a barrier to developing consistent relationships and working practices.

28. The Committee heard that the levels of investment and prioritisation vary across the PCTs and this makes it difficult for those that are trying to pursue city-wide agendas and the implementation of preventative strategies and commissioning strategies that need to be rolled out consistently and coherently if they are to impact on health inequalities. This can cause delays in decision-making and undermines best value.

29. The Chief Executives of the current PCTs believe that “Lead Commissioning” arrangements are working well. This is whereby one PCT acts in a lead role on behalf of the other PCTs. However, staff from the Health sector and some Council services, spoke of difficulties in securing consistency of service provision. It is important that the commissioning arrangements of PCTs for adults and children services are changed to reflect the outcomes framework of the Children Act 2004.

30. It was explained to us that commissioners have a broad remit and are not specialists in any particular area. Additionally, each PCT is often pursuing its own local organisational agenda. New projects for investment are therefore only likely to be considered if the arguments for investment are well understood and if the project fits into the organisational priorities at that point in time.

31. We were informed of problems with information sharing, communication, inconsistency of approaches, lack of cohesiveness and lack of capacity in terms of pursuing city-wide issues and services of a joint nature. The current structures were described as unwieldy, over bureaucratic and tended to slow down progress.

32. We also heard about duplication and inefficiencies in the present arrangements. Staff providing evidence, spoke of having to attend 4 sets of meetings, negotiating with 4 sets of people and working their way around 4 different organisational systems when trying to carry out their jobs and duties. This was extremely time consuming, confusing and elongated the processes for the development of strategies and the negotiation of resources. There was also concern that city-wide strategies became diluted and lost their original

focus because of the need to tailor activities to PCT specifications and levels of investment. As one witness succinctly put it: "sometimes you just need to relate to one big picture – not four."

33. In some cases, city wide initiatives were at risk of not being taken forward if one PCT decided not to engage, if it was late in making a decision or if it wasn't happy with what was being proposed. It was pointed out that greater clarity is needed about arrangements for joint commissioning with the Council and greater clarity of commitment to collaborative commissioning across PCTs.

34. In other cases there was a danger that different levels of services were being provided depending on where people lived in the City and whether their PCT was able to fund that particular service or not. The Committee heard that Heart of Birmingham Teaching PCT had the highest level of investment in reducing teenage pregnancy. This was commendable, but rates of teenage pregnancy are also high in outer city estates as this where targeted funding is needed.

35. Another example was given of Paediatric Occupational Therapy Services (OT) and access to Sensory Integration Therapy (SI). The SI service is not available on the NHS in Birmingham. Mainstream OT service is poor given the funding resources available. However demand for SI treatment is high and some PCTs have worked with the city- wide Specialised Children's Services Agency to fund private provision. A bid is being made as part of the Local Delivery Plan process to enhance mainstream provision as well as developing the SI service; however this requires significant investment and commitment from all PCTs. The knock on effect of this is the inequity of provision that children in the same school may experience, dependent on where their GP is located and whether their PCT is able to provide funding.

36. This inequity is exacerbated as many children requiring SI treatment, and those with disabilities requiring care and treatment, attend special school often in another area to where they live or are registered for primary services. This adds confusion about who takes responsibility for them and who funds the services they need. Access to equipment for disabled children also varies across the City and depends on how it has been ordered, where it is ordered from, who the child is known to (e.g. hospital, consultant, GP etc) and what money is available in local PCT budgets. Whilst the integrated children's equipment project has attempted to address this, investment has been variable and the inconsistencies have remained.

37. We learnt that much energy was lost in negotiating such provision across geographical boundaries and trying to maintain consistency for service users. The Committee was concerned to hear that about this "postcode lottery" of

provision and the inequalities it created, and felt it was crucial for this be urgently resolved.

38. We heard evidence of some service variation in support from the PCTs to the Healthy Schools programme. The role of school nursing varies in different PCTs. There has been some variation in support to special educational needs assessments, although this is starting to improve. It was also reported that there is variation in support and interpretation of the administration of medicines in schools. Immunisation teams vary in programme and resources.

39. Equally as regards the development of the Children and Young People's Plan and the establishment of the Children and Young People's Board, the City Council has led on these developments and city-wide structures are in place to strategically plan and commission services. But PCT representation at the agreed Priority Work Stream meetings has required a presence from each PCT increasing numbers attending meetings leading to delays and some uncertainty around decision making.

40. Strategic Partnerships and commissioning arrangements which involve 3 or 4 separate and autonomous health organisations bring additional complexities. Developing coherent approaches to tackling health inequalities and joint commissioning for vulnerable groups become difficult and take longer to agree and implement. Additionally Council officers said their capacity is sometimes stretched in dealing with four PCTs.

41. We also learnt that whilst PCTs have a local focus, not every PCT is fully engaged with their District Strategic Partnerships. Indeed, one particular District Committee reported to us that they had had no communication from their PCT until this consultation started. Similar perspectives emerged from voluntary sector organisations that we spoke to. They stated that local community and voluntary groups found it difficult to engage with PCTs as they did not appear to have the capacity or resources to link into neighbourhoods. Equally, there was a desire for PCTs to focus on targets and service specifications, when the nature of community work was focused on outcomes and was not target-driven. PCT priorities for investment were often not the same as those of voluntary organisations. This often meant funding was difficult to access or opportunities for investment were missed.

42. Clearly there are questions about how "local" PCTs really are, the depth, solidity and consistency of the relationships developed with local communities and District Strategic Partnerships and whether PCTs have the capacity to connect at ground level with service users and a variety of partners, not just the providers that they work with.

43. Furthermore, as regards having a local focus on health inequalities, it was reported that the existing PCTs have the potential to achieve greater equality

of outcomes; however there was limited evidence of them having successfully tackled health inequalities. Despite substantial improvements in healthcare over recent years, and despite extremely valid attempts by the PCTs, these inequalities have remained largely consistent.

44. Whilst Practice Based Commissioning was to be welcomed and offered opportunities to drive health improvements, the Committee was not convinced that either the existing PCTs, or their GPs were ready for this. It appeared that each PCT is developing its own strategy and is in a different state of readiness to implement this policy. The Committee was doubtful whether GPs are sufficiently engaged in this process and felt that some single handed practices in the City might always fall behind. There was concern that this would cause variations in access and availability of services, particularly in poorer areas and that a more consistent model was needed to drive Practice Based Commissioning.

45. Additionally, Practice Based Commissioning, Patients' Choice, Foundation Trusts and other policy initiatives would create an increased demand for management capacity in PCTs. These initiatives are all coming on stream at the same time that PCTs are required to make efficiency savings and reduce management costs. The Committee was concerned about the implications of this for service delivery, quality and standards. We were informed that the proposed reconfigurations and the need to strengthen the commissioning role of PCTs, would not adversely affect services. They were about cutting bureaucracy in the system and ensuring that any resulting efficiency savings were re-invested in front line services. Arrangements were being made for the development of a "Commissioning and Business Support Agency" that would enable PCTs to have shared "back office" functions such as pay roll, data management and estates management.

46. However, we also heard that the present model for sharing back office functions was not ideal. The Committee believed that assurances were required that such an agency would be able to relate to and support a range of services especially those involving joint commissioning and integrated provision between health services and the local authority.

47. The Committee also queried the practicality of creating yet another separate organization in the system. PCTs could potentially be reduced from four to three in order to rationalize management costs yet it the establishment of another organisation was being suggested. We were uncertain whether resources would actually be saved or whether they would just be moved around the system.

48. Finally the Committee heard that when they were first established, PCTs in Birmingham were some of the largest in the Country. However under the current proposals, the 3 PCTs in Birmingham would be of an average size

and would no longer be the largest. This raises questions about the competitiveness of the 3 PCTs, their bargaining power and their ability to recruit and retain the best staff - some of whom may be tempted by jobs in larger PCTs, particularly those PCTS that are coterminous with their local authorities. In this arena, the stability of current relationships and partnership arrangements is uncertain, as is the longevity of the proposed change.

1 PCT – advantages and disadvantages

49. The Committee heard arguments for and against a single PCT. Some people believed that moving to a single PCT would be disruptive and that the current momentum and pace of improvement would be adversely affected. Current partnership working, expertise and relationships would suffer and staff in the NHS would be distracted by the restructuring which in turn would impact on service delivery and service users. It was suggested that major restructuring could set organisations back by around 18 months. However this is disputed by the Government :

    "The Government simply does not accept that these changes will set services back 18 months, or indeed at all. This reconfiguration is not a sudden change. It is part of a planned and managed programme of NHS reform aimed at delivering improved quality of care and value for money for taxpayers" (Government's response to Health Committee's report on changes to PCTs, Page 13. March 2006)

50. Comparisons were made with the previous Birmingham Health Authority which was described as being too large and monolithic and unable to connect or engage at local level. We were told that a large organization covering a population of over 1 million people would find it hard to be flexible and cover the variation of needs in localities. As a result, Practice Based Commissioning would be difficult to deliver and performance management of providers and contracts would become complex and onerous. We were also informed that it would be difficult to move to a single PCT whilst PCTs had a dual role as providers as well as commissioners.

51. The Committee accepted that a single PCT would be large, however it did not accept comparisons made with the old Birmingham Health Authority. Clearly the policy, legislative and budgetary environment is a lot different now to what it was then. Both health partners and the City Council now have more powers to drive through integration and develop more co-ordinated approaches to delivering care. It was therefore inappropriate to assume that a single PCT would act in the same way as a previous organisation of a somewhat different nature.

52. Furthermore it was suggested that although a single PCT would provide a better strategic overview, it would find it difficult to maintain a local focus. It was more likely to concentrate its attention on inner city deprivation and would overlook poverty and health inequalities in outer city areas. Health improvements would be based on the lowest common denominator.

53. Heart of Birmingham Teaching PCT which is currently underspent in its budget stated that should the City move to a single PCT, there was a danger this money would be subsumed by the new organisation and would be diverted away from the capital developments in primary care, for which they were intended. Equally, moving to a single organisation may mean that major capital schemes such as the "Towards 2010" programme could face delays.

54. Whilst the Government's White Paper places an emphasis on coterminosity with local authorities, the Chief Executives of the current PCTs informed us that coterminosity is not necessary for joint working and that relationships, trust and effective ways of working were more essential.

55. Officers from the Council agreed that joint working was about capacity, willingness and commitment as much it was about structures. However, they also felt that coterminosity was very desirable both at a strategic level and at district level. At times and on certain issues, links would need to be made with regional and national structures. The varying degrees of convergence and involvement in the strata of partnerships would be easier to achieve and more consistent, working from the base of a single PCT. It was essential that the final reconfiguration of PCTs was able to work across these broader boundaries and operate within an agreed strategic framework which maximized efficiency, encouraged streamlined approaches and greater synchronization of working practices.

56. The Committee heard about the important role played by the City Council in delivering a massive strategic agenda that straddled a multitude of organisations and subjects. Partnership working with health needed to be in the context of this wider agenda.

57. The Council has a duty to promote the environmental, physical, economic and social well being of all its citizens, regardless of geographical boundaries within the City. We have a responsibility to improve social and community cohesion, mainstream equalities and provide the best outcomes for vulnerable groups and those with complex needs.

58. It is the role of the Council to develop strategies for the City as a whole and provide direction to ensure services are delivered in a co-ordinated and consistent manner and with due regard for equity and equality of access for all groups.

59. The economic regeneration and prosperity of the City is reliant upon concerted efforts to drive-up employment and employability of our populations, tackling crime and homelessness and investing in the development and sustainability of both our urban environments and outer-city estates.

60. Statutory duties such as Emergency Planning require commonality and co-ordination of approach across the City and for all partners to be fully engaged and committed. The Committee heard that at the moment, City Council and NHS structures and boundaries are not neatly aligned. The proposed merger of ambulance trusts and the strategic health authorities presents some opportunities for coterminosity on Emergency Planning, however the potential for duplication and working within different organisational structures will continue under a multiple PCT structure. It was reported that there was a preference for a single PCT from an emergency planning viewpoint as this would secure centralized and streamlined approaches, improve communication and coherence of emergency plans and maximise resource efficiencies, both in terms of people and finances.

61. We also heard that key commissioning of Children's Services, Adults and Housing are easier to achieve across the City if arrangements with our partners are equally consistent. Government White Papers and Green Papers such as Every Child Matters, Choosing Health, Independence Well Being and Choice and Our Health, Our Care, Our Say, place an increasing emphasis on integrated agendas, better prevention services, earlier intervention, more joining up of services at local level, sharing of information and improving outcomes for the most vulnerable groups in the City.

62. It was pointed out that the potential introduction of a Children's Trust in the City and future integration of the Public Health role within the local authority, will intensify some of the demands for greater co-ordination and clarity on issues. This points to the need for some coterminosity at strategic level. As a crucial element towards the establishment of Children's Trust arrangements, the City needs an agreed planning and commissioning framework with a detailed investment plan to meet desired outcomes for children and young people. This is likely to lead to changes in use of resources to better meet needs.

63. The appropriate investment and commissioning for vulnerable children and young people is of importance to the City Council. Improving educational achievement for disadvantages groups, improving life chances of Looked After Children, supporting children and adolescents with mental health, reducing teenage pregnancy and childhood obesity and reducing rates of infant mortality all require a centrally agreed framework and a consistent unified approach to funding. These areas of "low volume, high cost complexity" would be better served with integrated commissioning and

budgets. A much more corporate and holistic view is needed if the City is to invest effectively in these services and services users are to achieve the best outcomes. The same is equally true in securing provision for older adults, people with mental health, learning disabilities, physical disabilities and working age dementia. These point to the need for coterminosity at strategic level and transparency in approaches to funding and actual investments.

64. As the accountable body for delivering and monitoring Local Area Agreements, major regeneration schemes and the performance management of a range of city-wide and joint targets, there is a desire to ensure that there are consistent approaches to ways of working. Strong relationships and the development of parallel approaches through partnership working are essential. Developing and delivering joint agendas are easier to achieve when coterminous arrangements are in place at strategic level and mechanisms exist for priority setting, monitoring progress and rectifying the causes of poor performance or failure to deliver.

65. Officers from the City Council and external agencies, including those working in the NHS informed us that consistency and co-ordination in the planning, commissioning and delivery of services are essential in moving forward on city-wide issues. We heard that the current PCT structure can undermine this due to its competitive and autonomous nature and the “separateness” of each organisation.

66. There was a need for the current PCTs to “act as one” and work together to invest in commissioning for vulnerable groups. Although a joint commissioning forum has recently been developed bringing the 4 PCTs together with Social Care, it is too early to comment on its effectiveness. Concern was also raised about the length of time taken to recognise the necessity of this arrangement and to agree its establishment.

67. We heard that strong ownership and a strong delivery mechanism are needed to implement the policies of integrated and community-based services as set out in the White Paper, Our Health, Our Care, Our Say. The issues in the White Paper point to a joint social care and health agenda that will require long term planning and investment of resources and connectivity of management structures at a strategic level. It was felt that a single PCT would provide an explicit platform for planning, allow for quicker agreement on shared agendas and provide the opportunity to develop and use shared definitions across the city, particularly where these are essential to improve the performance of the Council.

68. Delivering on the White Paper would require the Council to maintain both operational and strategic balance. It was reported that in the past the Council and in particular Social Care, had concentrated too much on achieving operational alignment with PCTs. This had resulted in reduced capacity at the

centre and a loss of strategic focus. Whilst better partnership working with PCTs was improved, the drawback was that there was vacuum in terms of strategic planning and commissioning. This is only just beginning to be addressed.

69. As regards Local Area Agreements and joint assessment of commissioning functions, we were informed that these would also require uniformity of approach to funding, commissioning and setting of priorities and targets. Local Area Agreements and Joint Area Reviews will require co-dependency in working arrangements and will make performance inter-dependent. Under current structures, this co-dependency seems to be missing and needs to be established. It would be easier to achieve with a single PCT.

70. Other benefits of a single PCT were that it would enable greater consistency to be achieved in all the above areas and would secure strategic planning and delivery. It would provide a lead voice on health issues which doesn't appear to exist at the moment and bring coherence to commissioning arrangements, especially on joint arrangements which are strongly being advocated by the Government.

71. Through a single PCT, it would be easier to achieve demonstrable equity of access and provision across all areas of Birmingham without geography getting in the way. It was pointed out that a single PCT would offer benefits and stability in the long term although there would be a risk of disruptions to services in the short term. This disruption could be minimised if the change is managed well, takes place within a clearly defined programme and timecales and is underpinned with an effective communication strategy.

72. The Committee recognised that a single PCT also carries significant risks. Failure of a single PCT to perform, engage, and commit to partnership arrangements will have substantial repercussions for the City Council and its own performance. It is understood that changes to the structure of the PCTs will be implemented in October 2006, the same time as the Council is expecting a Comprehensive Performance Assessment inspection and Joint Area Review of Children's Services. Moving to a single PCT will involve more disruption than moving to three PCTs at a time when stability and partnership arrangements will be vital for the Council's performance.

Requirements of a strong commissioning function in Birmingham

73. The arguments for and against each of the options for the reconfiguration of PCTs in the City are equally valid and as stated at the start of this paper, there are no right or wrong answers. However regardless of the final outcome, the Committee feels there are some essential features that the new structure must encompass if it is to be a strong commissioning function.

74. A summary of what the Council is looking for in terms of strengthening partnership working, improving commissioning and investment planning and improving performance is as follows:

- consistency and cohesiveness in planning, commissioning and delivery of services and commonality of approach at strategic level,
- ownership and commitment to joint working across organisational and geographical boundaries so that there is equity and equality of access across the City.
- connectivity between management structures at a city-wide level and with District Strategic Partnerships with scope to broaden this at regional level when required.
- organisational capacity to support partnership working, commissioning and delivery at city-wide and district level,
- clarity about arrangements for Joint Commissioning with the Council and collaborative commissioning across PCT areas (If the outcome is for 3 PCTs).
- transparency about resources and budgets
- a clear and inter-dependent relationship with the Council on performance and financial planning

75. We believe that whether there are three PCTs or one PCT, **solid assurances need to be given that the structure will:**

- Be part of robust strategic commissioning arrangements with the City Council;
- Will adopt a shared model for working together and establish common, consistent care pathways;
- Be able to create a framework for planning and achieving outcomes within local areas - aligning the delivery of Practice Based Commissioning with other agencies, close to the service user;
- Use evidence, not postcodes, to justify different needs and types of services.
- Be able to commit resources to agreed priorities across the City when required and/or support different patterns of investment to achieve equality of outcomes.
- Be able to work locally as well as strategically.
- Be able to respond and act quickly
- Be able to work with the Council constructively to deliver on a range of agendas and the achievement of targets to improve performance
- Be able to plan and invest funding in children's and adults services, particularly as regards low volume, high complexity needs, using open book approaches which recognize the co-dependent relationship between health and care .
- In the case of three PCTs, have one strategic lead to act on behalf of all three PCTs.

Other issues

Comments on the consultation process

76. Whilst the consultation document stresses the importance of coterminosity, it has concentrated largely on the responsibilities of PCTs and does not relate to the corporate agenda and the wider responsibilities of the local authorities as a whole. The Health O&S Committee undertook its own objective analysis of the issues that were of importance to the Council in assessing which of the two options would work best and in identifying what was needed from a strong commissioning function in the City. The key lines of our enquiry and the issues that we felt were important to the Council are captured in our questionnaire along with an analysis of responses received (see appendix 1). These themes and questions also formed the basis of our enquiries at evidence gathering meetings. The whole process enabled us to evaluate what is working well under current arrangements and areas for improvement. Had we not done this, we feel these issues would have been missed and would not have been picked up elsewhere.

77. The Health O&S Committee has some concerns about the processes adopted for publicising the consultation. We're aware that the consultation is being led by the Strategic Health Authority and that it arranged a series of consultation events across the City. However approaches were made to individual District Committees by the PCTs. A discussion document was issued by the PCTs and accompanied the Strategic Health Authority's consultation document. In our view the presentations made to the District Committees and the discussion document issued by the PCTs gave an unbalanced view and described arguments that were more in favour of one option over the other. The advantages of 3 PCTs were promoted and little mention was made of any disadvantages. Likewise the disadvantages of a single PCT were highlighted and little mention was made of any benefits. Having conducted our own exercise into the matter, clearly this is not the case. We found that the approach taken by the PCTs was open to interpretation and also gave the impression that the discussion document and information being presented was fully backed by the Strategic Health Authority.

78. We were also concerned to hear from staff working in the NHS who said they had not been asked for their views by the PCTs. They were pleased to have the opportunity to make a contribution to the work of the Health O&S Committee. We also understand that some people (both within the NHS and Council) support the idea of a single PCT but are unwilling to make formal statements as they do not want to be seen to be going against the expressed preference of their Trust Boards. The Committee was disappointed to hear about this and felt such practice was contradictory to the principles of a "Patient-led NHS".

Conclusions

79. In the end, selecting between the two options proved to be a very close call for the Health O&S Committee and the Council. In helping us to determine which option might work best for the City, the Health O&S Committee undertook its own objective analysis of key themes of interest to the Council and its performance. This analysis and the evidence we collected showed that there are strong arguments for both options of 3 PCTs or a single PCT in the City. However. We also found that relationships, trust and joint working arrangements are more important than structures. The consultation and proposed changes have come at a time when partnership arrangements between the City Council and Health are improving. Whilst good progress has been made, further work still needs to be done. Co-operation and stability need to be maintained.

80. Neither of the proposed options in the consultation document offers a true choice or automatically appears to be the one that will work the best. Whichever one is finally chosen, it must be subject to refinement. Any structure for PCTs will require coherent mechanisms for linking into strategic and city-wide structures as well sub-PCT structures for linking at local level. This will no doubt have cost implications.

81. Clear commitments must be made to principles and requirements as set out in paragraphs 74 and 75 of this report, which we believe will lead to a stronger, unified commissioning function in Birmingham.

82. A key reason why choosing between the options is difficult is that their appeal depends on the angle and focus from which they are viewed. We found that there were three main dimensions of focus that influenced people's preference of one option against the other. The dimensions were organisational, locational and the longevity or period of the change.

83. At an organisational level, support for the options varies depending on whether we look at them from a City Council perspective or a NHS perspective.

84. At a locational level, support for the options varies depending on whether they provide a city-wide/ strategic focus or a local focus.

85. Finally, support for the options varies depending on whether they offer long term stability or can safeguard progress, achievements and relationships, at least in the short term. In summary the dimensions are:

Organisational	City Council	V	NHS
Locational	Citywide	V	Local
Longevity/ Period of change	Long term	V	Short term

86. We recognise that these dimensions of focus are not fixed and we accept that there are other permutations than the ones discussed here. The ones described are those that we feel are central to the debate and relate to evidence which we were given.

87. If viewed from a “City Council, city-wide, long term” perspective and bearing in mind the themes and criteria in our questionnaire, then the preference is to go for a single PCT, with caveats. As already emphasised elsewhere in the paper, a single PCT on its own would not be viable and would need to be underpinned by the right infrastructures and capacity to link with the Council’s devolved structures and District Strategic Partnerships.

88. If viewed from a “NHS, local, short term” perspective then the preference is to go for 3 PCTs, with caveats. Again, simply opting for 3 PCTs would not be viable. We would require strong assurances and a commitment that robust mechanisms will be in place for negotiating and agreeing strategic and city-wide agendas, developing and executing joint commissioning plans and securing open book approaches to financial planning and performance management. Additionally any structure for 3 PCTs would need to be underpinned by effective sub-PCT structures that can work constructively with District Strategic Partnerships to transform health services, developments and the effective use of resources in the heart of our localities.

89. Based on the two options and the dimensions of focus our preference, only marginally, is to support option 1, for the merger of North and East Birmingham PCTs and the retention of South Birmingham and Heart of Birmingham PCTs resulting in the creation of 3 PCTs in Birmingham. This support is conditional on the basis that commitments are made on the areas set out on paragraphs 74 and 75 of this report, outlining essential criteria and requirements for a strong commissioning function in the City.

90. We are aware that this response is one of many that will be received by the Strategic Health Authority and that the final decision rests with the Secretary of State for the Department of Health, pending the overall conclusion of the consultation. We are certain that the views and information contained in this paper will give a useful insight into what is needed for the City as a whole as well as for creating a “Patient-led NHS”.

91. We believe this information has consequences beyond the consultation itself. It is important that the evidence we have received and the issues raised in this paper are not overlooked once the consultation has ended. The City Council is keen to engage with the Strategic Health Authority and our health partners in resolving these matters and issues, regardless of the final outcome.

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17 March 2006

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Appendix 1

Health O&S Committee Questionnaire and Analysis of responses

Analysis of responses

A questionnaire was produced by the Health O&S Committee which set out areas and criteria that were of importance to the work, effectiveness and performance of the Council on health issues and partnership working with the local NHS.

The purpose of the exercise was to see how the two options compared against these key criteria. A copy of the questionnaire is set out further on in this appendix.

The questionnaires were circulated to key individuals within the Council, the NHS and the voluntary sector including those who had been invited to give evidence to the Committee. Approximately 60 questionnaires were distributed and 36 were returned.

Management teams and senior managers within the Council used the questionnaire to form a view about the viability of the two options for consultation. This information was reported as part of the evidence gathering meetings and is therefore captured in the main body of our report.

Key points from the quantitive data are set out below. It must be pointed out that due to the small numbers of people taking part in this survey, the data needs to be viewed with caution. Not all respondents completed the questionnaire in precisely the same manner. Some people only replied to questions relating to one option and not both. In other cases questions were missed out and no responses recorded. The data should therefore only be viewed as an indicative guide.

The data is based on average percentages based on actual numbers responding to specific questions. For the purposes of this brief exercise and due to time constraints, the analysis only covers scores for the ratings of likely, less likely and neutral or indifferent to show strength of feeling.

Theme 1 - To what extent do the options compare in terms of improving the health of people in Birmingham?

No strong views were expressed as to whether 3 PCTs or 1 PCT would improve the health of people in Birmingham. The highest level of scores was recorded in the “indifferent” or “neutral” category. 31% of people believed health improvements were *neither more likely nor less likely* under 3 PCTs while 27% felt the same about a single PCT.

28% of respondents said that health improvements were *likely* under 3 PCTs whilst 18% were of the view that this could be better achieved by a single PCT.

14% of respondents felt health improvements were *less likely* under a single PCT while 12% felt this to be the case with 3 PCTs.

Theme 2 - To what extent will the options improve partnership working with the City Council?

Of those responding, 30% said that the 3 PCTs were *neither more likely nor less likely* to lead to improvements in partnership working. 16% of people felt the same of a single PCT.

23% of people said improved partnership working was *likely* with 3 PCTs, while 22% said this would be the case with one PCT.

16% of people said improvements in partnership working were *less likely* under 3PCTs, compared to 14% of people who thought the same of a single PCT.

Theme 3 - Which option is more likely to result in continued performance improvement of council services?

Again, the highest score was for the neutral/ indifferent category. 39% of people said that the Council's performance was *neither more likely nor less likely* to improve with 3 PCTs compared to 22% of people who felt this would be the case with a single PCT.

24% of people said that the Council's performance was *likely* to improve under a single PCT compared to 16% who thought this could happen with 3 PCTs.

12% of respondents felt that the Council's performance was *less likely* to improve with 3 PCTs compared to 8% people who believed this would be the case under a single PCT.

Theme 4 - Which option will facilitate more effective use of finances?

In a similar pattern to the other three themes, the highest scores were recorded under the neutral/ indifferent category. 35% of respondents felt that use of finances would be *neither more effective nor less effective* under 3 PCTs while 16 % of people felt the same under a single PCT.

23% of respondents felt that more effective use of resources was *likely* to be secured under a single PCT compared to 16% who felt this would be the case under 3 PCTs.

15% of respondents said that effective use of resources was less likely to be achieved under 3 PCTs while 8% believed this would be the case with a single PCT.

Birmingham City Council Health Overview and Scrutiny - Consultation Questionnaire

This questionnaire is designed to aid the Members of Birmingham City Council's Health Overview and Scrutiny Committee in considering the implications of the current consultations to reconfigure Health Services. The consultations being considered are the creation of a West Midlands-wide Strategic Health Authority, the creation of a Region-wide ambulance service and proposals around reconfiguring the Primary Care Trusts in Birmingham.

Name	
Organisation	

Primary Care Trust Consultation

	1PCT option	*3 PCT option*
Which of the proposed options do you favour?	☐	☐

Please tick a box giving a score between 1 and 5 for the likelihood of each statement being achievable under each of the proposed options. With 1 being less likely and 5 being more likely.

Theme 1 - To what extent do the options compare in terms of improving the health of people in Birmingham?

	a) 1PCT option					*b) 3 PCT option*				
	1	*2*	*3*	*4*	*5*	*1*	*2*	*3*	*4*	*5*
1 Health inequalities will be reduced.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2 The development of practice based commissioning will be supported and delivered.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3 There will be consistency and equity of service provision across Birmingham.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4 Services will be responsive to local needs.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5 Public involvement and engagement in health services will be improved.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6 The potential for effective delivery of public health targets will be maximised.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7 Primary Care services will be well engaged	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8 Support for community and hospital services will be well balanced.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9 Local people will be confident of the new structure.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Theme 2 - To what extent will the options improve partnership working with the City Council?

	a) 1PCT option					*b) 3 PCT option*				
	1	*2*	*3*	*4*	*5*	*1*	*2*	*3*	*4*	*5*
1 Partnership working will be maximised at regional, city, constituency and district level.										
2 There will be more scope for improving the integration of care and delivering seamless services.										
3 Multi agency working will be improved.										
4 Capacity and resources to improve partnership working at district level will be maximised.										

Theme 3 - Which option is more likely to result in continued performance improvement of council services?

	a) 1PCT option					*b) 3 PCT option*				
	1	*2*	*3*	*4*	*5*	*1*	*2*	*3*	*4*	*5*
1 Working relationships between the PCT/s and all Departments within the City Council will be improved.										
2 The links between the PCT/s and the District structures will be improved.										
3 Statutory responsibilities such as Emergency Planning will be implemented more effectively.										
4 Local Area Agreements and joint targets will be delivered more effectively.										
5 Joint and city-wide targets will be better performance managed.										
6 The Council's CPA scoring could be improved.										

Theme 4 - Which option will facilitate more effective use of finances?

	a) 1PCT option					*b) 3 PCT option*				
	1	*2*	*3*	*4*	*5*	*1*	*2*	*3*	*4*	*5*
1 There will be a consistent approach to funding for priority neighbourhood and city-wide targets for reducing health inequalities.										
2 Investment in commissioning plans for vulnerable groups will be equitable.										
3 Use of resources and budgets will be more effective.										
4 The advantages of the unified commissioning processes will be maximised										
5 Economies of scale in back office functions will be maximised.										

Do you have any further comments that relate to the proposals to reconfigure the Birmingham Primary Care Trusts?

West Midlands Strategic Health Authority Consultation

		Yes	No
1	Do you agree with the proposal to create a West Midlands wide Strategic Health Authority?	☐	☐
2	Do you consider that the West Midlands wide body will maintain sufficient focus on the health provision in Birmingham?	☐	☐
3	Do you think that the larger organisation will provide economies of scale in addressing Health Inequalities?	☐	☐
4	Do you think the proposal will improve opportunities for partnership working across the region?	☐	☐
5	Do you think the proposal will allow for greater consistency Of Public Patient & Involvement?	☐	☐
6	Do you consider that the proposal will create the stated 15% of cost savings?	☐	☐

Do you have any further comments that relate to the proposal to create a West Midlands wide Strategic Health Authority?

West Midlands Strategic Ambulance Service Consultation

		Yes	No
1	Do you agree with the proposal to create a West Midlands wide Ambulance Service?	☐	☐
2	Do you consider that the proposal will improve services for patients in Birmingham?	☐	☐
3	Do you think the proposal will improve response times within Birmingham?	☐	☐
4	Do you think the proposal will provide benefits for strategic planning in the region?	☐	☐
5	Do you think it will be easier to spread best practice across the region in a larger organisation?	☐	☐
6	Do you consider that the proposal will create the stated 15% of cost savings?	☐	☐

Do you have any further comments that relate to the proposal to create a West Midlands wide Ambulance Service?

Thank you for completing this questionnaire. Please return your completed questionnaire by the 20th February to :-

Narinder Saggu, Group Manager,
Scrutiny Office, Room B147,
The Council House,
Birmingham, B1 1BB

Or email :- Narinder.saggu@birmingham.gov.uk

References

- Commissioning a patient led NHS – Nigel Crisp, letter 28 July 2005
- Commissioning a patient led NHS: Choosing the right configuration of PCTs for Birmingham – Discussion document produced by Birmingham's 4 PCTs in support of the current consultation led by Birmingham and the Black Country Strategic Heath Authority. January 2006
- Creating a patient-led NHS – Delivering the NHS Improvement Plan, Department of Health, 17 March 2005
- Commissioning a patient led NHS: criteria for considering the partnership implications of the proposed changes a discussion paper. John Glasby, University of Birmingham Health Management Centre. September 2005
- The Future of Primary Care - Richard Lewis and Jennifer Dixon
- Consultation on new primary care trusts – ensuring a patient led NHS, December 2005
- Commissioning a Patient-Led NHS: Choosing the right configuration of Primary Care Trusts for Birmingham. A discussion document compiled by the 4 Birmingham PCTs. January 2006
- Your Health, Your Care Your Say - A new direction for community services. Department of Health. January 2006
- Changes to Primary Care Trusts – Government's response to the Health Committee's report on changes to Primary Care Trusts. March 2006

List of people contributing to the review / responding to requests for information

Health O&S Committee

(Committee deliberations December 2005, January 2006, 13 February 2006, 17th February 2006, 8 March 2006 and attendance at Consultation events 16/02/06, 21/02/06, 27/02/06. 06/03/06)

Councillor Deirdre Alden (Chairman)
Councillor Abdul Aziz
Councillor Keith Barton
Councillor Rev. Richard Bashford
Councillor Steve Bedser
Councillor Susan Burfoot
Councillor Paulette Hamilton
Councillor Ray Hassall
Councillor Talib Hussain
Councillor Jane James
Councillor Ayoub Khan (Vice Chair)
Councillor Margaret Sutton

Birmingham City Council

Executive Management Team – 6th March 2006

Edgbaston District Committee
Erdington District Committee
Hall Green District Committee
Hodge Hill District Committee
Perry Barr District Committee
Sutton Coldfield District Committee
Tyburn Ward Committee
Yardley District Committee

Peter Hay, Strategic Director Health and Social Care
Bill Robertson, Assistant Director – Adults Strategy
Cheryl Hopkins, Assistant Director – Children's services
Julia Harding, Strategic Partnerships Officer, Learning and Culture
Richard Lodge, Emergency Planning
David Maxted, Strategic Director – Local services
Jan Kimber, District Director, Perry Barr

NHS

Sophia Christie, Chief Executive North/ East PCTS
Graham Urwin, Acting Chief Executive, South PCT
Denise McLellan, Deputy Chief Executive, Heart of Birmingham Teaching PCT

Tony Ruffell, Strategic Commissioning, East PCT
Janet Pomeroy, Commissioning, Heart of Birmingham Teaching PCT
Donna Darbyshire, Specialised Children's Services, South PCT
Ros Hamburger, Dental Public Health, Heart of Birmingham Teaching PCT
Sarah Falmer, Heart of Birmingham Teaching PCT
Sue Turner, Birmingham and Solihull Mental Health Trust

Voluntary Organisations
Susan Spencer, Birmingham Settlement
Gordon Will, NHS Concern

Questionnaire Responses
Approximately 36 individuals responded to the questionnaire and their views have been captured either in the main body of the report or in the analysis of responses to the questionnaire..