



Scrutiny Board 4 (Health)

3rd Report (2005-06)

Response to “Configuration of NHS ambulance trusts in England”

15 March 2006

Scrutiny Co-ordination Group
Coventry City Council
Council House
Coventry
CV1 5RR
Tel: 024 7683 1179
Email: michelle.hayes@coventry.gov.uk
Web: <http://www.coventry.gov.uk/scrutiny>

Other publications from the Health Scrutiny Board:

2005 – 2006

1st Report of Scrutiny Board 4 (Health), *Scrutiny Board 4 (Health) response to the consultation on the smokefree elements of the Health Improvement and Protection Bill*, August 2005

2nd Report of Scrutiny Board 4 (Health), *Scrutiny Board 4 (Health) response to the Coventry Teaching Primary Care Trust consultation, "Coventry City Centre Health Services"*, November 2005

2004 – 2005

1st Report of Scrutiny Board 4 (Health), *Statutory Consultation on the Development of Dental Training and Specialist Dentistry for the West Midlands*, January 2005

2nd Report of Scrutiny Board 4 (Health), *Review of Health and Social Care Services, City Centre – Update*, March 2005
Health Scrutiny: Annual Report 2004/05

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Foreword

Cllr Joe Clifford
Chair – Scrutiny Board 4 (Health)

Of all the consultation with which health scrutiny has been involved in recent months, reconfiguration of NHS Ambulance Trusts has seemed to be the most contentious, not least because of the perception that the outcome has already been decided. I hope that this is not the case, and that both the evidence we have received and the conclusions that we have come to will be taken into account before final decisions are made.

However well intentioned the proposals to create huge ambulance trusts across England, there seems to be little evidence to support the perceived benefits that are assumed will follow. Indeed most of the evidence that Coventry's health scrutiny board has received seems to point to the contrary.

In considering these proposals I was reminded of a famous anecdote. The celebrated dancer Isadora Duncan once wrote to George Bernard Shaw declaring that, given the then fashionable principles of eugenics, they should have a child together.

"Think of it!" she enthused. "With my body and your brains, what a wonder it would be."

"Yes," Shaw replied. "But what if it had my body and your brains?"

Forced unions are rarely a good idea and I am not convinced that as far as Coventry and Warwickshire Ambulance Services are concerned the proposal to create one of the biggest ambulance services in the world has been well thought out. If we are to believe Professor Matthew Cook's evidence to the health scrutiny board (and we have no reason not to do so), reconfiguration was never part of Peter Bradley's draft report in the first place and it is not clear why it was added later.

What is clear from *Taking Healthcare to the Patient* is that many of the recommendations reflect what Coventry and Warwickshire Ambulance Service is already doing. I agree wholeheartedly with UHCW Chief Executive David Roberts' comments in his letter to the Strategic Health Authority (see appendix 7) when he writes,

"The local collaborative working across the Ambulance Trust with primary, secondary and social care has already delivered improvements in quality standards and operational service integration. We believe that a merger with other ambulance services would make it more challenging for UHCW and other providers in Coventry and Warwickshire to deliver the required health care standards and targets

for the Annual Health Check. It is not proven that a single West Midlands Ambulance Service would be more financially economic and that the service, in terms of efficiency and performance standards, would improve."

The creation of Coventry and Warwickshire Ambulance Service brought the ambulance service into play as part of the primary, secondary and social care team. It would be sad if reconfiguration broke up the team that has delivered excellent services and sustained improvement for the people of Coventry.

I would like to thank the members of the health scrutiny board for their support in undertaking this consultation response, and their unanimous support for its conclusions. I think that we have shown that health scrutiny can bring to the fore the key issues in health service development, and undertake a thorough investigation of the issues at hand. I would also like to thank the witnesses who have spoken at health scrutiny meetings, and the members of the public who have responded to our survey.

Cllr Joe Clifford
March 2006

Scrutiny Board 4 (Health) – Background Information

The Health and Social Care Act 2001 and associated regulations, which came into force in January 2003, give Coventry City Council the power, through its health overview and scrutiny committee (Scrutiny Board 4 (Health) – the "health scrutiny board"), to review and make recommendations on matters relating to local health services. The health scrutiny board is made up of Councillors from across political parties and co-opted members of the public. It is not an executive body; it cannot make decisions and then require others to implement them. It can however make recommendations that local NHS organisations and the City Council must consider as part of their decision-making processes. Similarly, when local NHS organisations propose "substantial" changes to their services, they must first consult the health scrutiny board to obtain its views. The health scrutiny board's purpose is threefold. First, to open up health related decision-making to public oversight. Second, to make recommendations that will lead to improvements in the health of Coventry residents and health services they receive. Third, to work with others to help reduce Coventry's health inequalities.

Consultation on configuration of ambulance trusts in England

Copies of the consultation paper are available from West Midlands South Strategic Health Authority (www.wmsha.nhs.uk, 0845 257 7046). Responses should be sent to:

Mr David Nicholson CBE
Commissioning a patient led NHS
West Midlands Consultation Office
PO Box 2675
Stafford ST16 9BW

The consultation closes on 22 March 2006.

Members of Scrutiny Board 4 (Health)

Cllr Shabbir Ahmed	(Conservative, Foleshill)
Cllr Solly Bhyat	(Labour, St Michaels)
Cllr Joe Clifford	(Labour, Holbrooks – Chair)
Cllr Gary Crookes	(Conservative, Wainbody)
Cllr Susanna Dixon	(Conservative, Wyken)
Cllr John Gazey	(Conservative, Bablake)
Cllr Tom Ruddy	(Labour, Henley)
Cllr Val Stone	(Independent, Longford – Vice Chair)
Mr Terry Doyle	(Co-opted member)
Miss Diane Hackford	(Co-opted member)
Ms Shagufta Khan	(Co-opted member – UHCW PPIF)
Mr David Spurgeon	(Co-opted member – CTPCT PPIF)

Officer Support

John Bolton	Director of Community Services
Sally Burton	Community Services Directorate
Michelle Hayes	Legal and Democratic Services
Jonathan Jardine	Chief Executive's Directorate
Stella Manzie	Chief Executive
Carolyn Sinclair	Legal and Democratic Services

In attendance at the invitation of the Board

Cllr Andy Matchet	Cabinet Member (Health and Housing)
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Background to the consultation on ambulance services in Coventry

1974:

Coventry Ambulance Service becomes part of West Midlands Ambulance Service (WMAS).

1976:

WMAS centralises ambulance service control centres. The Emergency Operations Centre (EOC) for the West Midlands is at Ambulance Headquarters in Brierley Hill, near Dudley.

8 April 2003:

Coventry Teaching Primary Care Trust (PCT) Board decides to change its management arrangements for emergency and routine ambulance services. The new organisation will be based on Warwickshire Ambulance Service, and will be called Coventry and Warwickshire Ambulance Service (CWA).

A progress report to Coventry Teaching PCT Board on 8 July 2003 describes the advantages on the amalgamation as follows:

"The amalgamation of Coventry & Warwickshire Ambulance Services supported by the expansion the emergency ambulance control facility at Leamington Spa forms a key part of the West Midlands South Strategic Health Authority's [SHA] plan to develop an emergency care network for Coventry & Warwickshire. This will provide a platform from which it is planned to develop a fully integrated Operations Centre to support the Emergency Care Network and major incident planning and co-ordination."

03:00 hours 1 April 2004:

CWA based in Leamington Spa takes responsibility for ambulance service provision within Coventry City Council boundaries.

May 2004:

The Department of Health invites Peter Bradley CBE, Chief Executive of London Ambulance Service NHS Trust, to become National Ambulance Adviser and to lead a review of NHS ambulance services in England.

30 June 2005:

Peter Bradley's report, *Taking Healthcare to the Patient*, setting out the review's conclusions, is published. Recommendation 40 states,

"There should be a reduction in the number of services broadly in line with SHA boundaries. Precise decisions on the configuration and number of services should be made after consultation with NHS and the public to ensure that configuration reflects local operational requirements."

There are 23 SHAs outside London, and 30 ambulance trusts.

The foreword, by Lord Warner, Minister of State for NHS Delivery, says,

“Our initial view is that the number of trusts should be reduced by at least 50%”

27 July 2005:

CWA is awarded three stars, out of three, in the 2004/05 Healthcare Commission ratings. Of 31 ambulance trusts, thirteen achieve this standard. In the west midlands region, Staffordshire Ambulance Service NHS Trust also receives three stars, Hereford and Worcester Ambulance Service NHS Trust gets two, and West Midlands Ambulance Service NHS Trust gets one.

28 July 2005:

Commissioning a patient led NHS, a programme for NHS organisational change (prefaced by an explanatory letter from the then NHS Chief Executive Sir Nigel Crisp) is published. The document sets out how the NHS commissioning role will develop and how, from this, structural reorganisation is required. Sir Nigel writes,

“These changes in [commissioning] will mean that the NHS will want to reconsider the optimal configuration of PCTs, and where appropriate Care Trusts, and SHAs and their fitness for purpose. This will be done alongside the reform in the provision of ambulance services described in *Taking Healthcare to the Patient*.”

Paragraph 8 of the programme document states,

“We are also looking to reconfigured SHAs to move towards alignment with Government Office boundaries where appropriate”

Paragraph 36 states:

“The review of ambulance services published on June 30 (*Taking Healthcare to the Patient*) proposed to strengthening ambulance services with an associated reduction of a least 50% in the number of ambulance trusts.”

Commissioning a patient led NHS includes a timetable for ambulance service reorganisation. Public consultation was to be complete by November 2005, with a ministerial decision in December 2005. Implementation was to begin with the new trusts operating in “shadow form” by April 2006, with statutory implementation from July 2006.

26 August 2005:

West Midlands South SHA initiates a pre-consultation on the proposals it intends to make to the Department of Health for organisational reform in its area. Pre-consultation recommends a single ambulance trust for the entire west midlands region.

Cllr Andy Matchet (Cabinet Member – Health and Housing) and Cllr Joe Clifford (Chair – Scrutiny Board 4 (Health)) respond in the following terms,

"We have serious concerns about the proposal to create a single Ambulance Trust for the whole of the region. We have been very happy with the services provided by the Coventry and Warwickshire Ambulance Trust and have seen measurable improvements in ambulance services since this trust took over from the current 'West Midlands Ambulance Trust'. We have not seen any evidence that this proposal will achieve the desired level of savings or that clinical and response standards can be maintained. We would urge the Strategic Health Authority to produce more than one option and also to produce evidence about how this proposal will maintain and improve standards."

28 September 2005

West Midlands South SHA agrees a submission to the Department of Health with the following recommendation,

"Agree proposals for the reconfiguration of the four NHS Ambulance Trusts within the West Midlands to create a single West Midlands Ambulance Trust. In particular SofS [Secretary of State for Health] is asked (subject to national guidance) to approve permission to consult on the merger by dissolution of Coventry and Warwickshire Ambulance Service NHS Trust, Hereford and Worcester Ambulance Service NHS Trust, Staffordshire Ambulance Service NHS Trust and West Midlands Ambulance Service NHS Trust and the establishment of a single West Midlands Ambulance Service NHS Trust."

The report estimates that savings will be "in the order of £4.5 million".

13 December 2005

Coventry City Council passes the following motion:

"This Council has real concerns about the quality of the Ambulance service that is being proposed for the West Midlands region. Coventry citizens are served well by the current Coventry and Warwickshire service which is already delivering most of what is being proposed in "Taking Health care to the patient, Transforming NHS ambulance services". The Council needs to be assured that what is being proposed is safe and at least as good as what we have now."

14 December 2005

The Department of Health publishes *Configuration of ambulance trusts in England*. This consultation proposes a single ambulance trust for what the consultation paper calls the "west central" area of England.

22 March 2006

Consultation closes.

April 2006

Ministerial decision on ambulance service reconfiguration expected.

Overall conclusions

1. Coventry City Council's health overview and scrutiny committee (Scrutiny Board 4 (Health) – "the health scrutiny board") has concluded that the proposal to dissolve the four ambulance trusts in the west midlands region and replace them with one new trust is **not in the interest of health services in its area**.
2. The health scrutiny board's view is the same as that of Warwickshire County Council and its health overview and scrutiny committee, University Hospitals Coventry and Warwickshire NHS Trust, North Warwickshire PCT, Rugby PCT, South Warwickshire PCT, and Coventry Teaching PCT. A public survey revealed that 90% of respondents who expressed a preference were against the proposals.
3. It is the health scrutiny board's view that **the proposed creation of a regional ambulance service trust should not go ahead**.
4. The health scrutiny board is disappointed that the consultation paper offers no alternative options. **The health scrutiny board's preferred option would be for Coventry and Warwickshire Ambulance Service NHS Trust to continue providing excellent services to the people of Coventry and Warwickshire.**
5. The health scrutiny committee is of the view that the hoped-for benefits from the proposals are overstated, and are outweighed by both the risks posed, and the likely negative consequences. The health scrutiny board therefore recommends that the Secretary of State for Health refer the proposals to the NHS Independent Reconfiguration Panel.
6. The health scrutiny board is of the view that this consultation has been undermined by mounting evidence that **implementation of the proposals has begun before the consultation has concluded**. The health scrutiny board concludes that this will undermine public faith in this and future government consultations.
7. The health scrutiny board is of the view that the proposals, if implemented, will clearly impact on how ambulance services are provided, in the immediate, short and medium term.
8. The health scrutiny board therefore concludes that the proposals represent a **significant change to and development of services in its area**, and should have been the subject of consultation on this basis.

Key findings

9. The health scrutiny board agreed these overall conclusions based on a series of key findings, summarised below:
 - a) The expert reference group that made the recommendations in *Taking healthcare to the patient* did not consider or propose ambulance service reorganisation
 - b) The recommendation in *Taking healthcare to the patient* that relates to ambulance service reorganisation proposes a 23% cut in the number of trusts; SHA reorganisation has transformed this into a 66% cut in the number of ambulance trusts

- c) The process by which this reduction in the proposed number of ambulance trusts came about was arbitrary and not evidence based
- d) The modest savings anticipated from reorganisation are unlikely to be realised, will do little in practice to add to frontline capability, and yet risk degrading service performance
- e) Savings to the health economy would be better made by reductions in conveyance rates than management staff cuts
- f) The proposed cuts in management staff will fall in areas necessary for ambulance trusts to reduce their conveyance rates
- g) Ambulance service reorganisation poses a significant risk to maintaining current standards, and there is no evidence of a link between organisational change of the sort proposed and improved performance
- h) The proposed “local delivery units” will be superimposed on existing organisational boundaries and therefore there is no clear causal link between their introduction and service improvement, in Coventry and Warwickshire or elsewhere in the region
- i) The introduction of a Coventry and Warwickshire “local delivery unit” jeopardises service development plans, notably provision of a new local control centre for the area
- j) The method by which new digital communication centres are being procured raises additional concerns about the future for a local control centre in Coventry and Warwickshire
- k) Coventry and Warwickshire Ambulance Service has demonstrated that *Taking healthcare to the patient* can be delivered without the distraction of organisational reform; effective leadership, well trained and motivated staff, and strong links with local partners are the way to improve services
- l) The introduction of a regional trust will reduce the influence PCTs derive from their commissioning function, thereby potentially reducing responsiveness to local need
- m) A regional trust creates the possibility that commissioning of emergency ambulance services will be done regionally, rather than locally
- n) The success of Coventry and Warwickshire Ambulance Service’s staff training and development, which is based on strong local links, is jeopardised by a regional ambulance trust
- o) The supposed benefits to disaster planning are not as great as stated, and anticipated cost savings in this function may reduce capability to respond to a real incident
- p) A regional trust will be less accountable to patients, the public, local authority health overview and scrutiny committees, and other stakeholders
- q) A west midlands regional ambulance trust that sought foundation trust status would not be able to meaningfully represent its membership because of the large and diverse population of the west midlands region
- r) No-one in the local or regional health economy is accountable for these reorganisation proposals, even though they impact on a local service
- s) The recruitment of a “pool” of chairs and chief executives suggests that implementation is going ahead regardless of the outcome of the consultation
- t) National procurement of new digital communication centres on the basis of the proposed ambulance service structure, rather than the existing one, also suggests that implementation is underway
- u) The scale of the change in these proposals, coupled to the developments to services that will follow after implementation, suggests to any reasonable observer that these proposals represent a “substantial development and variation” to services, and therefore consultation should have taken place on this basis.

Analysis of the consultation proposals

10. The health scrutiny board has reached these conclusions and made these findings following extensive deliberations and evidence gathering.

11. The health scrutiny board took evidence from the following witnesses:

- Mr Malcolm Hazell, Chief Executive, Coventry and Warwickshire Ambulance Service
- Ms Sally Burton, then Head of Older People's Services, Coventry City Council
- Mr Mike Burdett, Coventry and Warwickshire Ambulance Service
- Mr Steve Thompson, Coventry and Warwickshire Ambulance Service
- Mr Graham Swain, Coventry and Warwickshire Ambulance Service
- Mr Jim Leach, CWA Patient and Public Involvement Forum
- Dr Matthew Cooke, Professor of Emergency Medicine, Warwick Medical School, University of Warwick
- Mr Charles Goody, Chair, West Midlands South Strategic Health Authority
- Ms Catherine Griffiths, Managing Director, West Midlands South Strategic Health Authority
- Ms Bronwen Bishop, Director of Primary Care Development and Corporate Services, West Midlands South Strategic Health Authority
- Mr Stephen Jones, Joint Chief Executive, Coventry Teaching Primary Care Trust
- Mr Clive Townend, Assistant Head of Public Protection, Coventry City Council
- Mr Peter Streets, Emergency Planning Officer, Coventry City Council

12. The health scrutiny board received correspondence from:

- Mr Malcolm Hazell
- Mrs Sonia Godfrey, Associate Head of Nursing, Midwifery and Healthcare, Coventry University (see appendix 3)
- Mr John Amphlett, Director Of Strategic Partnerships And Corporate Development, University Hospitals Coventry and Warwickshire NHS Trust
- Lord Norman Warner of Brockley, Minister of State for NHS Delivery (Lord Warner was invited to attend a health scrutiny board meeting, but declined – see appendix 4)

13. Coventry City Council debated ambulance services at its meeting on 13 December and agreed a resolution expressing concern at the proposals.

14. The health scrutiny board undertook with Warwickshire County Council a web-based survey of public opinion concerning CWA and attitudes to the proposed mergers. The survey revealed strong support for CWA and opposition to the proposals. The full results are at appendix 5.

15. The consultation paper was considered at five out of six of Coventry's local area forums (see appendix 6).

16. The Chair and officers attended various meetings related to the consultation, and liaised with other interested parties including Warwickshire County Council.

17. The health scrutiny board's opposition to the proposals is based on six areas of evidence. These are set out below:

1. Flawed interpretation of *Taking Healthcare to the Patient* and the lack of expert support for reorganisation

18. Peter Bradley CBE is the Chief Executive of the London Ambulance Service. His report, *Taking Healthcare to the Patient*, was published by the Department of Health on 30 June 2005, and set out a series of recommendations for the future development of ambulance services. Recommendation 40 of the report states;

“There should be a reduction in the number of services broadly in line with SHA boundaries. Precise decisions on the configuration and number of services should be made after consultation with NHS and the public to ensure that configuration reflects local operational requirements.”

19. There are – and were at the time of publication – 31 ambulance trusts and 28 strategic health authorities. If one exempts London, then there are thirty ambulance trusts and twenty-three strategic health authorities.

20. Thus, if the recommendation were followed, the number of ambulance trusts would fall by seven, or under a quarter.

21. However, Lord Norman Warner (Minister of State for NHS Delivery) writes in the foreword to *Taking Healthcare to the Patient*, “Our initial view is that the number of trusts should be reduced by at least 50%”, which is far beyond the recommendation in the report. This suggests to the health scrutiny committee that Lord Warner’s 50% reduction is not based on any evidence about what makes for good ambulance services, but a more arbitrary judgement.

22. A month later, on 28 July 2005, the Department of Health published *Commissioning a patient led NHS*, a directive instructing the NHS to begin a process of reorganisation that would lead to the proposed reduction in the number of strategic health authorities across England from 28 to nine. Proposals for ambulance services followed suit, with the proposed number of trusts falling from 31 to eleven (only in the south west of England will ambulance services not be coterminous with strategic health authority boundaries). Thus, thanks to strategic health authority reorganisation, **but no change to the circumstances of ambulance trusts**, the number of ambulance trusts will fall not by 23%, as actually recommended in *Taking Healthcare to the Patient*, but by over two-thirds.

23. Charles Goody, Chair of West Midlands South Strategic Health Authority, said in evidence to the health scrutiny board that the reason for this discrepancy between the recommendation in *Taking Healthcare to the Patient* and the outcome in *Commissioning a patient led NHS* was that “the authors” of *Taking Healthcare to the Patient* had foreknowledge of the coming strategic health authority reorganisation and drafted the recommendation accordingly.

24. If this explanation is true, it represents very bad practice to make a recommendation in a national public document that is based on assumptions that are not revealed to the public reader; nowhere in *Taking Healthcare to the Patient* does it say that recommendation 40 is predicated on future reductions in the number of strategic health authorities. Lord Warner, in his foreword, may well have known what was coming for the strategic health authorities and hence made the reference to 50%

cuts in the number of ambulance trusts, but the health scrutiny board hopes that he did not write recommendation 40, given that the recommendations were supposed to have come from the reference group and not the Department of Health. The health scrutiny board is therefore concerned by what it sees as arbitrariness and a lack of integrity in the process by which the final number of ambulance trusts was conceived.

25. However, overall, the health scrutiny board rejects Charles Goody's explanation. Professor Matthew Cooke is a leading expert on emergency services, and was a member of the reference group that made the recommendations in *Taking Healthcare to the Patient*. In evidence to the health scrutiny board, he said that the reference group did not consider ambulance service reorganisation. He said that reorganisation was "not on the horizon". Thus the health scrutiny board concludes that ambulance service reorganisation was not considered a priority by the experts involved in recommending how ambulance services should be developed in coming years. The health scrutiny board accepts Professor Cooke's explanation that ambulance service reorganisation was added to *Taking Healthcare to the Patient* after the expert reference group had finished its work. It is therefore the case that the fundamental rationale for scrapping Coventry and Warwickshire's excellent ambulance service and replacing it with a regional trust is flawed.

26. Instead, the health scrutiny board concludes that reorganisation is the result of a desire to be seen to be reducing "bureaucracy" in the NHS, even though, as Charles Goody would later say at a public meeting about the reconfiguration proposals, NHS management is already leaner than the private sector average. Malcolm Hazell echoed this in his description of the modest "back office" management resources available to CWA. The health scrutiny board accepts, of course, that it is right to seek efficiency savings and use public money well. However, what the health scrutiny board does not want to see – and neither does the public – are cuts in what is pejoratively labelled "bureaucracy" that lead to a decline in performance that, as Jim Leach said, "could lead to patients' deaths".

2. These proposals seek cost savings the wrong way

27. In evidence to the health scrutiny board witnesses from West Midlands South Strategic Health Authority argued both that the savings from the reorganisation would be modest – because local structures would be retained – but also that there was a significant risk to future investment in ambulance services if the savings were not made. These positions appear contradictory. Under questioning it became clear that while the new ambulance trust would be tasked with making savings of £3 million a year from 2008, there was no available assessment of what the costs would be of the reorganisation, which would include redundancies and other factors. Professor Cooke suggested that previous experience of NHS reorganisations suggested that costs were usually higher than planned, and in many instances, the proposed savings never materialised. The experience of the City Council often mirrors this assertion. It is also worth pointing out that the £3 million saving reported to the health scrutiny board in February is already a third less than the £4.5 million saving suggested in West Midlands South SHA's submission to the Department of Health five months earlier.

28. For example, evidence from ambulance service trade union representatives stated that renegotiating terms and conditions in a new organisation can take many years, and tie up staff for hours of time. These costs are not included in the proposed saving.

29. The health scrutiny board is of the view that a quicker and more effective way to make savings in ambulance services is to reduce conveyance rates. It is widely accepted that many 999 calls, perhaps even a majority, do not require conveyance to hospital. Despite this, conveyance rates vary widely, from the exemplary 65% of Coventry and Warwickshire Ambulance Service, to over 95% in West Midlands Ambulance Service. Reducing conveyance rates is a win-win proposition, both for the patient and the NHS. First, most callers would probably prefer to avoid a trip to A&E if they could help it, particularly when their condition is one that could be diagnosed and treated at the scene, meaning that it is relatively less serious and hence more likely to lead to a wait of several hours if taken to hospital. The experience of ambulance trusts with low conveyance rates has borne out this assertion – CWA has reported just two complaints since it took over providing ambulance services in Coventry, and has a policy of conveying patients on request. Second, the NHS gains because not only is treating someone at home significantly cheaper (just conveying someone through the A&E front door costs an average of £60), but also it takes pressure off A&E units faced with the ever-present four-hour maximum wait (which is itself a major factor in over-performance in unscheduled care). In evidence, Malcolm Hazell estimated that bringing West Midlands Ambulance Service conveyance rates down to those in Coventry and Warwickshire would save £7 million a year.

30. It is the conclusion of the health scrutiny board that Coventry and Warwickshire Ambulance Service has made this progress because of the efforts of staff and managers, and the policies and practices that have been adopted and implemented. Furthermore, the health scrutiny board concludes that better operational practices will lead to greater savings than management cuts. If other ambulance services are to follow this approach, then they will face significant changes to working practices and staff development. This will lead to an additional burden on financial planning teams and human resource departments across the ambulance services, and yet in evidence to the health scrutiny board these were the service areas repeatedly singled out as likely to yield cost savings. Making workforce reductions in these areas just when organisations are seeking to adapt to the requirements of the new health white paper *Our Health, Our Care, Our Say* and *Taking Healthcare to the Patient* seems counterintuitive. The health scrutiny board concludes that now is not the time to be making cuts in these areas. As Malcolm Hazell pointed out, there has been massive investment in the NHS in recent years, and big increases in performance have followed. Now is the time to consolidate and build on those gains, not distract managers, practitioners and staff with organisational upheaval.

3. Further improving services and risks to current performance

31. There is widespread agreement on the “direction of travel” for ambulance services. West Midlands South Strategic Health Authority, Coventry Teaching PCT and Coventry and Warwickshire Ambulance Service all said similar things about how ambulance services should develop. The issue therefore is how to preserve current good practice, and facilitate future improvements. Is a new regional trust necessary? The health scrutiny board has concluded that it is not. As many witnesses observed, on both sides of the argument, there is not always clear link between the size of an ambulance trust and its performance. While it is generally the case that smaller trusts have higher performance – a point that should not be overlooked in this consultation – there are examples of mediocre small trusts and, similarly, there are good larger trusts. It is the health scrutiny board’s view that while smaller ambulance trusts are structurally advantaged in delivering better performance, good performance is not really about the size of a trust; other factors are more important.

If this is the case, then organisational change would seem secondary at best, and at worst could create risks that damaged patient care.

32. This was the clearly stated view of ambulance staff who spoke to the health scrutiny board. They feared that staff would be looking more to securing their position in the new organisation rather than worrying about maintaining patient focus. They feared that the effective internal communication in CWA that is key to resolving problems could be lost. Those with many years of service looked back to the dislocation and even “chaos” caused by earlier mergers, and were pessimistic about what would happen in future.

33. Professor Cooke said that there was a risk that amalgamating ambulance services could lead to performance slipping to the level of the average, rather than levelling up to the best.

34. The defence against these charges has been two-fold. First, it is intended that “local delivery units” will be maintained that ensure continuity with existing practice. Second, local PCTs will be responsible for commissioning ambulance services and hence they will ensure both the quality of the service and retain local focus.

35. The health scrutiny board accepts Catherine Griffiths’ assertion that this is the best way to organise a regional service, and recognises this approach as a genuine effort to make the best of the nationally-driven requirement to reduce “bureaucracy”. However, the health scrutiny board is of the view that this is the second best option.

36. The option of a Coventry and Warwickshire “local delivery unit” is appealing because there is wide recognition that the city and the county are a fairly natural “health economy”. Patient flows reflect this, and were a core rationale for the decision by Coventry Teaching PCT to commission ambulance services from Warwickshire Ambulance Service rather than stay with WMAS. The outcome of the Acute Services Review and the opening of the new University Hospital will doubtless reinforce this reality. However, is the same true across the rest of the region? Are Solihull, Birmingham, the Black Country and Shropshire a “natural health economy” that is best served by one “local delivery unit”? Are Hereford and Worcestershire a “natural health economy”, or even Staffordshire? In truth, the “local delivery unit” approach will be superimposed on existing organisational boundaries that may not make as much sense as the Coventry and Warwickshire unit, which has the advantage of being the product of deliberate design.

37. This poses a further question. In evidence, it was said that the local delivery units would preserve local good practice and that they would have considerable autonomy to innovate. What was less clear were the mechanisms by which that good practice would be disseminated between local delivery units. How would one avoid the largest local delivery unit becoming the *de facto* leader of the organisation – the “not invented here” problem identified by Malcolm Hazell? Would the local delivery units be so autonomous that poor working practices might be sheltered and preserved?

38. Local control of ambulance services is at a delicate juncture in Coventry and Warwickshire, and the health scrutiny board is concerned our “local delivery unit” may not have the autonomy to secure a local control centre in the future. Ambulance services are currently headquartered at Leamington Spa. It is planned that the control centre will move to a new purpose built site in the Coventry city centre “Local Improvement Finance Trust” (LIFT) health facility. This new control centre would be co-located with the “walk in centre”, out-of-hours service and a range of other

services, in order to secure greater synergy and co-operation. Regrettably, the proposed city centre health facility is far behind schedule and poses significant financial challenges to Coventry PCT. The health scrutiny board welcomes the reassurances it received from Stephen Jones that the new ambulance service control centre will go ahead, but remains concerned that local control in the longer term is not as secure as might be hoped – particularly if financial problems either restrict the size of the city centre LIFT building, or lead to its cancellation. The new regional ambulance trust would also have to decide whether it wishes to continue as a shareholder in Coventry Care Partnerships, Coventry's local LIFTCo. The health scrutiny board is persuaded by evidence from Professor Cooke and others of the value of local control centres, and is therefore keen to maintain a control centre in Coventry and Warwickshire for the indefinite future. This was one of the main themes of public's responses to the web based survey (see appendix 5). It should be noted that the evidence that national procurement of new digital communication stations is going ahead on the basis of the new ambulance service organisational boundaries (see section 6, paragraph 51) is also causing concern, because it suggests that that the number of control centres in the west midlands region could fall from five to just two. In essence, if Coventry and Warwickshire has its own ambulance trust, then it can be more or less certain that it will have a control centre. If all it has is a "local delivery unit", the autonomy, responsibilities and, indeed, the survival of which are reliant on decisions taken by a distant regional hierarchy, then the future of local control in Coventry in Warwickshire is much less certain.

39. The consultation paper states that organisational change brings about risk. Witnesses from West Midlands South SHA went to great lengths to set out how those risks were being managed, and Stephen Jones gave a very useful summary of the key issues to be addressed. The health scrutiny board accepts the good faith with which the SHA is approaching the proposed reorganisation. Catherine Griffiths pointed out that the NHS reorganises itself so often that there is considerable experience of how to manage these processes. The health scrutiny board acknowledges her expertise and that of her team. However, Ms Griffiths also said that this reorganisation was unlike any that had gone before, because rather than centralising, it sought to create a regional trust with a devolved operational structure. Thus while there have been reorganisations in the past, this one is something of a step into the unknown, and that means risks. As many witnesses observed, merging four NHS trusts is unprecedented, and in this case the outcome is supposed to be different to anything that has been tried previously.

40. Fundamentally, the health scrutiny board is unconvinced that organisational change is an essential precursor to performance improvement in ambulance services. The proposed "local delivery unit" structure is a relatively new approach, and therefore the outcomes cannot be reliably predicted. On the other hand, thanks to *Taking healthcare to the patient* and *Our Health, Our Care, Our Say*, there is a well developed understanding of what ambulance services should be doing now and in the future. Coventry and Warwickshire Ambulance Service, along with other ambulance services of varying sizes, has demonstrated that most, if not all of the objectives set out in these government reports, can be achieved by well-led, local trusts that integrate with their partners in acute and primary care, social care and academia. Creating regional organisations seems a step in the wrong direction. Coventry and Warwickshire Ambulance Service has been an integral team player in the recent improvements in unscheduled acute care and social care in Coventry. The Coventry and Warwickshire Emergency Care Network is one of the most effective in the country, helping to ensure that patients get the right treatment, at the right place, at the right time. These improvements have come about because of the "nearness" of senior managers able to build partnerships and develop services. In

evidence to the health scrutiny board, Bronwen Bishop said that because CWA had to both respond to national issues and develop local services, it could only provide a "standard national service" to Coventry and Warwickshire. Evidence from Professor Cooke, UHCW, Sally Burton, ambulance service staff, Coventry University and Malcolm Hazell, would seem to refute this. CWA has done almost everything that has been asked of it by a wide range of stakeholders in a remarkably short period of time, and the health scrutiny board is of the view that it is well placed to deliver continued improvement. Organisational change is no panacea, and it is not necessary now.

41. If the proposed "local delivery unit" structure offers no guarantee of performance improvement, then the other argument offered as evidence that services will not suffer is the local commissioning by primary care trusts. As Catherine Griffiths said in evidence to the health scrutiny board, "Legally, they [PCTs] are the ones responsible for the quality of the service". Stephen Jones echoed this point when he made local commissioning one of his key issues for the reorganisation. Ambulance services are commissioned locally now, and the health scrutiny board is firmly of the view that they should remain so. However, the difference will be that instead of PCTs commissioning from a locally accountable ambulance trust, negotiations will be with a large regional trust that will be the sole supplier of ambulance services. As Coventry Teaching PCT so admirably demonstrated in 2003, there is a degree of contestability in the current arrangements that will be lost in a regional structure. The health scrutiny board is minded to agree with what Sally Burton suggested in evidence; it is not that local variations are impossible within a regional framework, it is simply that they are much harder to negotiate. The health scrutiny board is unconvinced that PCTs will be powerful enough to demand the local variations they require to meet local needs.

42. Questions have arisen about how ambulance services will be commissioned. In evidence to the health scrutiny board, it was stated that PCTs would be able to commission services appropriate to local needs. Examples were given around out-of-hours services and patient transport. In evidence from Malcolm Hazell, it has been suggested that while commissioning of non-emergency services may be retained locally, there is active consideration underway at SHA and Department of Health level of regionalising the commissioning of emergency ambulance services. This would seem to conflict with the clear assurances given by SHA representatives to the health scrutiny board. The health scrutiny board is strongly of the view that commissioning of emergency and non-emergency services should stay local, and hopes that consideration of proposals to regionalise commissioning has concluded in favour of giving PCTs this role.

4. Other arguments put forward in support of reorganisation

43. The Department of Health consultation paper and the local preface both indicated that reorganisation would be beneficial for training and development of staff and disaster preparedness and response.

44. CWA has one of the best training and development programmes for its staff in the country. Evidence from Professor Cooke of Warwick Medical School and Sonia Godfrey, Head of Nursing, Midwifery and Healthcare at Coventry University, speaks of how innovative investment and well-developed links with local academic institutions have given CWA more emergency care practitioners than any other ambulance service in the region, and staff training and development that is the envy of trusts across the country. Indeed, Staffordshire Ambulance Service is sending its staff to Coventry University for training. A key advantage of the local programme is

that it integrates local healthcare practitioners across a variety of disciplines. Witnesses from West Midlands South SHA suggested that current training and development was "fragmented" and that regionalisation would offer more opportunities for staff. However, the health scrutiny board is more inclined to conclude that CWA has developed an excellent staff training and development regime – so attractive indeed that other trusts are following its lead – and that organisational change is more likely to jeopardise these local links than facilitate them. The health scrutiny board notes with concern that the evidence received from Coventry University states that, as of January 2006, there had been no attempt to contact the university with regards to the outcome of amalgamation. As Ms Godfrey said in her submission to the health scrutiny board,

"The working relationships, partnership working and mutual respect that has been developed between the paramedic teaching team in the university and CWAS has arisen from a determination to succeed in providing a workforce who are ready and able to meet the challenges of "Taking Healthcare to the Patient: Transforming NHS Ambulance Services" (DH 2005). If this relationship, innovation and effort were to be dismantled or replaced by alternative education provision as a result of reconfiguration, I feel it would be both sad and potentially detrimental to future service provision and the people of Coventry and Warwickshire."

45. Again, with regards to disaster planning and response, the health scrutiny board is unconvinced that supposed benefits are as substantial as indicated, or that they are worth the risks already described. In evidence to the health scrutiny board, it was suggested that disaster planning is best done at the regional level, while disaster response mechanisms are already in place that would be unaffected by regionalisation. The health scrutiny board has significant concerns about this proposition. First, regional disaster planning will lead to a reduction in the "duplication of job titles" across the four existing trusts, as Catherine Griffiths put it. However, it is the health scrutiny board's view that what might seem to be "duplication of job titles" is in fact additional capacity that would be vital in a real disaster response.

46. Coventry City Council officers asked about the consequences of the proposed changes were studiously non-committal, which in itself suggests that organisational changes make little overall difference to the efficacy of disaster planning or response. However, they did note that close working links with their counterparts in other organisations were vital to successful disaster planning and response. If there are to be fewer local ambulance service staff concerned with disaster planning and response, then it would seem that these links with local authority officers and others will be diminished, and the robust working relationships necessary *in extremis* could be undermined.

5. *Loss of accountability*

47. Despite the wider problems that have beset the Government's reforms of patient and public involvement in health, the Patient and Public Involvement Forum for Coventry and Warwickshire Ambulance Service has established itself as an important conduit through which issues can be aired and discussed. The health scrutiny board has been impressed by the enthusiasm and dedication the PPI Forum members have brought to their role. The health scrutiny board is therefore concerned that the progress that has been made will be lost if and when the regional ambulance service is formed. Public accountability seems much more nebulous in a regional organisation, and it is not clear from the responses received from the SHA

witnesses whether the PPIF model will continue. The new regional ambulance service chief executive and board could in practice have little or no "external" accountability to patients and local authority health overview and scrutiny committees, perhaps delegating this to the local delivery unit managers. The health scrutiny board is of the view that this will represent a loss. The current chief executive and chair of CWA have diligently supported consideration of this consultation for example, and have been available repeatedly on previous occasions to respond to queries and issues raised as part of the scrutiny board's wider work programme. As the health scrutiny board reported in its submission to the Healthcare Commission Annual Health Check for CWA:

"CWA has demonstrated full engagement with Coventry City Council health overview and scrutiny committee (the "health scrutiny board").

CWA has participated in scrutiny reviews, attended meetings on request and sought to implement recommendations made by the health scrutiny board. Requests for information have been met in a timely and comprehensive fashion. CWA has positively assisted the health scrutiny board in its work planning.

CWA Chief Executive has attended all appropriate meetings with the health scrutiny board, and CWA has been forthright, open, and honest about all matters raised, and has sought to ensure that the health scrutiny board has been made aware of issues that might affect patient care, but might otherwise not have been brought to their attention."

48. The health scrutiny board concludes that a regional organisation will not be able to match this high standard.

49. In the background to this consultation is the wish to create ambulance trusts fit for foundation trust status. Principally, the concern has been to establish trusts of sufficient size to meet the criterion of an organisation with requisite financial stability. This ambition misses the other component of a successful foundation trust; it must also be locally responsive and accountable via a representative membership. It is the health scrutiny board's view that a regional ambulance trust would not be able, in any meaningful sense, to engage with a membership in such a way as to meet the spirit of the idea behind foundation trusts. A foundation trust should be representative of the population it serves, and an ambulance trust serving a population of over five million would simply not be able to achieve this goal.

6. *The nature of the consultation*

50. This consultation has caused the health scrutiny board considerable unease. The outcome of the consultation will impact on local services, yet no-one could say to the health scrutiny board that they were responsible for the proposals. Instead, the SHA witnesses said that the Department of Health was responsible for the proposals, and therefore they could not answer questions about why the reconfiguration was as proposed, or whether any alternative options would be supported. With this in mind, the health scrutiny board invited Lord Warner to attend its meeting on 15 February 2006, but he declined. Of course a minister of state cannot attend every health scrutiny meeting in England, but it is unfortunate that accountability always seemed in this case to rest with someone who was "not in the room".

51. The health scrutiny board is concerned that implementation of the proposals has started before the consultation has closed. Most notably, recruitment of new chairs

and chief executives is already underway and may even have concluded. The adverts for up to sixty non-executive directors appeared in the national press on 12 March 2006. The health scrutiny board acknowledges the point that these appointments are conditional on the outcome of the consultation. However, undertaking these recruitment exercises – which would have cost thousands of pounds – when there is a realistic chance that regionalisation will not take place, seems improbable. Similarly, the health scrutiny board has heard that procurement of new digital radio communication centres was changed in November 2005 – i.e. just before the current consultation started. Up to this point, the national plan had been for 31 communication centres – one per ambulance trust – for a new digital radio network that would allow transmission of data as well as voice communication. After November 2005, the procurement of communication centres was reduced to 22, which coincides with two per proposed ambulance service. The health scrutiny board acknowledges that the digital "communication centres" are not the same as control centres, and accepts at face value the assurances from SHA witnesses that local control centres will remain. It is technically possible to network almost any number of control centres with the two communication centres per trust – though there is of course a financial implication that adds to concerns about the future of Coventry and Warwickshire's local control centre (see section 3). However, the shift from 31 to 22 itself suggests again that the consultation is a "done deal". The health scrutiny board has been asked for its views, and in response to professional and public concern has launched a substantial investigation of the issues. It is unfortunate that this work is tinged by a nagging suspicion that the response will be ignored. There is frequent commentary on the widespread disillusionment that exists with politics and public affairs, and consultations that take no interest in the responses received will merely fuel that cynicism.

52. Finally, the consultation paper and witnesses went to some length to state that the proposals were merely organisational and would not impact on services. The changes would not therefore pull the "substantial change or development" trigger that engages the statutory powers granted to health overview and scrutiny committees in the Health and Social Care Act 2001 and associated regulations. The health scrutiny board rejects this interpretation. The health scrutiny board concludes that to any reasonable observer, the proposals represent a substantial change to services immediately, and will lead to substantial developments in the short to medium term. During the evidence gathering sessions, as discussion became more detailed on what the consequences of the proposals would be, the harder it became to state that substantial developments would not take place. For example, when Cllr Clifford asked Bronwen Bishop about the potential cost savings from reduced conveyance rates, she replied, "That's right; this consultation is about doing things differently". Later, she said that, "the issue is a fundamentally different vision for the role of the ambulance service". It is the health scrutiny board's view that the proposals represent a significant variation to and development of services in its area, and should have been the subject of consultation on this basis.

Appendices

Appendix 1

Note of a meeting of Scrutiny Board 4 (Health) at 2.30pm on 18 January 2006

This record is an amalgamation of notes taken by City Council Officers. It has been prepared at the request of the Health Scrutiny Board. This is not a verbatim record of comments made at the meeting, and the notes should not be accredited as such. Only statements in quotation marks are comments made in the meeting, and these have been cleared with the participants. This note is not an approved formal record of this meeting.

Malcolm Hazell, Chief Executive, Coventry & Warwickshire Ambulance Service NHS Trust (CWA)

Miss Hackford asked whether training would be affected by the proposals.

Mr Hazell answered that while it was proposed to retain the existing areas of operation inside the new organisation, he had concerns. He said he is already aware of attempts to reverse some of the steps that have been taken. Training in CWA is of a very high standard. It is delivered by Coventry University (CU), and its implementation was overseen and audited by Warwick Medical School. CU is leading the country in Higher Education paramedic training. However, there is a “not invented here” effect that means that other organisations are showing unwillingness to learn from what is already in place. As an example, Mr Hazell referred to the Emergency Care Network (ECN), which he feels is jeopardised by the proposals. The ECN allows the capacity of unscheduled care in Coventry and Warwickshire to be monitored, and can, for example, allow better decision making about which hospital has the capacity to receive a patient following a 999 call in Bedworth or wherever. Where similar networks are not in place as effectively, such as Hereford and Worcester, it is not unusual for 150 incidents each week of ambulances waiting outside A&E units unable to admit a patient. There are a very small number of such incidents in CWA because of the ECN. The ECN covers every facility in the patch and the whole range of unscheduled care, and allows cross-rotation of staff. There are now common group patient directions across the network offering consistent, high quality care to patients. This infrastructure must be retained.

Mr Spurgeon asked about the proposed local delivery units.

Mr Hazell answered that in order to maintain current standards, the new organisation would have to keep the current methods of delivery. He saw this as potentially in conflict with the aspiration to make management savings. Each area has a local Director of Operations. Without this person in post, the organisation would lose a key individual who marshals resources and ensure that the service is operating as efficiently as possible. It would also be necessary to retain the local clinical directorate to ensure that clinical audit functions were carried out. As an example, Mr Hazell mentioned the protocols in place to ensure appropriate treatment of asthmatics. He went on to point out that the “backroom” functions – Finance, Human Resources (HR) and corporate services – were no more than five people each, and that therefore there seemed little scope for big savings. Instead you would end up with a more remote organisation with less local flexibility. At a practical level, centralisation would mean an HQ perhaps 40 miles away, and valuable staff could well leave rather than relocate.

Mr Doyle asked what role the ambulance service had played in University Hospitals Coventry & Warwickshire NHS Trust (UHCW) attaining its three-star status.

Mr Hazell replied that the appropriate conveyancing a key factor. CWA was using the full range of primary care services to support unscheduled care, including GPs, social services and pharmacists. Thus log jams were avoided. WMAS was conveying 100% of Coventry

patients to A&E, whereas this fell to 75% when CWA took over. Now, in year two, this rate had fallen to 65% - one of the lowest in the country. People were being treated at home, or treated elsewhere in primary care. This change had led to very few complaints – just a couple in two years – and ambulance crews were instructed to convey patients if the patient requested it. The basis for this change is in robust education and training, a result of the close partnership with Coventry University. CU offered a diploma in emergency medicine that allowed staff to reduce conveyancing rates. A university accredited mentoring system was in place and working well, developing staff skills via formal education and on-the-job training. Emergency care practitioners with this training could “swing” to work in hospital A&E units when demand was high, thereby influencing how patients are treated and ensuring close collaboration between the local hospitals and the ambulance service.

Cllr Stone asked whether the anticipated cost savings could be made.

Mr Hazell responded that he thought that the potential managerial savings were very small. CWA is very lean managerially and cuts would degrade performance. In his view, if the wish was to save money, then bring in measures to reduce conveyancing rates in other ambulance services seemed to be a more effective solution. For example, he said that if WMAS could reduce its conveyance rates to the same as CWA, there would be a recurring saving in the health economy of £7 million a year, based on £60 per patient passing through the A&E entrance. The need for ambulance stations across the WMAS patch would fall too, offering further savings. He therefore argued that the merger was not necessary, and not the most effective way to ensure health funds were well spent. He estimated that CWA management costs were in the order of £1 million a year. However, he argued that the performance of CWA suggested that this was money well spent. To suggest that this expenditure was not a contributory factor in operational performance was simply “a fallacy”. Management does affect performance, and good management means good performance. Denuding the service of managers at a time of change hugely increases the risk that performance will fall.

Cllr Gazey asked what risks were created by the proposals.

Mr Hazell stated that some risks would be mitigated if the new organisation retained the existing areas and made few or no changes to existing operational structures. He noted that this would rather defeat the purpose of the reorganisation, however. If the new organisation started removing managers from local structures, then there would be a series of effects. The corporate integrity of the service would decline – for example, complaints would not be dealt with as quickly or, probably, as thoroughly. Maintaining good performance would become more difficult. As an even clearer example, if the number of operational centres were reduced then a risk would be introduced that was both very real and considerable. Mr Hazell has learned that Department of Health (DH) has initiated a procurement exercise for new base stations for operations centres. The procurement is based on two base stations per ambulance service, suggesting that there may be just two operations centres for the whole of the west midlands region.

As evidence of what can happen when the number of operations centres is reduced, Mr Hazell recounted the history of the creation of the East Midlands Ambulance Service (EMAS), which led to low performance and higher costs. He noted that there a larger service approaching regional size had seen 19 minute response performance fall, with only 77% of calls reached within the target. This contrasted with 96% in CWA. Despite this, the funding per response was actually the same in EMAS as in CWA. These figures reflect the position several years after the merger took place. To create a regional service would be an even larger enterprise, and in Mr Hazell’s opinion it would take three to four years to bed down.

In Mr Hazell’s view, to embark on the reorganisation now, just after a major injection of resources into the NHS, would be a “tragedy”. The investment has led to many services getting much better, and those benefits could be lost to confusion over implementing reorganisation.

Cllr Ahmed asked whether the reorganisation would affect response times.

Mr Hazell replied that CWA had excellent response times, and reorganisation posed an obvious risk. The target was to reach 75% of category A calls in 8 minutes. CWA had consistently achieved this target. Its official performance was 79% across the whole Trust. In Coventry that figure is 82%, and performance is increasing. Mr Hazell said that when he left the office that day, the figure was 98%. This high performance was therefore reflected also in the response to category B calls, where CWA reaching the scene within 19 minutes 98% of the time. Today that figure was 100%. Larger Trusts rarely fared as well; the category B figures for London (70%), Mersey Regional (77%) and EMAS (77%) were not as good.

Cllr Crookes asked whether a larger Trust could provide more specialist services.

Mr Hazell replied that CWA was at the leading edge of ambulance service provision, and there was not a clear link between larger Trusts and better services. CWA has more Emergency Care Practitioners (ECPs) than any other Trust, and that these sorts of services were more about the strength of the management team rather than the size of the Trust. To suggest otherwise was simply a “fallacy”. Initiatives developed by CWA meant that staff could rotate into A&E units and gain extra experience; that was an example of how local knowledge and links improved a service, not merely having a larger organisation.

Cllr Crookes asked whether the reorganisation posed a threat to CWA resources.

Mr Hazell replied that he feared the influence of other Trusts in the future development of services. He said that the new organisation may not seek to adopt the practice of the best, but instead look for the lowest common denominator as a starting point for the development of the new organisation. He said that he had already encountered a “not invented here” attitude that could restrict the future development of services in Coventry and Warwickshire. The Coventry and Warwickshire local delivery unit would be just one small part of a much larger organisation, and would probably be difficult to ensure that development and progress here continued. As an example, he cited the issue of the two base stations. In the larger organisation, Coventry and Warwickshire could lose its control centre. He pointed out that the merger of four trusts was unprecedented – nothing on this scale had ever been tried before, and that would impose enormous stresses on the new organisation. Not only did this create the risk of failure, but it could shape how the new organisation deals with the local delivery units.

Cllr Crookes asked how important local knowledge is in a control room.

Mr Hazell acknowledged that this was an area of risk in any ambulance service. Mistakes get made. He recalled one incident where a misunderstanding meant that an ambulance was sent to a wrong address, leading to a 40-minute response time. This is a particular problem with road traffic accidents, where those calling in may be uncertain of their location. It was a simple truth that the larger the area a control room was expected to cover, the larger was the risk that staff unfamiliarity would lead to mistakes. Satellite navigation was a useful tool, but it was limited by the need to enter postcodes that may not be available.

Ms Khan asked whether the larger service would be better able to deal with major emergencies.

Mr Hazell answered that this part of the consultation was deeply flawed. Merging, he said, offered no additional capacity to respond to major incidents. Instead, the proposal to reduce the number of managers actually made the service less able to respond to major incidents. He said that CWA had a duty senior officer on duty at all times, supported by a duty incident officer. There was a well-practiced procedure for organising the despatch of vehicles to a major incident, and stopping transfers for elective activity. If these officers were not in place then the capacity to deal with a major incident goes down. He noted that because CWA is a provider of routine patient transfer, there are an additional 150 vehicles available to both deal with “routine” 999 calls and be assigned to the incident. He added that this was as many vehicles as the London Ambulance Service (LAS) could muster. He challenged the assertion in the consultation paper that even a regional service could respond to major incidents autonomously. Responses to major incidents were dependent on their scale, type and

location, and there would always be the need to liaise and co-operate with neighbouring services. It was “simply rubbish” to suggest otherwise.

The Chair thanked Mr Hazell for his attendance and the useful evidence he had provided.

Sally Burton, Head of Older People’s Services, Coventry City Council

Mr Doyle asked what links community services had with CWA.

Ms Burton replied that Community Services provided services to a wide range of people, many of whom are elderly and frail, and therefore there is often a question over ensuring the most appropriate care, and deciding if conveyance to hospital is appropriate. The objective generally is to keep people out of hospital if possible, and CWA plays its part in these decisions. It is an efficient service that plays its part to support the work of the hospital and nursing homes to ensure that people get the right care.

CWA is integrated into the provision of intermediate care, which in turn supports out-of-hours services; increasingly CWA can support care for patients in their own home, which is better. The community care plan sets out how supporting care in the home is better for the patient and cheaper. It maintains social networks, and it is recognised that hospital admission can often lead to a loss of independence.

The ECN provides an information system about what capacity is available, and provides contact with an emergency care nurse, which is often important when dealing with a frail person. It provides a clear picture of what is available, so there is less uncertainty for the local authority (LA), NHS and the patient.

This network was created locally and addresses local needs; it is built on local knowledge and there is a working trust between the partners. One concern about the reorganisation would be that the network could be diluted or undermined. Key people could be moved away, and resources devoted to the network might be allocated elsewhere. The local authority has a central interest in this because the current provision means that more money is available for long term care that sustains independence in the elderly. This means that the LA can better meet its targets and get better value for money. It means that GPs can make better decisions about referrals, for example.

Members asked about the wider views of the local authority on the proposals.

Ms Burton replied that at the same time as this consultation, the acute services review is underway that is examining different patterns of service for Coventry and Warwickshire. One of the early lessons from that work is that “one size fits all” approaches will not be successful. Different demographics and needs mean that a tailored response is necessary. Local ambulance crews understand what intermediate care is about and respond to that.

The Chair asked whether CWA delivers the service that the LA wants.

Ms Burton replied that in as far as it can it does. The intention and spirit are there, and the direction of travel is right. Problems can arise at the links between the different elements involved. For example, there is a lack of clarity about what a GP should pay for, and what the ambulance service is responsible for with regards to routine community transport. You might get more consistency and clarity on these issues if Primary Care Trusts (PCTs) are commissioning services across PCTs rather than separately. On the other hand, if one GP practice is the issue, then local knowledge and local negotiations will probably be more effective. A smaller organisation might get better results.

Cllr Crookes asked what risks Ms Burton saw in the proposals.

Ms Burton replied that that the loss of local knowledge and focus was her concern. Coventry is pushing ahead with a local vision of intermediate care that is as good as anywhere. She

questioned whether a larger organisation would understand this local vision and be as responsive to it.

Cllr Crookes asked whether Ms Burton meant that she thought the service would not be as good.

Ms Burton replied that this was a risk; we would be looking for a service that reflected local needs and that might be harder to achieve. We could be a lone voice in a larger organisation. We could be looking for different treatment to the rest of the region. She feared that we could end up spending time trying to persuade a larger organisation to give us what might be seen as “special treatment”. This sort of situation soaks up capacity.

Cllr Crookes asked whether it was realistic to expect a larger organisation to offer separate policies for different communities.

Ms Burton replied that it was possible, and cited mental health services as an example. However, the question remained about how much effort this would require.

The Chair thanked Ms Burton for her attendance and the useful evidence she had provided.

Mike Burdett, Steve Thompson, Graham Swain, CWA

Mr Burdett made an introductory statement setting out the combined experience of the witnesses – a total of 79 years of service – and making it clear that they had come of their own volition, not as a result of a request of management or anyone else. It was noted that this would be the third significant reorganisation of local ambulance services. Before CWA was formed, Coventry was part of the West Midlands Service, and before that it was a separate service. Based on this experience, the witnesses had serious concerns about the proposals.

Mr Spurgeon asked if there was a Transport and General Workers Union (TGWU or T&G) view of the proposals.

The witnesses replied that there was local concern and that a statement had been issued. However, there was not a national position. T&G officers did not agree with the Unison position which was generally supportive of the proposals; instead they had very serious concerns with what was proposed. Their general view was that the proposed organisation was simply too large and unwieldy to deliver good services. They also had an interest on behalf of their members with regards to terms and conditions. There are substantial variations across the four trusts in terms and conditions, and they were keen to ensure that the proposals did not disadvantage their members. The witnesses sought to explain the seriousness of this issue; before Coventry transferred into CWA, there were 12 months of negotiations, and the complete process of agreeing all the relevant policies and terms and conditions took twenty months. The witnesses were of the view that rationalising all the west midlands regional trusts into one would require around three years to go through the same process of negotiation and agreement.

Miss Hackford asked what specific issues were of concern.

The witnesses responded that their first concern was with redundancies. There were likely to be redundancies in management, and there would be other redundancies too. For example, the CWA amalgamation led to the loss of twenty staff. The second issue was the uncertainty and stress caused to staff generally. It was pointed out that working for an ambulance service can be stressful, and requires quick, clear thinking in life-and-death situations. At times the job can seem thankless and demanding. Uncertainty about the future can cause significant problems in these circumstances. The outcome of the proposals was not clear, and the consultation itself was “vague and woolly”. It was not clear whether the local control room would be affected, and whether it was to be expected that jobs and lifestyles would be altered.

Mr Burdett recounted that he had originally opposed the formation of CWA, and he had fought to keep Coventry part of WMAS. However, he had been persuaded. Warwickshire, he acknowledged, was a “pretty good” service. Being smaller meant that issues could be dealt with quickly and it was possible to speak to the Chief Executive directly. WMAS had provided a good service to Coventry, he argued, but the transfer had out worked well for patients.

Cllr Crookes asked if the proposals represented a risk to patients.

Mr Burdett said that his previous experience of amalgamating into a larger organisation led him to be concerned about what was being proposed. Up until 1974, Coventry had had its own ambulance service. Then it was taken over by WMAS, which had not gone well. The Coventry Evening Telegraph was reporting “bodies in the street”. The new organisation simply “couldn’t cope”, and as a result patients and staff suffered. When faced with trying to set up a new organisation, people tend to get more focussed on repositioning themselves in the new organisation, protecting themselves and looking for promotion, rather than worrying about patient care. Patient focus is lost as the organisation looks inward on itself.

In 1976, the WMAS control rooms were centralised and “chaos” ensued. Local knowledge was lost, and it took the organisation many years to recover. The witnesses were keen to emphasise at this point that satellite navigation was only a partial response at best to the issue of local knowledge. Satellite navigation has definite limits. The merger of four trusts is unprecedented and creates even more risk; the outcome will be “less safe than as we are”.

Faced with the consultation, the witnesses’ view was that the approach should be:

1. Keep CWA unchanged – the organisation works, and should be retained
2. Merge, if necessary, on a smaller scale, with just one other trust.

Anything larger would duplicate and face problems even larger than that created by, for example, EMAS.

Cllr Stone expressed objections to the proposals, and voiced concerns about the issue of local control.

In response, the witnesses set out some of the limitations of relying on satnav. It was noted that, for example, an ambulance responding to a 999 call could be travelling faster than satnav can update, meaning that crews cannot rely on it exclusively. There were also reported instances of “dead ground” where Sat Nav does not function completely reliably. It was certainly better than trying to read a map on your lap in the middle of the night, but its limitations make it a tool rather than a panacea. The witnesses agreed that regional accents can sometimes pose a problem in distant control rooms.

Cllr Stone asked about what the consequences would be of only having two control rooms.

Mr Burdett replied that if Coventry was not one of the control rooms, then the impact on staff would be considerable. The local control room has approximately 60 staff, many of them young women. If the local control room closed, many would face redundancy as they would be unable and unwilling to do the extra hours and travelling required to work at a more distant control centre.

Miss Hackford asked about the consequences for training.

The witnesses replied that training in CWA was linked to the way that the organisation’s medical director could set the standards for treatments. With a new structure, and a new medical director, change could follow that disadvantaged patients. CWA, with its well-trained staff, could do procedures that couldn’t be done in other trusts. A big, centralised trust might lead to a “pulling back”, with an effort to standardise practice at a lower, common level.

Mr Doyle asked about how the service would be affected, and whether there might be advantages.

The witnesses answered that from the perspective of staff “on the ground”, the rationales for change just don’t stack up. A centralised service would mean a more remote service. At present it’s six miles to the headquarters. Depending on the where the HQ is, this could turn into a ninety mile round trip.

Mr Doyle asked if the ambulance crews had been consulted as part of the consultation.

The witnesses replied that Department of Health will not negotiate, and there has been no consultation about the proposals. There has been no explanation of how the changes will be implemented, not timetable. To the witnesses, this is comparable to Agenda for Change, which is still not complete after seven years of work. It too has created confusion and uncertainty among ambulance service staff, and throughout staff have had the perception that the Department of Health does not understand how ambulance services work, and how they are moving forwards. The witnesses pointed out that it’s the same people at Department of Health bringing forward these proposals. The information produced by DH is confusing, with incorrect statistics and evidence. The witnesses concluded that this situation was causing grave concern among CWA staff, and frustration that they could not influence what was being proposed. The witnesses implored the committee to support their efforts to get DH to think again about the proposals.

Jim Leach, CWA Patient & Public Involvement Forum (PPIF)

Mr Leach made an introductory statement in which he emphasised both his and the Forum’s independence from both CWA Board and staff. He said that this proposal had left him “appalled at the NHS”, in that they had “got it totally wrong” and were trying to drive through change based on “fallacious assumptions”. He sought to make clear to the scrutiny board that “reduced performance could lead to patient deaths”.

Cllr Ruddy asked what the consequences of the proposals would be for patient and public involvement.

Mr Leach replied that the new trust would be less efficient in all respects, not just the frontline services. He said that it would cover a huge area, meaning that accountability would be less clear, as the organisation would be remote and impersonal.

Cllr Gazey asked what the new trust would be like from the perspective of the patient.

Mr Leach replied that having the control room in Leamington Spa, and in Coventry in the future, gave clear local knowledge and local involvement. A new trust would jeopardise this local knowledge and link with the local community. Patient confidence would suffer; a recent survey of users of the routine transport service showed that patients valued and supported their local service [details of this survey have been requested].

Mr Spurgeon asked why the issue of amalgamation had not caught the public imagination.

Mr Leach replied that ambulance services were low in the public’s perception, probably because we have a good service that works well. Budgets were relatively small and the public had yet to comprehend the risk associated with what was being proposed.

Mr Spurgeon asked if the witnesses could shed any light on the proposed local delivery units.

The witnesses replied “if it ain’t broke, don’t fix it”.

Members asked about the accountability of the new organisation.

Mr Leach replied that it was not possible to see how the patient and public involvement (PPI) structure could be applied to a regional structure. It would be even more difficult to attract and retain members, and there would be a fear that rural interests could be overwhelmed by the concerns of the populous conurbations. PPI for the new trust could easily be dominated

by Birmingham. Mr Leach raised the issue of how LA overview and scrutiny committees (OSCs) would relate to the new trust; any attempt at scrutiny would require the collaboration of many LAs. The witnesses pointed out that the NHS's attitude to PPI was exemplified by the fact that the consultation paper contained no alternatives. They said, "It is a single proposal which looks like a *fait accompli*."

Cllr Gazey asked if the witnesses saw any advantages in the proposals.

The witnesses replied that CWA provides an excellent service. Everyone agrees; the NHS, staff and the public. There is no evidence that bigger trusts are better. If what we have now works, why not get other trusts to copy us, rather than change?

Cllr Ahmed asked if the PPIF was working with other PPIFs.

The witnesses replied that they were liaising with their counterparts in Staffordshire in particular to raise publicity for the campaign.

Dr Matthew Cooke, Professor of Emergency Medicine, Warwick Medical School

Professor Cooke made an introductory statement in which he outlined his involvement in the development of training for ambulance crews, and his role as a member of the reference group for the review of ambulance services *Taking Healthcare to the Patient*. He also said that he worked as an A&E consultant. Professor Cooke stated that he also worked as an advisor to the Department of Health, but was speaking today in a personal capacity.

From the outset, Professor Cooke made clear that the reference group of which he had been a part had not put forward the reorganisation proposals. Those had come from elsewhere. He said, "I was not part of the group that suggested reconfiguration. That was not something we considered".

Members asked Professor Cooke for his views on the amalgamation.

Professor Cooke replied that it depended on the perspective one took. There were advantages and disadvantages, and from the viewpoint of CWA, the issue was whether good practice and high performance could be sustained and further developed. Professor Cooke explained that he was involved with the review work of Commission for Healthcare Improvement (CHI) and later the Healthcare Commission. In the case of CWA, a review found many examples of exemplary practice, and rated the service very highly. He had also evaluated and audited the development of ECPs in CWA, and the education and training programmes that been established. He concluded that CWA was "leading the way" in the development of its staff. The concern therefore was whether reconfiguration would mean that services across the region would be brought up to that level, versus the "danger" that the new trust would instead perform at the average of all the services. He said that if staff development and training were not introduced across the new service to the standard achieved in CWA, there was a real risk that performance would not be as good as it could be. Professor Cooke outlined how when Coventry had been taken into the Warwickshire service, practices around reducing conveyance rates and caring for people in their homes had been introduced without any problems. The issue was whether the new organisation would be able to absorb best practice in the way to benefit of efficiency and patient care.

Cllr Stone asked how long it would take for other trusts to develop staff training to the level maintained in CWA.

Professor Cooke said that paramedic qualifications were to a national standard now, but ECPs were the result of a local initiative between CWA and Coventry University. WMAS, for example, is behind other ambulance trusts in the development of ECPs; they are planning to start training ECPs within a year, and the training takes two to three years depending on the level. Thus introducing significant numbers of ECPs across the proposed organisation is going to take three to four years.

Cllr Crookes asked whether the proposals would save money.

Professor Cooke replied that he was uncertain about whether they would. The history of NHS reorganisations suggested that they often ended up being more expensive than predicted and actually cost money rather than saved it. The areas he could see where savings might be made were obviously in the reduction in the number of Boards and directors. The proposals would mean going from four boards to one. A Board costs between £650,000 to £1,000,000 a year in salaries and support costs. The new organisation should need fewer finance directors, for example. However, by adopting a devolved "local delivery unit" structure, some of the savings might be offset by maintaining local management and direction. He went on that some training might be unified which would have some operational advantages as well as saving money. However, the sums involved would be in the tens of thousands, not the millions. There might also be small savings in maintaining the disaster management function with one organisation rather than four.

Cllr Crookes asked whether other amalgamations, such as EMAS, had saved money.

Professor Cooke replied that he was not really an expert in financial matters, and couldn't offer an answer to this question. However, he said, that EMAS case had shown that reorganisation could produce two to three years of "turbulence" as the new organisation was established. Merging different IT, communication and managerial systems had proved very challenging in that case.

Mr Doyle asked for an assessment of the particular areas of performance that were at risk from the proposals.

Professor Cooke highlighted the issue of control rooms. It was not clear in the proposals whether there would be five, as now, less than that, or perhaps even only one. He said, "local knowledge does matter". The larger the area covered, the bigger the challenge that is faced. It is a bigger problem, and mistakes can be larger. Satellite navigation can offer a partial solution. He said, "If I were given responsibility for control centres in the new organisation, I would look to have several, all carefully linked with the capacity to take up overflow from each other. The advantages of local knowledge outweigh centralisation on this issue."

Cllr Stone asked further about how DH involvement in the recommendation to reorganise.

Professor Cooke replied that the work he had done for *Taking Healthcare to the Patient* as part of the reference group had been about the role of ambulance crews, and the development of ECPs. It had focussed on how to reduce conveyance rates, and make more appropriate use of ambulances and other resources. There had been no discussion of reconfiguration; that was "not on the horizon".

Cllr Gazey asked if the new organisation would be better placed to respond to a disaster.

Professor Cooke replied that it was difficult to answer this as the West Midlands had not had to face this situation. The lesson from other incidents elsewhere was that mutual aid worked well; other ambulance services were able to take up the routine 999 work as a service responded to a major incident on its patch. Boundaries disappear in these circumstances and support would arrive. However, the detail of how well that support works is always an issue. Differences in equipment between services have caused problems, but with national ambulance procurement coming soon, that problem should be reduced. Differing standards of training and operational procedures have caused problems at times. Generally speaking, ambulance services do not have problems communicating with each other, but there have been difficulties in ambulance services communicating with other agencies.

Miss Hackford asked what the criteria would be by which the new organisation would locate its control rooms.

Professor Cooke replied that this would be a matter for the new Board; they could do what they liked.

Cllr Ahmed asked if there were any merits in the proposal in Professor Cooke's view.

Professor Cooke answered that from the CWA point of view, the proposals offered no definite promise of improvements to services. There might be some very specialist services that could be more widely available, but these were things that were non-time dependent such as transfer of critically ill patients, where there might be more capacity to procure very specialist equipment and maintain more redundancy. As regards the "999" service, there was little advantage to CWA. Other services might see it differently; they might see the proposals as a way to try to make their service better.

Mr Spurgeon asked if he felt that the consultation was adequate.

Professor Cooke reflected that as an A&E consultant, he acted as a "conduit" by which operational issues affecting how A&E units work could be fed to DH. He said that no such route from the "coal face" to DH existed for ambulance services, everything went through the ambulance service chief executives. This meant that DH was perhaps not as aware of concerns and issues as they might be.

Mr Doyle asked what recommendations Professor Cooke thought health scrutiny should make.

Professor Cooke replied that the training and development CWA had put in place should be preserved by the new organisation.

The Chair asked whether there should be national training for ECPs.

Professor Cooke replied that this is a live issue, and one he has debated. The variation in further training "makes life harder" as it means there are differences across the country, when in fact most of the skills necessary are common across the country. There has never been a positive response to this proposal from DH. On the downside, separate training for ambulance crews could undermine the relationship with the rest of the NHS, breaking the link with nurse training for example, and perhaps limiting the ability of ambulance crews to work in other environments.

Mr Doyle asked for further clarification around what specialist services might be available.

Professor Cooke replied that with a larger organisation should come greater flexibility to offer specialist services. However, he noted that one sort of specialist service often mentioned – specialist ambulances for children – were already in place in CWA.

Cllr Gazey asked whether there is a case to stay as we are.

Professor Cooke replied that most other services probably see reconfiguration as a good thing, a way to improve services.

Mr Jardine asked for clarification of the issue around medical directors and services available.

Professor Cooke replied that clinical guidelines are now national, meaning that variations in how a given treatment is provided are very small. What varies is the scope of treatments available depending on the qualifications and training of the ambulance crews. Practice is standardised, but the range of treatments vary. This affects what may happen to a patient who is seriously ill, or whether the patient is treated at home and not conveyed.

The Chair thanked Professor Cooke for his attendance and valuable contribution.

Appendix 2

Note of a meeting of Scrutiny Board 4 (Health) on 15 February 2006

This record is an amalgamation of notes taken by City Council Officers. It has been prepared at the request of the Health Scrutiny Board. This is not a verbatim record of comments made at the meeting, and the notes should not be accredited as such. Only statements in quotation marks are comments made in the meeting, and these have been cleared with the participants. This note is not an approved formal record of this meeting.

The Chair welcomed **Charles Goody (Chair, West Midlands South Strategic Health Authority)**, **Catherine Griffiths (Managing Director, West Midlands South Strategic Health Authority)** and **Bronwen Bishop (Director of Primary Care Development and Corporate Services, West Midlands South Strategic Health Authority)** to the meeting.

Mr Goody made an introductory statement noting that the consultation covered three areas – primary care trusts, strategic health authorities and ambulance services. He acknowledged that the scrutiny committee was particularly interested in ambulance services, and said that this was a national consultation from the Department of Health. He said that Bronwen Bishop was the former Chief Executive of Warwickshire Ambulance Service, and thus was well placed to answer any questions. He noted with emphasis that the proposals were about restructuring of services and not service delivery. He said that the proposals would have "no bearing" on services, only their organisation. He went on that the proposals would bring commonality across the region in terms of clinical governance, so as to ensure that patients were treated in the best possible way all across the west midlands region. He said that the reorganisation would also create a trust better able to apply for foundation status should this become an option for ambulance trusts, and said that the reorganisation would also respond to the issues being raised and the likely conclusions of the "acute services review that Cllr Clifford has been a member of".

Jonathan Jardine asked a question relating to the evidence of Professor Matthew Cooke, which had indicated that the expert reference group of which Professor Cooke had been a part had not considered reorganisation.

Ms Griffiths replied that the report "Taking Healthcare to the Patient" had been agreed by its author Peter Bradley CBE, Chief Executive of London Ambulance Service NHS Trust, and it included the recommendation to reduce the number of trusts. The Department of Health had responded to this report by issuing the consultation.

Mr Jardine asked if the witnesses knew how the proposal to reduce ambulance trusts had been included in "Taking Healthcare to the Patient".

Ms Griffiths replied that the witnesses were not in a position to answer or comment on this question.

Mr Jardine asked about the relationship between "Taking Healthcare to the Patient" and "Commissioning a patient led NHS", specifically the number of ambulance trusts. "Taking Healthcare to the Patient" suggested a 50% cut in the number of Trusts, but the recommendation was that ambulance trusts should be broadly in line with SHA boundaries. Mr Jardine asked if there was confusion here, given that "Commissioning a patient led NHS" was not published until after "Taking Healthcare to the Patient".

Mr Goody replied that there were presently 31 ambulance trusts 28 SHAs. This would fall to 11 ambulance trusts and 9 SHAs. He said that those drafting "Taking Healthcare to the Patient" would have been aware of the forthcoming proposals in "Commissioning a patient led NHS". He added making NHS management savings – and that is what this proposal is, not a service change – was an election commitment.

Mr Jardine pointed out that even under the proposals, there were two instances of where proposed ambulance trusts would not follow SHA boundaries. It was therefore possible in the

West Midlands to reduce the number of ambulance trusts by 50% - and thus hit the target – without going for just one trust.

Ms Griffiths replied that this was a national consultation on eleven proposed ambulance trusts that included a proposal to have an ambulance trust for the west midlands region. The issue is what this means for the people of Coventry. She went on that the consultation meant that a "proposal can be put forward to influence the design of the reorganisation".

Mr Goody added that the current position meant that management structures in the ambulance trusts were being stretched by the requirement to both deal with local operational pressures and respond to national initiatives and requirements. This reorganisation was about addressing these pressures and not about changing services.

Mr Jardine asked if, given that a 50% cut in the number of ambulance trusts was the target, why not offer a lower risk option of having two ambulance trusts in the west midlands region rather than only one.

Ms Griffiths replied that the committee could put forward counterproposals. However, on the issue of risk, she observed that she had experience of previous reorganisations, and therefore a good understanding of how to manage this process. The NHS was getting better at business continuity, and undertook organisational design exercises in advance that reduced risk. There is much more risk assessment than previously, and more preparatory work for new organisations. Performance targets were a "critical" part of this process, and there is a clear focus on ensuring that performance is maintained.

Cllr Ruddy asked about fears that there would be a loss of local control.

Ms Griffiths replied that local control will be maintained by both the local management structures and the way that the service will be commissioned. The service will be bought by local PCTs, and Stephen Jones [Joint Chief Executive of Coventry Teaching PCT] will be able to say what service he wants to buy. It may be that locally Coventry and Warwickshire PCTs collaborate on commissioning, but together they will specify what service they want and this will keep local control. "Legally, they are the ones responsible for the quality of the service", she pointed out. This will be a "strong counterbalance" to the regional level; the local PCTs will need to ensure that they get the right mix of services as they are the ones who are paying.

Cllr Ruddy observed that this was not the same as a guarantee.

Mr Goody said that increasing the size of the service made it better able to take on the larger role that was required for the future.

Ms Bishop went on that the new organisation had to be organised locally to fulfil its role. "Taking Healthcare to the Patient" and "Our Health, Our Care, Our Say" talk about co-ordinating out-of-hours services and resources with mobile healthcare and ambulance services, and this meant that commissioning and management of the service had to be local. Proper co-ordination meant that patients wouldn't be passed from "pillar to post" and would get the right treatment in the right place. This inevitably meant local control centres and ambulance staff sitting and working with local practitioners and other health professionals.

Mr Goody added that a larger organisation would have more resources, including those from savings, to invest in improved local services.

Ms Bishop went on that in effect, the guarantee of local control came from the policy that was in place, and the government documents that had brought about the change.

Cllr Stone said she thought the consultation was a "done deal".

Cllr Dixon asked about the training and development of staff in CWA and the proposed new trust.

Ms Bishop acknowledged that CWA had developed good links with local universities and had made good progress in developing its staff.

Ms Griffiths said that there were good examples of staff development in all four current trusts, and that the objective therefore was to use the new organisation as a way to share best practice so all could learn from each other.

Ms Bishop said that nothing in the proposals would interfere with the relationship between local ambulance service staff, local universities and other health professionals. Both "Taking Healthcare to the Patient" and "Our Health, Our Care, Our Say" are full of how ambulance services should look at the sort of service they provide, in order to reduce conveyance rates and offer more diagnosis in the home. All this meant offering a local service that was interlinked with local health professionals.

Cllr Dixon asked if this meant training would be centralised and students would have to travel further.

Ms Griffiths replied that training had to stay local to maintain take-up. However, current training contracts were fragmented, disparate and did not always achieve "critical mass". Training departments in the existing trusts were small and overstretched. While the delivery of training would stay local, the contracts could come together to get better value for money.

Ms Bishop noted that much of the training was now "competence based", which made it easier for staff to move between settings and trusts.

Cllr Dixon asked about what factors had made training and development work well in CWA, and how this linked to good performance.

Ms Griffiths replied that there were examples of innovation in each trust.

Ms Bishop said that the proposals would not affect operational practices. What works would continue. Delivery of care would go on as before. Over the coming years specific new services and best practice would be developed and introduced. Local variation would remain and a locality structure is essential to delivering this. The objective is to retain the best of what we have now, and bring all services up to the best standards.

Mr Goody said that from a management point of view, the focus would stay on monitoring performance and ensuring that maintaining standards comes first.

Ms Bishop noted that the proposed saving was only £3 million; the target could have been much bigger. There will be fewer managers, but not big cuts in numbers. The aim is not to make as big a saving as possible. The savings will be in areas where centralising makes sense and helps improvement, such as HR and finance. Standardisation of IT and vehicles were other examples. Additional savings will only come over time. In no sense were the proposals "decimating" the management structures.

Cllr Ahmed asked about disaster management. He asked whether the proposals would be actually reducing the capacity of the organisation to respond to a major incident.

Mr Goody said that, as Ms Bishop was responsible for disaster response for the SHA, she should reply.

Ms Bishop made a distinction between planning for an emergency and the actual response itself. The procedures for making the response are agreed nationally, with agreed service level agreements and arrangements for mutual cover. Those processes will remain. Planning for a disaster response has undergone big changes in recent years, with far greater planning required, most of it on a regional basis. The Health Protection Agency, for example, leads regionally on NHS preparedness for a disaster situation, working with the Government Office for the West Midlands and the three SHAs. Local planning duplicates effort, in effect

"reinventing the wheel". A regional SHA would set the parameters in which the other NHS organisations could work.

Cllr Ahmed asked whether having fewer managers would reduce the capacity of the organisation to respond.

Ms Griffiths replied that there is at present a "duplication of job titles", with people in different organisations ["suits"] doing the same job. She pointed out that management reductions could release resources for more ambulances and more frontline staff such as paramedics.

Mr Doyle suggested that this response was "disrespectful" to the work these managers do.

Ms Griffiths replied that accountants and HR staff weren't integral to disaster response, and explained that this wasn't meant as disrespect. The NHS colloquial jargon term "suits" just referred to posts that were no longer required in the new structure. The service would be provided just as well, with more resources available to the frontline.

Mr Doyle asked how the risks posed by the merger were being managed.

Ms Bishop replied that the four ambulance service chief executives are working closely to assess the process for implementing the changes if it is decided to go ahead. Their work is not pre-empting the consultation. This work will identify and assess the risks. Ms Bishop said that she had not seen the output of this work, but it has been going on for about a month.

Ms Griffiths said that there was considerable experience of merger – she noted that she had been through several – and she acknowledged that there always are risks that staff might leave or performance could fall. This is part of what the risk assessment is about, and no one was ignoring these issues.

Mr Goody pointed out that the risks associated with change had to be balanced against the risks of doing nothing. He said that the £3 million for services would be lost, and that there is a danger that quality of care could fall over time.

Mr Doyle asked how the performance of the new trust would be measured.

Ms Bishop replied that performance monitoring would be the same as currently, though the performance standards required by commissioning PCTs would mean there would be more local standards too.

Mr Doyle asked whether information would be available for the whole trust or by localities.

Ms Bishop replied that there would be data at both levels. Some reporting would be done centrally, but reporting for each local delivery unit would continue. There is no reason why this should stop, indeed, performance on a postcode basis would still be available.

Mr Doyle asked whether Emergency Care Practitioners might be moved out of Coventry by the new trust.

Ms Bishop replied that the local delivery unit structure would mean that resources would generally stay local. She said that staff and resources are deployed out of the region for specific jobs, but Coventry and Warwickshire will have its own control room and will therefore have control over its resources.

The Chair asked how one could stop the new ambulance service chief executive from redeploying resources, such as Emergency Care Practitioners, to elsewhere in the region.

The PCTs will decide what they want to spend on the local delivery units, and the PCTs will performance manage this; they will get the service they pay for. There will be arrangements for helping each other, but this must be paid for.

Mr Doyle asked what previous experience of ambulance service mergers said about these proposals.

Ms Griffiths replied that this proposal was fundamentally different to previous ambulance service reorganisations, which were about centralisation and making big cost savings. This proposal is about retaining local control and local focus, and that is what the local delivery units are all about. It is about making the ambulance service fit for the future.

Ms Bishop cited the example of Shropshire PCT, which was a provider of ambulance services. The ambulance service became part of West Midlands Ambulance Service, yet retained a control room, independence and the previously agreed investment plans.

Ms Griffiths added that a local control centre remained part of planning for Coventry and Warwickshire. There is strong support for it from Coventry PCT and UHCW. If the plan is to have a local control centre in the LIFT building in Coventry city centre then there is no reason why that will not still go ahead. She added that the Coventry and Warwickshire Acute Services Review has reiterated the need and wish for a local control centre. Such a centre helps patients get to the right place for treatment as soon as possible. She said that the experience of the merger of Coventry and Warwickshire ambulance services had gone well, and this is an opportunity to take that progress to the next level.

Mr Doyle asked for clarification about whether there was any risk of staff, particularly Emergency Care Practitioners, being moved around the region.

Ms Bishop replied that local control, with local commissioners monitoring performance, would see standards continue to rise, which would help retain staff. There would be new local targets that saw PCTs becoming more engaged in obtaining value for money from their ambulance service, and helping to keep staff local.

Cllr Stone asked questions about whether the new service would make the cost savings anticipated.

Mr Goody replied that savings of £3 million annually had to be made from 2008. He said that Agenda for Change addressed the issue of consistency across ambulance services, and that this would have rolled out anyway.

Cllr Dixon asked about the recent strike in WMAS.

Ms Griffiths replied that this was to do with allowances related to Agenda for Change, and had now been resolved, as had similar disputes elsewhere in the patch.

Cllr Stone asked whether there would be additional costs renegotiating contracts with PCTs.

Mr Goody replied that negotiations with PCTs would carry on as they do now, so there would be no additional costs.

Cllr Stone asked how the cost effectiveness of the changes would be measured.

Ms Griffiths replied that PCTs will at minimum have to commission services at a specific level, but that a PCT will be able to specify variations to meet local circumstances. Ms Griffiths was of the view that increasingly PCTs will be looking to commission "add-ons" to meet local needs, particularly around GP out-of-hours services. She noted that a PCT will get money back from the ambulance trust if targets and agreements are not being met. She went on that PCTs may commission jointly to be more efficient.

Cllr Stone asked whether staff cuts were anticipated.

Ms Griffiths replied that some workforce reductions were anticipated. This meant that the £3 million saving won't be realised until 2008, because there will be off-setting redundancy costs. She said that these have not been costed as yet, but that, for example, temporary

appointments were being made to reduce the workforce. The total cost of the changes was not known; more important was the requirement to have staff that could provide the sort of high quality service that was fit for the future.

Cllr Stone pointed out that some of the staff changes, notably the recruitment of chief executives and chairs, was already underway.

Mr Goody replied that the recruitment was to build a pool of chief executives who could be based anywhere in the country, in any of the eleven trusts. Their appointment would be subject to the outcome of the consultation. The recruitment is a pragmatic initiative to ensure that the NHS can move quickly after the consultation if appropriate.

Ms Bishop added that if the scrutiny committee had other options it wished to put forward then it was welcome to do so. The process was being driven by statute, with statutory consultation processes, including all the relevant stakeholders and public meetings.

Cllr Stone asked why the consultation included no alternative options.

Ms Bishop replied that the Department of Health was responsible for the consultation proposals – the SHA was just presenting them.

The Chair asked first what would happen if the cost saving targets were not met, and suggested that this would be hard to monitor. Second, he said that he had heard evidence that there are a million unnecessary conveyances each year, and that if these cost £60 each – at least – there was enormous scope for savings there, rather than through reorganisation.

Ms Bishop replied, "That's right; this consultation is about doing things differently", and that reorganisation is part of that.

Mr Goody added that savings were being recycled; it wasn't that the money would go out of the local health economy, it would go back into services.

Ms Bishop recounted how when she was chief executive of Warwickshire Ambulance Service she had to deliver on both national initiatives and local targets. With a small management team and local administration, it was hard to innovate. The small trust had to match large organisations. The local delivery units will be more free to innovate as CWA has done, with even greater potential to develop and provide services that meet local needs.

Ms Khan asked how PPIFs will work in the new trust.

Ms Bishop replied that "Our Health, Our Care, Our Say" set out plans for more engagement with patients and the public, and proposals for making services more responsive to patient and public wishes. She said that she saw a relationship with the local delivery units, possibly including the PPIFs.

Ms Khan asked whether the new trust will be as accountable as what we have now.

Ms Bishop replied that there was no reason for it not to be. For an organisation to be patient focussed requires patients to be engaged. Practice based commissioning meant that primary care services were becoming more important.

Mr Goody added that the agenda now is to move services closer to the patient where possible. He said that in the longer term the larger trust would be in a position to apply for foundation trust status.

Ms Khan stated that the CWA Chief Executive has made great efforts to attend health scrutiny meetings. She asked whether the same would be true of the new trust.

Ms Griffiths replied that the chief executive and the local delivery unit manager would fulfil this role. The local delivery unit manager would need to be a high calibre individual who could

take on these responsibilities. She also pointed out that the local PCT chief executive would also be responsible for the quality of the service and therefore would also be accountable to scrutiny.

Mr Spurgeon asked whether the consultation was a "fait accompli", and noted that "no change" was not an option.

Ms Bishop replied that the concept for the new organisation is the same as any that seeks to cover a wide geographical area. The centre's role is to focus on setting the parameters for action, while acknowledging and facilitating local discretion where it is needed. The centre would ensure that there are needs assessments of local service requirements. The "how" of the service would remain local.

Mr Spurgeon asked whether WMSSHA would be drafting a document about the consultation for the Department of Health.

Ms Bishop replied that the SHA is only collating responses, to forward to the Department of Health.

Mr Spurgeon asked what had changed between the amalgamation of Coventry and Warwickshire ambulance services and today.

The Chair added that what was being proposed was the change from a large area to an enormous area.

Ms Bishop replied that the "issue is a fundamentally different vision for the role of the ambulance service". Expectations have changed, and therefore the trust must be "fit for purpose". The proposals will allow greater local focus, more local services and a tailored needs assessment. The local delivery units will have more capacity to focus on local needs, for example, the differences between Coventry and Warwickshire. There will be a core standard, plus better, more appropriate services where they are needed.

The Chair said that we have a local focus already.

Ms Bishop said that this was not the case. CWA provided a "standard national service". The local service was "by no means perfect". Rural Warwickshire needed a very different service to urban Coventry and this was not always reflected.

Ms Griffiths added that the reorganisation would centralise administration and reduce bureaucracy, thereby avoiding duplication.

Cllr Gazey asked how, in the light of the trend towards "localism", one could determine the right size for an organisation.

Ms Griffiths replied that there were different levels, and each was appropriate to certain aspects of services. For example, primary care is at a local level where there are good links with GPs, versus hospitals that work across communities and the higher level for other strategic services.

The Chair thanked the witnesses for their attendance.

The Chair welcomed **Stephen Jones (Joint Chief Executive, Coventry Teaching Primary Care Trust)** to the meeting.

Mr Jones made an introductory statement. He explained that CTPCT Board had considered the consultations at its meeting the previous day, and the preliminary impression was that the Board was generally in agreement with the proposals the SHA was presenting – there are a lot of "fits" with what the PCT wants to do. The flow of patients across Coventry and Warwickshire suggested that the area is a natural health economy, and an ambulance service local delivery unit for that area seemed appropriate. The local emergency care network

performs well, and this would be retained. There was much sense in the proposal to centralise back office functions; this was a pattern across the NHS. As long as a Coventry and Warwickshire local delivery unit was retained, he could "see the case" for the changes. The issue was to ensure that the local delivery units were able to provide the services local PCTs wanted, and build on the good performance in place.

The Chair asked why the decision had been taken two years ago to move to a smaller service.

Mr Jones answered that the move to a smaller service allowed a concentration on the issues that mattered to Coventry and Warwickshire. It better matched the patient flows in the sub-region, and reflected the need that trauma patients were treated appropriately. The move from a larger management structure to a smaller one was an issue in the transfer; it allowed more local links, but this had to be balanced against the issue of ensuring that the ambulance service responded to the national agenda.

Cllr Ruddy asked if there should still be a local control centre.

Mr Jones said that the plan to include a local control centre in city centre LIFT was still in place.

Mr Doyle asked whether the funding would be available for further innovation.

Mr Jones replied that out of the total PCT spend of £380 million, about £15 million is spent on ambulance services. The way to pay for ambulance service innovation is to reduce hospital admissions. He noted that there was some way to go on this; he made reference to a report in the media saying that Coventry was in the top 5% for "frequent flyers", that is, patients who are admitted to hospital regularly, and thus impose a disproportionate burden on NHS spending. With better support, these patients would not need to be admitted as often. There is a lot of work to do around making best use of intermediate care, and the PCT's role will be to ensure that we get the level of service we want and need. By retaining a local delivery unit, the PCT would look to ensure that benefits from management savings are distributed equitably, and that there is clarity about how pressures elsewhere in the system impact on Coventry. Any proposal to shift resources like emergency care practitioners would have to be done by agreement, so as to ensure there were not detrimental consequences for Coventry and Warwickshire. Conversely, Mr Jones sought to point out that the service in Coventry was not perfect, and there would be hoped for lessons from good practice elsewhere.

The Chair asked what would happen if conveyance rates in Coventry and Warwickshire got worse after the merger.

Mr Jones replied that the PCT's view was that conveyance rates will not get worse. This issue is one of balance; if conveyance rates got worse, then it means more resources are required to support A&E. The PCT's job is to maintain an appropriate balance. The PCT's objective is to support continued improvement in conveyance rates, and that is why he expects CTPCT Board to be strongly supportive of a local delivery unit for Coventry and Warwickshire.

The Chair asked if we had a successful ambulance service.

Mr Jones replied that Ms Bishop's answer had largely covered this point. Smaller ambulance services were not necessarily better, "performance is not necessarily about size" he commented. It is important that the local delivery unit has sufficient autonomy to be able to deliver service improvement.

Cllr Gazey asked if the change was inevitable, and whether it would be good for specialist services.

Mr Jones replied that significant progress had been made in supporting people at home, as an example of the culture of innovation now in place. That pattern, of developing and

"experimenting" with new services in a controlled and systematic way, would be carried forward. He noted that service improvement was more about attitudes and culture; "you can't legislate for innovation", he said.

Cllr Stone asked about the PCT's responsibilities as a commissioner.

Mr Jones replied that the PCT had a role in specifying what services it wanted. If the PCT doesn't get what it wants, what it has specified and agreed, then the first step is negotiation with the ambulance service chief executive, and, in response to comments from members, Mr Jones said that he was comfortable negotiating with a chief executive at the regional level. He said that he negotiates with the Strategic Health Authority across a variety of issues, for example, and they call him to account for the performance of his trust. Conversely, much of the day-to-day work is done with local operational managers, and a local delivery unit unburdened of high-level strategic issues would have that operational focus. He said that the PCT would be able to hold the ambulance trust to account for the services it provides.

Members asked what sanctions there were if there were concerns about performance.

Mr Jones replied that if the PCT was not getting value for money then there would be a number of options. The PCT could refuse to pay for services, or perhaps look at alternative suppliers. It could invoke penalty clauses that would mean charging the ambulance service for the costs the PCT incurred following acute admissions.

Cllr Stone observed that all PCTs across the region would face the same issue.

Mr Jones replied that the Coventry and Warwickshire local delivery unit would be responsive to the local needs. He pointed out that the Coventry and Warwickshire acute services review was bringing forward proposals for further developing emergency care in the sub-region.

Mr Spurgeon asked for a response to the concerns raised by Malcolm Hazell.

Mr Jones replied that he had heard the concerns Mr Hazell had raised, and his view was that the reorganisation had to address the risks that had been identified. First, there needed to be a robust risk management strategy. Second, he emphasised that throughout the reorganisation process, no one should "take their eye off the ball" of service delivery. Third, the essential direction of travel had to stay in place, with further development of the emergency care network and this was being reinforced by the acute services review. Fourth, staff should be confident that their established patterns of working would be maintained. Fifth, the money saved should go to strengthening the local delivery units. Finally, the role of Coventry and Warwickshire PCTs in commissioning the service should be maintained.

The Chair thanked Mr Jones for his evidence.

The Chair welcomed **Clive Townend (Assistant Head of Public Protection)** and **Peter Streets (Emergency Planning Officer)**.

Mr Townend made an introductory statement in which he explained his role and that of Mr Streets. He said that the City Council's responsibility was to ensure that its emergency plans "dovetailed" with those of other organisations. A big part of that is building relationships with the individuals with whom one would have to work in the event of a major incident.

Members asked for the officers' views on the proposals.

Mr Townend replied that generally speaking, "bigger is better" when planning for a major incident, but that not all services are the same. This led him to "sit on the fence" on this issue for the ambulance service. For example, a larger police force is better able to both plan and respond to an incident because it will have more of the specialised equipment and resources it may need to respond to a major incident. For ambulance services, which must be able to integrate with other organisations, this may not be the only issue. The arguments are more balanced for ambulances.

Mr Streets observed that with both police and fire services moving towards regional structures, there would be pressure for ambulances to follow this trend. He said that when negotiating mutual aid agreements, which are a central part of emergency planning, again arguably bigger is better.

Cllr Stone asked about local links between different organisations.

Mr Townend replied that crucial to successful planning and response was a close working relationship with the individuals who would be dealing with an incident. It was important to know their style of working and thus anticipate which actions will work best with them. These are the people who will be at an incident, and it is of tremendous value to know them already.

Cllr Gazey asked whether emergency planning and response would be disadvantaged by maintaining the status quo.

Mr Streets replied no. He said that planning takes place in tiers from local, to sub-regional, to regional and then national, and from that perspective, the proposals for organisational change didn't make a great deal of difference.

Mr Spurgeon observed that this assumed that the new local delivery units had the authority to reach agreements on emergency plans.

The Officers agreed that this was an important consideration.

The Chair thanked the Officers for their attendance, and thanked members of the committee for their questions.

The meeting closed at 4.55pm.

Appendix 3

Letter from Sonia Godfrey, Associate Head of Nursing, Midwifery and Healthcare, Coventry University

Dear Councillor Clifford

Re: "The Council needs to be assured that what is being proposed is safe and at least as good as we have now".

Thank you for asking me to comment on how the proposed amalgamation of the ambulance services will impact upon training and education of ECP's and Paramedics in the future. It is difficult to predict the impact on these activities, as no formal proposals on this are currently available, although I am aware that Dr Ian Robertson Steele from West Midlands Ambulance Service has been assigned this provision to review for the reconfigured regional ambulance service. To date we have not received any contact from him to discuss the current education provision that Coventry University provides for Coventry and Warwickshire and more recently for Staffordshire Ambulance Services.

It would be inappropriate to speculate on what might happen to current education and training in the reconfigured service, however we can provide the Council with an overview of the excellent collaborative partnership working that has been established with the two identified services and the early developments with Hereford and Worcestershire Ambulance Service to provide placement experience for some of our paramedic students also.

Four years ago there was no ambulance service education or training taking place at Coventry University. All continuing education was provided at Rugby Ambulance Station, which had a small education facility, or ambulance personnel were sent away to other parts of the country to ambulance training schools to train as Ambulance Technicians and Paramedics. This required them to be away from their Station and families for up to 8 weeks. Cover for their absence was provided by the ambulance stations from which they worked. The courses that they undertook were vocational in nature and did not lead to any academic awards. This has long been an issue for Ambulance personnel, in that they found it difficult to develop their knowledge and skills beyond this point, and could not gain credit from their vocational courses to continue their personal, professional and academic learning. Release from practice and funding issues were often prohibitive in developing academically as the service relies on its work force being fully staffed and not supernumerary where new skills and knowledge are best learned and explored. This approach to developing practitioners meant that continuing professional development was limited to updating of skills, which though essential, may not have offered individuals enhanced educational opportunities, which in turn can promote a culture of stagnation and limited innovation.

In 2001 following a successful bid to the Department of Health (DH) by Coventry and Warwickshire Ambulance Service (CWAS) to explore the overlap between accident and emergency nursing and paramedic skills acquisition and delivery, we became involved in a pilot project funded by the Modernisation Agency (DH). The aim was to provide education and training for 3 paramedics and 3 Nurses to prepare them for a new role within emergency care provision in Coventry and Warwickshire to delivery care to patients in the community on a "see and treat basis". The aspiration of this project being to prevent patients being transported unnecessarily to hospital to be treated in accident and emergency departments. The majority of this care focussed upon meeting the needs of patients who sustained minor injuries or minor illnesses. These new practitioners known as "Emergency Care Practitioners" are educated to degree level and have developed the skills necessary to conduct health assessments on patients and determine the best and most appropriate referral to other agencies, transport to hospital or treatment in their own home, as well as health advice or guidance. Whilst both disciplines (the Nurses and Paramedics) had some skills to bring to the new role they both needed development in decision making, clinical judgement making, advanced minor injury and illness skills, evidence based practice and confidence in autonomous emergency practice. To date 61 students have or are undergoing this, with the courses initially being funded by Modernisation Agency Funding and later on by the Strategic

Health Authority & Work Force Development Directorate and Primary Care Trusts. This has resulted in ECP's in Coventry and Warwickshire achieving 60% non conveyance of patients to local hospitals which in turn has prevented blocking of facilities for more urgent cases in Accident and Emergency Departments or GP practices (CWAS 2006). The success of this pilot work led to the programme being rolled out by the Modernisation Agency across 17 other UK sites and the emergence of the Emergency Care Practitioner role being fully established. It is likely to undergo registration with the Health Professions Council in the future.

This new role has been further expanded and developed to meet the needs of patients in the county who require "GP Out of Hours Services". Many of the students exiting the ECP programme are now working in this service, again reducing the need for many patients to be transported to busy Accident and Emergency Departments. Without the partnership, collaboration and vision between Coventry and Warwickshire Ambulance Service and Coventry University in the joint venture the people of Coventry and Warwickshire would not have benefited from this initiative.

In 2002, the University and CWAS again worked collaboratively in a project to develop the first pre-registration programme for Emergency Care Practitioners (BSc Adult Nurse – Paramedic Science) which was a programme of education and skills development to take unqualified people from the community and develop them as both a Nurse and Paramedic. The delivery of this programme has led to a further programme being developed with CWAS called the Foundation Degree in Paramedic Science, which to provide Coventry and Warwickshire Ambulance Service with well educated paramedic practitioners, who have been able to learn their skills as supernumerary students, in a supportive and mentored environment (instead of learning on the job and doing the job at the same time). The benefits of this approach to teaching and learning have been recognised by the regulatory body for the Paramedic profession, who have recently stated that all future education for paramedics should take place in a higher education environment. CWAS recognised their limitations in achieving this for their own personnel and were brave enough to take the initiative to develop links with their local higher education provider, whilst at the same time recognising the challenges and opportunities that this would provide. Across the region the trust is at the forefront of ensuring its staff have the opportunities for the best possible education and training available to them. The dissemination of this approach to other ambulance trusts has more recently brought Staffordshire Ambulance Service to the University and they now commission places for students on the Foundation Degree for Paramedics in the same way.

The development of all of these courses has necessitated the university committing to the purchase of paramedic equipment which is the latest and most up to date available. This is sited in state of the art clinical skills laboratories, which provide paramedic and ECP student's opportunity to practice their skills under supervision before practicing on patients (the same cannot be said of traditional vocational paramedic courses). We are able to offer simulated patient experiences and we have developed considerable expertise around observed clinical examinations to be able to reassure ourselves and the unknowing public on the safety and competence of those students who will be involved in their care under the supervision of a registered paramedic mentor.

The greatest benefit of the higher education experience to paramedic students is the interprofessional focus of our courses, which encourages students to study topics of interprofessional practice, diversity, equality, ethnicity, gender, religion and culture. The added benefit of being an interprofessional learning environment is that paramedic students can learn alongside other health care disciplines and are taught by teachers who have expertise in caring for all vulnerable groups in society (neonates, children, pregnant ladies, elderly, mental health and learning disabilities). The application of their teaching to the local population and National Service Frameworks gives students an added advantage over paramedics being trained elsewhere in the county or indeed nationally.

CWAS commitment to educating its workforce has recently been shown by funding places for their Ambulance Technicians to convert to Paramedics via a new course developed in collaboration with the university called the Diploma in Professional Development in Paramedic Science. This programme enables ambulance technicians to convert to paramedic status,

which will ultimately provide a quality ambulance service with well-educated and motivated personnel, which can only be to the benefit of the local population. To date we have received many enquires from personnel in other ambulance services across the country who espouse this proactive intervention of CWAS as an exemplar of good practice in ambulance personnel professional development.

The investment in higher education by CWAS was brave and innovative and the trust has risen to the challenges that this approach to service development has given to them. From the feedback we receive at conference presentations and individual enquires it is clear that CWAS is seen to be an employer committed towards its staff's professional development. This is not reflected in many enquirers own ambulance trusts. They have now invested in a joint post with the university to enhance the teaching and learning experiences of existing staff and paramedic students and regularly second staff to participate in teaching on the courses offered at the university. This collaboration in teaching and learning contributes to maintaining standards of care for the local population of Coventry and Warwickshire.

The working relationships, partnership working and mutual respect that has been developed between the paramedic teaching team in the university and CWAS has arisen from a determination to succeed in providing a workforce who are ready and able to meet the challenges of "Taking Healthcare to the Patient: Transforming NHS Ambulance Services (DH 2005). If this relationship, innovation and effort were to be dismantled or replaced by alternative education provision as a result of reconfiguration, I feel it would be both sad and potentially detrimental to future service provision and the people of Coventry and Warwickshire.

Mrs Sonia Godfrey
Associate Head of Nursing, Midwifery and Healthcare
Coventry University
January 2006

Appendix 4

Letter from Lord Warner

Lord Warner, Minister of State (NHS Delivery)

MS(D)101275



Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 3000

Councillor Joe Clifford
Chair, Health Scrutiny Board
Council House
Earl Street
Coventry
CV1 5RR

31 January 06

Dear Councillor Clifford

Thank you for your letter, dated 10 January 2006, inviting me to attend a meeting of Coventry's health overview and scrutiny committee to discuss the proposals of NHS ambulance trust configuration. As you will be aware, the Department published a consultation document, setting out the key factors in developing the proposal of how ambulance services should be structured in the future.

These proposals are primarily about improving the services provided to patients, by ensuring that ambulance trusts have the capacity and capability to deliver the vision set out in Taking Healthcare to the Patient. This fourteen-week public consultation process is already underway and your meeting will form a part of that.

If the proposals are accepted, it will be a matter for the new ambulance trusts to ensure they continue to deliver and manage high quality services for their local populations. They will still be required to achieve the national performance requirements. This is not about one trust taking over other trusts, but an opportunity to bring services up to a high level - levelling up not down. The proposed new ambulance trusts would build on existing good practice and high performance to provide efficient, effective, locally responsive ambulance trusts that best meet patient need.

Unfortunately, I must decline your offer, due to diary commitments. It would be helpful if you could send your committee's response to this consultation to your SHA. I will then consider your committee's views as part of the feedback sent to me by SHAs for my consideration, following the consultation process.

*Yours sincerely
Norman Warner*

NORMAN WARNER

Appendix 5

Web based survey results

Warwickshire County Council hosted a web-based survey from 6 February 2006 to 6 March 2006. The survey was advertised via press releases, the Coventry City Council website, electronic communication and direct mailing.

The results were as follows:

Q1 Do you live in Coventry or Warwickshire?

Coventry	41.0%	(98)
Warwickshire	56.5%	(135)
Elsewhere in the west midlands region	1.3%	(3)
Other	1.3%	(3)

Q2 Have you used the ambulance service in Coventry and Warwickshire?

Yes	72.5%	(174)
No	27.5%	(66)

Q3 When did you last use the service?

Less than a month	24.7%	(43)
2 – 6 months	26.4%	(46)
7 – 11 months	4.6%	(8)
12 – 17 months	7.5%	(13)
18 – 24 months	6.3%	(11)
More than 24 months	30.5%	(53)

Q4 Which service did you use?

Pre-booked transport	20.2%	(35)
Emergency 999	68.2%	(118)
Both	11.6%	(20)

Q5 How would you rate the ambulance service in Coventry and Warwickshire?

Excellent	54.3%	(94)
Very good	22.5%	(39)
Good	11.6%	(20)
Fair	6.9%	(12)
Poor	2.9%	(5)
Very Poor	1.7%	(3)

Q6 What are your reasons for your rating in question 5?

(See attached information for responses from Coventry residents)

Q7 Before receiving this questionnaire were you aware that the government is planning to amalgamate the ambulance services across the whole of the west central area?

Yes	65.8%	(158)
No	34.2%	(82)

Q8 Do you support the proposals to combine Coventry and Warwickshire Ambulance Service with others in the west central area?

Yes 7.1% (17)
 No 76.5% (182)
 Don't know 16.4% (39)

Q9 What do you think will be the benefits of combining ambulance services in the west central area?

(See attached information for responses from Coventry residents)

Q10 What do you think would be the concerns of combining ambulance services in the west central area?

(See attached information for responses from Coventry residents)

Q11 Please indicate your age.

0 – 17 0.4% (1)
 18 – 40 24.7% (59)
 41 – 65 55.6% (133)
 66+ 19.2% (46)

Q12 Are you:

Male 42% (100)
 Female 58% (138)

An ethnicity monitoring question indicated that 4.6% of respondents came from BME backgrounds.

Cross tabulation of responses to questions 5 and 7 by location of respondent

Absolute Analysis % Respondents	Base	How would you rate the ambulance service in Coventry and ...					
		Excellent	Very Good	Good	Fair	Poor	Very Poor
Base	173	94 54.3%	39 22.5%	20 11.6%	12 6.9%	5 2.9%	3 1.7%
Do you live in Coventry or Warwickshire?							
Coventry	72	30 41.7%	19 26.4%	9 12.5%	8 11.1%	4 5.6%	2 2.8%
Warwickshire	98	63 64.3%	20 20.4%	10 10.2%	3 3.1%	1 1.0%	1 1.0%
Elsewhere in the west midlands region	1	1 100.0%	- -	- -	- -	- -	- -
Other	2	- -	- -	1 50.0%	1 50.0%	- -	- -

Absolute Analysis % Respondents	Base	Do you support the proposals to combine Coventry and Warw...		
		Yes	No	Don't Know
Base	238	17 7.1%	182 76.5%	39 16.4%
Do you live in Coventry or Warwickshire?				
Coventry	97	7 7.2%	72 74.2%	18 18.6%
Warwickshire	135	6 4.4%	108 80.0%	21 15.6%
Elsewhere in the west midlands region	3	1 33.3%	2 66.7%	- -
Other	3	3 100.0%	- -	- -

Responses to Q6 by those living in Coventry

- 1 Very good response to an emergency.
- 7 Fast, efficient and knowledgeable staff
- 14 It made it very easy for me to get to hospital but I did have to wait for a ambulance home.
- 15 They arrived very quickly, They were very good with my mother who was having a glycemc problem, polite, supportive, understanding
- 18 Although the ambulance was a little late arriving the staff manning ambulance was courteous and apologetic.
- 21 Speed of response and care offered when I required an ambulance, and also my experience of when my father in law required the service
- 36 They arrived promptly and took me straight to the appropriate hospital on the way they cared for me and passed on the relevant information to the emergency people at the hospital
- 40 Whenever I had to call the ambulance service for my husband I always found them to be prompt, and reassuring to me and to him.
- 42 They are efficient, quick, have good local knowledge of the area and hospitals and knew how to do their jobs.
- 43 Arrived inside 5 minutes...Paramedics very professional.
- 50 Quick response time, well trained paramedics
- 52 Prompt arrival
- 54 staff were very professional, friendly and calm.
- 55 Fast, effective response by people who know local area. Excellent and reassuring treatment.
- 57 find some ambulance crews abrasive and insensitive. Some are very helpful and considerate
- 58 Very prompt response times & excellent staff
- 60 arrived quickly
- 62 operator was excellent and got to the accident within sufficient time
- 63 Have heard on many occasions of quick arrival times from call to clinical assistance. I can also appreciate some of the conditions they work in
- 64 Expert staff, time of response,
- 67 They responded very quickly and efficiently took my mother to hospital. My only criticism would be that they were clearly VERY busy and needed to rather rush things. It was, however, clearly the right action.
- 68 they were very quick, polite, professional, kind and caring.
- 72 Quick response and efficient dealing with problem
- 73 They turned up to the RTA, treated and took my girlfriend and myself to hospital straight away after treating us.

76 When phoned they came but felt they might have been quicker given that the hospital is only over the road from where we live.

79 Arrived quickly and staff treated me really well.

81 It arrived within 15 minutes

84 Because they responded very quickly and were really helpful

86 Good quick response - efficient staff

94 personal experience, friends experience and information received from medical staff, care workers and public meetings all combine to convince me that the ambulance service works very efficiently with the resources available

96 They knew what they were doing and where they were going

97 IT HAS GIVEN US VERY GOOD SERVICE

101 arrived within 15 minutes of calling and were very efficient and reassuring

102 This is due to the competence and skills applied by the staff who were able to provide the required medical support

107 Did not arrive quickly had to phone again!!

109 Arrived promptly, dealt with patient very well and got to hospital speedily

110 The ambulance came quite quickly, the staff were friendly and helpful

112 the 999 service was wonderful. As the adult daughter of the patient the staff were also caring and comforting of me. The other outpatient service was awful.

113 I was very happy with the service provided and the response time

119 Excellent care - very professional

140 always room for improvement

141 Very prompt

175 Ambulance came straightaway. Treatment and the confidence given to me was first class.

184 Speed of response. Treatment given to injured person.

185 Coventry and Warwickshire Ambulance Service is excellent now. To merge it very poor.

191 Quick response, very friendly, stayed with me at the hospital and reassured me I would be ok.

193 1

194 Long waiting after dialysis.

195 Waiting too long after dialysis

196 Waiting too long after dialysis

198 Keeping us waiting. Not always passing message on if transport needs rebooking if we are not ready. Information given over phone to staff is mainly lies. Not reliable. Makes a 4-hour dialysis a whole days worth.

200 Very nice ambulance staff but usually have to wait a long while for transport to take me home.

201 Very helpful drivers

202 9 times out of 10 they are on time

203 Getting me to hospital on time and home at night time.

204 Little bit poor with timing

210 Service erratic

211 Delays in being picked up and taken home

212 It takes an hour for me to get home when I live a short distance away and I understand this is on the contract but it is every week, three times a week. I wait this long for transport to turn up

213 Not picked up on time - not collected on time.

214 Because they try their best

215 Always on time

222 On the 9th January 2006 the service I received from the crew was very poor and the attitude of member of staff was very ignorant. On the 14th January 2006 I was very poorly and the service and treatment of staff were more than excellent. That is what I call good service.

228 That is the position and find the service I receive.

234 The Ambulance (2 occasions) came within minutes. Paramedics great! Delays from assessment and treatment could be fatal.

239 Not 100% confident with the reactions of both people who came with ambulance.

Responses to Q9 by those living in Coventry

- 67 It should be more cost effective and more able to respond to major incidents
- 86 Because it will reduce some of the bureaucratic costs of boards etc without affecting the local operational unit and thus enable more money to be put into the front line services.
- 107 More support and resources available
- 191 The more ambulances you can call on must be better. A very good idea.

Responses to Q10 by those living in Coventry

- 1 Too large an area.
- 2 Response times, lack of local knowledge, remote management
- 5 longer for ambulances to turn up
- 6 Services should be locally focussed, twice in the last six months I have had to give directions to ambulance crews who did not know where they were going. This would be worse in an enlarged, combined service.
- 7 Too big
- 14 ambulances coming in from other areas and not having a clue where to go, especially if their sat nav is stolen, maybe making it a question of life or death
- 15 Delays, arrival times, not enough ambulances and staff to cover such a big area. Hoax calls placing wanted ambulances out of reach etc.
- 16 That the co-ordinators and drivers will not have sufficient knowledge of the areas they are being sent to and hence there will be delays in them turning up. It has been widely publicised that time costs lives.
- 18 No centralised service with people manning controls and driving vehicles with direct local knowledge might lead to delays in the ambulances reaching the people who need them - so it might lead to loss of life
- 19 Longer response times caused by coordination issues
- 21 I think speed of response is key to saving lives, and the loss of some of the 'local' element involved in the amalgamation could have a consequence in this
- 22 To large an area. Conflicting names of roads and areas. Persons on the phone and driving the vehicles would have insufficient knowledge on the geography of the areas. Large Cities would have the bulk of the commitment.
- 29 longer response times
- 31 3
- 36 When we were part of the west midlands service the response times were poor and the crews & control did not know where to go.
- 40 It would be to larger area to cover, training would not be to the same standard of our service, the control centre would only be one, causing confusion as to where the ambulance had to go. I greatly fear that lives will be lost if this goes ahead, as there seems to be a problem with others that have merged. I noticed that Staffordshire Ambulance Service are considering going private if this goes ahead, as they too have grave concerns over this.
- 42 Local knowledge of both area and hospitals could be lost, resulting in critical time delays. Operations and running of one huge service would be a nightmare. Operations rooms/telephone call centre staff also have local knowledge and this is useful in some instances when the caller does not know their location. This would also be lost. Redundancies in our area would come about as operations staff were relocated to a regional control room.
- 43 Lack of local knowledge
- 50 area too large, response times will suffer, problems with locations (we should NOT rely on Satnav)
- 52 Bigger is not better. Lack of local knowledge.
- 53 I am concerned that there is more scope for misunderstanding of areas and also longer waits for emergencies. Local services understand areas and can negotiate traffic hold-ups better
- 55 lose of local knowledge, difficulties obtaining ambulance when needed. Lack of adequate service, which could lead to a death.
- 58 Slower response times for 999 calls

60 too large an area - crews more likely to be unfamiliar with area - longer time to reach patient

61 Geographical area covered by the service is too large for a quality service that can only be delivered by the staff who are fully conversant with the local conditions. A remotely operated service can only result in impersonal and insensitive service. Costly managerialism must be avoided. LEAVE THE LOCAL SERVICE WITH LOCAL PEOPLE.

62 could take longer from ambulances to come and control room staff not familiar with my local area

63 Arrival times may be affected if ambulance depots are more centralised. You may get a better trained advisors on the phone but it may become harder to get through due to the higher volume of work going through one point rather than several. Ambulance crews need to have good local knowledge of their designated areas, this could be lost by increasing the allocated area.

64 Time of response, overworked staff, distance crew would have to drive (their own safety) affect on people requiring emergency treatment

65 My fear is that with this re-organisation and centralisation of services there will be job losses leading to a poorer quality service. I can't see any benefits for the people that need the service which surely should be the top priority?????

67 The new service must remain responsive to local needs and ensure paramedics etc know their way round the area

72 Reduction in response times, reduction in available staff / resources, lack of local area knowledge when covering

73 the bigger it will be the less speedy service we will receive

75 That they will not any local road knowledge and that it will take much longer for ambulance to be sent out.

77 The excellent service provided in Coventry would go because resource would be spread to thinly. The proposed area is way too large.

79 Response times, reduction in services and qualified staff. I have the impression that this is probably a money-saving exercise, with implications to lives rather than an attempt to improve services.

80 Quality of local services, response times and adequate resources and manpower to provide a quality quick customer first service

81 That there wouldn't be one available if needed in an emergency

82 Concern resources will be 'spread more thinly', vehicles and staff may cover the Coventry area but be based elsewhere - they may not have local knowledge to be able to get to locations as quickly as a services based in Coventry. Coventry will be geographically at the edge of the region so it will take longer for a 'cover' vehicle to arrive than a dedicated Coventry ambulance

84 I would worry that the service will be greatly affected by having to expand to a wider area and managed regionally rather than locally

85 Response time

86 This is a biased question from those who do not agree with this change.

88 Lack of local knowledge for dispatched drivers

93 Areas covered by local services are already very large. Loss of local knowledge at call centres (previous bad experience of 999 call to Fire Brigade being re-routed). If a central call centre is used, would there be any redundancy in the system i.e. would a power failure wipe out all services? Will standards of service slip? Coventry & Warwickshire is currently considered a 3-star service. Staff morale - e.g. being line managed by someone without any experience of the local area, being move

94 Staff would probably be less familiar with the geographical areas covered. Fewer base stations would surely result in longer response times, as indicated by performance figures from E.Mids., Mersey Region and London. If ambulance staff are faced with possible redundancy or having to travel further just to get to work centres, would they want to remain with the service, or even be able to? The whole idea of a larger service seems to contradict the idea of taking healthcare into the community

96 Coventry & Warwickshire have one of the most efficient and cost effective ambulance services in the country they did not when Coventry was last part of the West Midland ambulance service ambulances got lost or had to travel large distances which meant delay which could cause loss of lives or poorer outcomes to treatments.

- 97 IT IS VERY BIG AREA TO SERVE GENERAL PUBLIC. IT WILL AFFECT RESPONSE TIMES. I DO NOT THINK IT IS GOOD IDEA!
- 98 Geographical area would be too large to have local knowledge Efficiency savings expected might not be realised
- 101 Ambulance cover stretched over too wide an area - slower response times
- 102 I am concerned about the geographical area the staff will be expected to cover. Ambulance staff need to be composed whilst reaching an incident and the increase in distance may put added strain on staff as well as have an impact on treating conditions where time is of the essence. Staff get to know their own geography and this ensures that they use the local transport system to reach patients. Moving geography could impact on lives if the ambulance staff do not know the road systems. Sat Nav
- 107 Communication breakdown, too many areas to cover
- 109 Seems like a very large area to run one service within. Concerns would be over budgets, staffing, equipment and overall management of a service covering such a large area
- 110 Lack of knowledge of local area, increased times for ambulances to arrive at homes
- 112 I am concerned that local knowledge will be lost and arrival times on emergencies will increase. There are numerous places with similar names and if someone is upset it may be even harder to get necessary details. Additionally I feel there will be a reduction in staffing and in ambulances. Large organisations may bring cheap bread, meat etc but I do not feel these principles should apply to the emergency services As a carer my experiences of the service to hospital appointments is one of poor service
- 113 Lack of local knowledge to find people's homes
- 119 reduced funding/financing
- 140 1. Officers in any call centre would lack local knowledge. People dialling 999 are not always coherent and can forget important information concerning details of address etc. Local knowledge is valuable. 2. Each community will try to get a bigger share of resources, their community has 'special needs' which need to be addressed. A rural community cannot understand the needs of a large city and vice versa. Over such a huge area people cannot become 'one team'.
- 141 Response times would be slower because they don't know where they are going. Also slower if coming from a centralised unit
- 159 Local geography is imp. with it going bigger. This will be lost. Small can focus better.
- 184 Disjointed and unco-ordinated service. A regional call centre (as opposed to local).
- 185 Keep Coventry Warwickshire Ambulance Service NHS only.
- 191 None that I can think of.
- 194 Local ambulances know their area.
- 195 Don't know areas
- 196 Don't know local area
- 198 Where the base will be? Will it change time distance? Different areas for drivers to be aware of. How trained will the operators be in areas such as e.g. CV4 and CV5 are a big difference away. Can the control cope? How knowledgeable will the operators be where duplications of street names + elders forget post codes
- 200 May have to wait longer as ambulance men will need to travel longer distances.
- 202 Too big - further to travel
- 203 Not knowing if I will be picked up on time, or time of getting home at night.
- 210 Lack of knowledge of local news
- 211 Delays with drivers not being familiar with the area.
- 214 More delays. Bigger areas to cover
- 222 Lower response times.
- 228 Longer wait for service
- 234 Stretched too thinly on the ground! As stated in Q.6 delays in treatment could be dangerous. Fatal.
- 239 The bigger the field the less general knowledge will be known.

Appendix 6

Minutes from Coventry City Council area forum meetings relating to the reconfiguration of ambulance services. Full agendas, reports and minutes for all Council public meetings are available at:

<http://cmis.coventry.gov.uk/CMISWebpublic/>

South Central Area Forum: 19 January 2006

Consultation: "Configuration of Ambulance Trusts in England"

The Area Forum received a presentation by Malcolm Hazell, Chief Executive of the Coventry and Warwickshire Ambulance Service, on proposals by the Department of Health for the reconfiguration of ambulance trusts in England. A consultation document issued by the NHS had been circulated with the agenda for this meeting of the Area Forum.

The documentation circulated indicated that the proposals involve the establishment of 11 ambulance trusts across England which have been designed to improve service delivery. The proposals affecting Coventry involve the four ambulance trusts covering Staffordshire, Coventry and Warwickshire, West Midlands and Shropshire and Hereford and Worcester being replaced by one ambulance trust covering the whole of the West Midlands area. Within this structure, there would locally managed operational 'delivery units' within the overall strategic management.

Malcolm Hazell, in his presentation, expressed grave concerns about the result of these proposals on the effectiveness of the service as a result of the sheer size of the new area to be covered by the new Trust and the possible consequences of them on the standard of patient care. He also drew attention to the fact that, although the NHS Consultation Document indicates that the closing date for the receipt of all responses is 22nd March 2006, administrative procedures in preparation for the management and operation of the new enlarged Ambulance Trusts, including the recruitment process, had already commenced. The Area Forum expressed the view that this would suggest that the consultation process is merely a PR exercise and is likely to have little if any effect on the final decision. Under the circumstances, Malcolm Hazell urged the Area Forum to participate in the consultation process by vigorously opposing the proposed merger of the four Ambulance Trusts in the West Midlands to form a single Regional Trust.

Reference was made at the Area Forum meeting to Malcolm Hazell's attendance at the meeting of the City Council's Scrutiny Board (4) (Health) held on 18th January 2006, when his written response to the proposals contained in the Consultation Document was considered along with the Consultation Document itself. Evidence from a variety of other sources was also heard. Councillor Clifford, the Chair of Scrutiny Board (4), attended the Area Forum meeting and confirmed that his Scrutiny Board, at their meeting on 15th February, 2006, were due to hear evidence from the West Midlands South Strategic Health Authority (the consultation sponsors) and other NHS Stakeholders and that Lord Warner, the Minister of State for NHS Delivery, had been invited to attend the meeting for the consideration of this item. Scrutiny Board (4) were due to meet again on 15th March to consider all the evidence it had received, including submissions from the other Area Forums and the results of a survey of responses from Coventry and Warwickshire residents. The Scrutiny Board would then agree on the contents of a submission to be made prior to the consultation deadline on 22nd March.

ACTION:

1. Colin Swann to send a copy of Malcolm Hazell's response to all Members of the Area Forum and that the appropriate community representatives be requested to ensure that arrangements are made for this, and the Consultation Document, circulated with the Agenda for the meeting, are considered by the various committees, forums and groups etc., whom

they represent, as soon as possible; so that appropriate representations regarding the proposals can be made by 22nd March, the deadline for the receipt of all responses.

2. Colin Swann to also send copies of these documents to Jim Cunningham, the Member of Parliament for Coventry South, in whose Constituency the area covered by the South Central Area Forum falls (i.e. Cheylesmore and St Michael's Wards), and that he be asked to make appropriate representations to Department of Health Ministers opposing the configuration proposals.

South East Area Forum: 15 February 2006.

Consultation: "Configuration of NHS Ambulance Trusts in England"

The Area Forum received a presentation by Malcolm Hazell, Chief Executive of the Coventry and Warwickshire Ambulance Service, on proposals by the NHS (Department of Health) for the reconfiguration of ambulance trusts in England and Wales. A consultation document issued by the NHS had been circulated with the agenda for this meeting, along with a copy of an appraisal written by Malcolm Hazell. Councillor Clifford, Chair of Scrutiny Board 4(Health) attended the meeting for the consideration of this issue.

The consultation documentation circulated indicated that the proposals involved the establishment of 11 ambulance trusts across England which had been designed to improve service delivery. The proposals affecting Coventry involved the four ambulance trusts covering Staffordshire, Coventry and Warwickshire, West Midlands and Shropshire and Hereford and Worcester being replaced by one ambulance trust covering the whole of the West Midlands area. Within this structure, there would locally managed operational 'delivery units' within the overall strategic management.

Malcolm Hazell, in his presentation, expressed grave concerns about the result of these proposals on the effectiveness of the service as a result of the sheer size of the new area to be covered by the new Trust and the possible consequences of them on the standard of patient care. He also drew attention to the fact that, although the NHS Consultation Document indicated that the closing date for the receipt of all responses was 22nd March 2006, administrative procedures in preparation for the management and operation of the new enlarged Ambulance Trusts, including the recruitment process, had already commenced.

Malcolm Hazell urged the Area Forum to participate in the consultation process by opposing the proposed merger of the four Ambulance Trusts in the West Midlands to form a single Regional Trust.

Councillor Clifford referred to the meeting of the City Council's Scrutiny Board (4) (Health) held earlier that day when evidence had been heard from the West Midlands South Strategic Health Authority (the consultation sponsors), Stephen Jones, Coventry Teaching PCT, John Amphlett, University Hospitals Coventry and Warwickshire NHS Trust and Peter Streets, City Services Directorate. The Board were due to meet again on 15th March to consider all the evidence it had received and would then agree on the contents of a submission to be made prior to the consultation deadline on 22nd March.

Members of the Forum highlighted the importance of ensuring that the City continued to benefit from a high quality ambulance service

North East Area Forum: 16 February 2006

Consultation: "Configuration of NHS Ambulance Trusts In England"

The Area Forum received a presentation by Professor Langman, Chair of the Coventry and Warwickshire Ambulance NHS Trust, on proposals by the NHS (Department of Health) for the reconfiguration of ambulance trusts in England and Wales. A consultation document issued by the NHS had been circulated with the agenda for this meeting, along with a copy of an appraisal written by Malcolm Hazell, Chief Executive of the Coventry and Warwickshire Ambulance NHS Trust. Councillor Clifford, Chair of Scrutiny Board 4 (Health) attended the meeting for the consideration of this issue.

The consultation documentation circulated indicated that the proposals involved the establishment of 11 ambulance trusts across England, which had been designed to improve service delivery. The proposals affecting Coventry involved the four ambulance trusts covering Staffordshire; Coventry and Warwickshire; West Midlands and Shropshire; and Hereford and Worcester being replaced by one ambulance trust covering the whole of the West Midlands area. Within this structure, there would be locally managed operational 'delivery units' within the overall strategic management.

Professor Langman, in his presentation, expressed grave concerns about the result of these proposals on the effectiveness of the service as a result of the sheer size of the new area to be covered by the new Trust and the possible consequences of them on the standard of patient care. He also drew attention to the fact that, although the NHS Consultation Document indicated that the closing date for the receipt of all responses was 22nd March 2006, administrative procedures in preparation for the management and operation of the new enlarged Ambulance Trusts, including the recruitment process, had already commenced.

Professor Langman urged the Area Forum to participate in the consultation process by opposing the proposed merger of the four Ambulance Trusts in the West Midlands to form a single Regional Trust.

Members of the Forum highlighted the importance of ensuring that the City continued to benefit from a high quality ambulance service, both in terms of emergency provision and out-patient services. In addition, concern was expressed regarding the possible confusion when calling for an ambulance, for example to Stoke Heath, Coventry, when the proposed area covered by a Regional Trust would also cover Stoke Heath, Shropshire, particularly if the call centre staff are located a significant distance away and don't have a knowledge of the local area.

North Area Forum: 2nd March, 2006

Consultation: "Configuration of NHS Ambulance Trusts in England"

The Area Forum received a presentation by Malcolm Hazell, Chief Executive of the Coventry and Warwickshire Ambulance Service, on proposals by the NHS (Department of Health) for the reconfiguration of ambulance trusts in England and Wales. A consultation document issued by the NHS had been circulated with the agenda for the meeting.

The documentation circulated indicated that the proposals involved the establishment of 11 ambulance trusts across England, which had been designed to improve service delivery. The proposals affecting Coventry involved the four ambulance trusts covering Staffordshire, Coventry and Warwickshire, West Midlands and Shropshire and Hereford and Worcester being replaced by one ambulance trust covering the whole of the West Midlands area. Within this structure, there would be locally managed operational 'delivery units' within the overall strategic management.

Malcolm expressed grave concerns about the result of these proposals on the effectiveness of the service as a result of the sheer size of the new area to be covered by the new Trust and the possible consequences of them on the standard of patient care. He also drew attention to the fact that, although the NHS Consultation Document indicated that the closing date for the receipt of all responses was the 22nd March 2006, administrative procedures in preparation for the management and operation of the new enlarged Ambulance Trusts, including the recruitment process, had already commenced. Malcolm urged the Area Forum to participate in the consultation process and voice their concerns to the Strategic Health Authority (SHA) and their MP.

Reference was made at the Area Forum to Malcolm's attendance at the meeting of the City Council's Scrutiny Board (4) (Health) held on 18th January 2006, when his written response to the proposals contained in the Consultation Document was considered along with the Consultation Document itself. Evidence from a variety of other sources was also heard. Councillor Clifford, the Chair of Scrutiny Board (4), attended the Area Forum meeting and confirmed that his Scrutiny Board, at their meeting on 15th February, 2006, had heard evidence from the West Midlands South Strategic Health Authority (the consultation sponsors) and other NHS Stakeholders and that Lord Warner, the Minister of State for the National Health Service, had been invited to attend the meeting for the consideration of the item. Scrutiny Board (4) were due to meet again on 15th March to consider all the evidence it had received, including submissions from the other Area Forums and the results of a survey of responses from Coventry and Warwickshire residents. The Scrutiny Board would then agree on the contents of a submission to be made prior to the consultation deadline on 22nd March.

The Chair, Councillor Mrs Lucas, informed the Forum that the City Council's view on the proposals was that, 'Coventry people receive an excellent service and despite the outcome of the consultation process we expect no less than the equivalent of the service that is currently provided'.

Bob Arnott, Holbrook's Community Representative, asked Malcolm if, in his view, the proposals were part of a money saving exercise or an effort to improve efficiency?

Malcolm responded that if the merger were to go ahead it was expected that £3m would be saved, therefore, in his opinion, the proposals were part of a money saving exercise.

In addition, Bob sought clarification on what could be done if the proposals went ahead and did not work out as expected.

Malcolm reported that when previous mergers in the East Midlands and East Anglia took place the Coventry and Warwickshire region were able to offer help and support when needed. This proposed merger would affect everyone and therefore mutual support would be

lost. Malcolm felt that no consideration had been given to the risks these proposals posed to patient care.

John Bolton, Director of Community Services, reported that the SHA had given a presentation to the Council reflecting the positive side of the proposals. John asked Malcolm why they were convinced the merger would work?

Malcolm informed the Forum that it was the SHA's job to sell the proposals to the general public. He also explained that the West Midlands region were £3m in deficit, therefore, the £3m saving that was expected would balance the budget and not be reinvested into the ambulance service as they had stated.

Bob Arnott felt that the consultation would seriously demoralise the staff of the ambulance service and it was probable that a large number of good employees would be lost.

Councillor Mrs Lucas queried whether or not Malcolm and the SHA had aired their views regarding the proposals in a public forum.

Malcolm confirmed that he had attended four public forums where the SHA had presented information on the merger; Malcolm had then followed their presentation by expressing his views on the proposals.

A local resident felt that the proposals seemed to be detrimental to Coventry and enquired as to whether or not it had been taken up with the Local Strategic Partnership (LSP).

John Bolton explained that the City Council were expected to produce their own individual response, which was being undertaken through Scrutiny Board (4) (Health).

Councillor Mrs Lucas asked if ambulances would be based at the two centres that were planned?

Malcolm could not confirm this and stated that this would be unknown until a Chief Executive of the service had been appointed on 1st April, 2006.

Councillor Mrs Lucas thanked Malcolm for his informative presentation and informed him that the views of the North Area Forum would be submitted to Scrutiny Board (4) (Health) as part of the overall consultation process. The Forum endorsed this approach.

South West Area Forum: 23 February 2006

Consultation: "Configuration of ambulance trusts in England"

The Area Forum received a presentation by Malcolm Hazell, Chief Executive of the Coventry and Warwickshire Ambulance NHS Trust, on proposals by the NHS (Department of Health) for the reconfiguration of ambulance trusts in England and Wales. A consultation document issued by the NHS had been circulated with the agenda for this meeting. Tabled at the meeting was an appraisal, written by Malcolm Hazell and subsequently endorsed by the Board of the Trust, which was critical of the proposals in the consultation documents in a wide range of respects. Councillor Joe Clifford, Chair of the City Council's Scrutiny Board (4) (Health), attended the meeting for the consideration of this issue, outlined the Scrutiny Board's role and their concerns so far (although they were still drawing evidence together and had not come to definitive conclusions), encouraged people to look at the Scrutiny Board's website in that connection and emphasised the importance of people making their views known.

The consultation documentation circulated indicated that the proposals involved the establishment of eleven ambulance trusts across England, which had been designed to improve service delivery. The proposals affecting Coventry involved the four ambulance trusts covering Staffordshire; Coventry and Warwickshire; West Midlands and Shropshire; and Hereford and Worcester being replaced by one ambulance trust covering the whole of the West Midlands area. Within this structure, there would be locally managed operational "delivery units" within the overall strategic management. In his presentation, Malcolm Hazell expressed grave concerns about the reasons for the proposals and their consequences on the effectiveness of the service as a result of the sheer size of the new area to be covered by the new Trust and their possible effects on the standard of patient care.

He also drew attention to the fact that, although the NHS consultation document indicated that the closing date for the receipt of all responses was the 22nd March 2006, administrative procedures in preparation for the management and operation of the new enlarged Ambulance Trusts, including the recruitment process, had already commenced.

In response to a question, he voiced concern about the future of the air ambulance. Malcolm concluded by urging Area Forum members to participate in the consultation process by opposing the proposed merger of the four Ambulance Trusts in the West Midlands to form a single Regional Trust.

Individual members highlighted the importance of ensuring that Coventry people continued to benefit from a high-quality ambulance service, both in terms of emergency provision and out-patient services, and that they get at least a good as a service as they have now.

In addition, concern was expressed regarding the possible confusion when calling for an ambulance. An example cited was the despatch of an emergency ambulance to Stoney Stratford, instead of to Stoneleigh, Warwickshire. This would be exacerbated when the proposed area under a Regional Trust covered a far more extensive area, particularly if the call centre staff were located a significant distance away and lacked local geographic knowledge.

Most of the people who spoke on this matter expressed serious reservations about the proposals and were not convinced of their validity.

In conclusion, the Chair urged people to read the paperwork, and to convey their comments to the relevant authorities - namely, to David Nicholson at the West Midlands Consultation Office, to the appropriate Government Minister and to the local Members of Parliament - as well as to Scrutiny Board (4) for their awareness.

Appendix 7

Response by University Hospitals Coventry and Warwickshire NHS Trust to *Configuration of ambulance trusts in England*, approved at the UHCW Trust Board meeting on 28 February 2006.

"Reconfiguration of ambulance trusts

UHCW believes that there is a better option, than the recommendation in the consultation to create a large Ambulance Trust to cover the whole of the West Midlands.

The West Midlands South SHA, UHCW, Coventry PCT and the former Warwickshire Ambulance Service worked together very successfully to create the new Coventry and Warwickshire Ambulance Trust from 1 April 2005. This new organisation has already shown that aligning ambulance services to a natural local health community brings significant service benefits. We believe that this service should be retained, as a reintegration of the Coventry and Warwickshire Service into a much larger organisation would lose the benefits that we have already achieved and that are planned to further grow from this new organisation.

The local collaborative working across the Ambulance Trust with primary, secondary and social care has already delivered improvements in quality standards and operational service integration. We believe that a merger with other ambulance services would make it more challenging for UHCW and other providers in Coventry and Warwickshire to deliver the required health care standards and targets for the Annual Health Check. It is not proven that a single West Midlands Ambulance Service would be more financially economic and that the service, in terms of efficiency and performance standards, would improve.

UHCW asks therefore that the proposal in the consultation document be reconsidered to include the continuation of a separate Coventry and Warwickshire Ambulance Trust."