Health and Social Care Committee

Meeting Venue:
Committee Room 4 – Tŷ Hywel

Meeting date:
11 October 2012

Meeting time:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

1. Introductions, apologies and substitutions

2. Health board reconfiguration plans – Hywel Dda Health Board (09.30 – 10.55) (Pages 1 – 6)

HSC(4)-26-12 paper 1

Chris Martin, Chair
Trevor Purt, Chief Executive
Kathryn Davies, Director of Therapies & Health Science
Chris Wright, Director of Corporate Services

Break 10.55 – 11.05

3. Health board reconfiguration plans – Betsi Cadwaladr University Health Board (11.05 – 12.30) (Pages 7 – 34)

HSC(4)-26-12 paper 2

Geoff Lang, on behalf of Chief Executive
Neil Bradshaw, Director of Planning
Dr Brendan Harrington, Chief of Staff Children and Young People
Sally Baxter, Assistant Director, Strategy and Engagement

Break 12.30 – 13.30

4. Health board reconfiguration plans - Patients' Association 13.30 - 14.15 (Pages 35 - 38)

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Ann Lloyd, Trustee
Heather Eardley, Director of National Projects

5. Papers to note (Pages 39 - 40)

Minutes of the meeting held on 27 September

5a. Health board reconfiguration plans - Letter from the Older People's Commissioner for Wales (Pages 41 - 45)

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Agenda Item 2

GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

BRIEFING FOR HEALTH & SOCIAL CARE COMMITTEE
THURSDAY 11 OCTOBER 2012

1. Background

Hywel Dda Health Board recently launched a consultation on its Clinical Services Strategy, which will run from 6 August – 29 October 2012.

The purpose of the consultation is to seek public and stakeholder views on our proposals for the future of healthcare in our area and follows an extended period of clinical, stakeholder and public engagement (see Section 4 below).

The Health Board's vision (See Section 2 below) is to:

- Improve health and wellbeing for all
- Move from a sickness to a wellness service with a focus on chronic disease management and the demographic challenges we face
- Deliver quality healthcare in the most appropriate setting with care provided as close to home as possible
- Have person-centred, high quality, safe and sustainable hospital services that meet the needs of our population
- Be recognised as Wales' leading integrated rural health and social care system

Our consultation is a response to the over-arching strategic direction in Wales and has taken into account of *Together for Health: A Five-Year Vision for the NHS in Wales (2011); NHS Wales: Forging a better future. A report by the Bevan Commission 2008 – 2011 (2011); Our Healthy Future (2009); Rural Health Plan – Improving Integrated Service Delivery Across Wales (2009); Setting the Direction: Primary and Community Services Strategic Delivery Programme (2010)* and a number of other all-Wales strategies (see Section 3 below).

Our plans have been discussed with the National Clinical Forum on two occasions with the most recent in June 2012 (see Section 5 below).

A number of key pieces of evidence are submitted in bilingual format with this briefing:

- Consultation Document
- Summary Consultation Document
- Questionnaire
- Presentation of our strategy (DVD format)

Each section of the brief will refer to the relevant section in the main Consultation Document.

The consultation is supported by a series of Technical Annexes, which analyse current and future service delivery across all aspects of healthcare. These are substantial documents and are not included with this submission but are available in bilingual formats at www.hywelddahb.wales.nhs.uk/consultation - along with details of our consultation plan and other consultation resources.

2. Key Principles

Our aim throughout the process has been to ensure that we can provide our population (and the populations of other Health Boards who access our services) with high quality, safe and sustainable services that meet the needs of local people. (*See Consultation Document: Introduction and Setting the Scene*).

We need to address the challenges we face. The process has been clinically-led and we considered a number of options before reaching a conclusion on those that have a clinical fit and are deliverable (this is covered in more detail in the *Consultation Document: What we have done so far* section).

In terms of sustainability, a key challenge facing the NHS in Wales is recruitment and training of Doctors – particularly in Emergency Medicine and Paediatrics (these issues are covered in the *Consultation Document: Hospital Services* section).

A financial overview is contained within the Technical Annexes (Background and Introductions) and in the *Consultation Document: Making every penny count* section.

Following agreement with key clinicians and stakeholders, including the Community Health Council, we adopted the following criteria to assist in developing options:

- Quality and Safety
- Workforce
- Accessibility
- Deliverability
- Strategic Fit
- Health and socio-economic impact (including equality impact)

3. Alignment

3.1 Together for Health

Our vision is fully aligned with the Minister's strategic direction as identified in the Welsh Government's 5-Year vision for the NHS: *Together for Health*, (November 2011).

Our objectives are:

- to provide 80% of healthcare as close to home as possible with a significant element being provided in a primary and community setting
- ensuring our acute services are of the highest standards and sustainable
- having a focus on improving the health of our citizens and to support this aim we have made 10 pledges to the local population:

In 3 years time we will:
- Help 12,000 people to lose weight
- Help 5,000 people to stop smoking or prevent from starting
- Help prevent or stop 7,500 people drinking to excess
- Increase by 20,000 a year the number of people treated in a community setting that would have previously been treated in hospital

In 5 years time we will:
- Help prevent 200 people a year from developing heart disease
- Ensure, wherever possible, that no one with a known Long Term Condition is admitted unexpectedly to hospital with that condition
- Reduce the number of people dying from cancer by 100 a year
- Help prevent 125 people a year from suffering a stroke
- Double the number of mothers breastfeeding their babies from birth up to 6 months of age

In 10 years time we will:
- Increase life expectancy by 3 years in the areas with the lowest life expectancy and improve quality of life for all

Our strategy builds on these pledges and focuses on developing care closer to home, improving access to the wider primary care team and addressing the transport issues our rural geography presents.

3.2 Local Views

We take into account the views of our population but our role is to ensure the services we provide are clinically safe and appropriate, sustainable, equitable in terms of access and of the highest quality.

Our services (whether provided or commissioned) must meet the needs of our population and we must plan their delivery taking into account demography, Royal College Standards, workforce availability, deliverability and affordability.

This means that we will never be able to provide all the services that our disparate population might want.

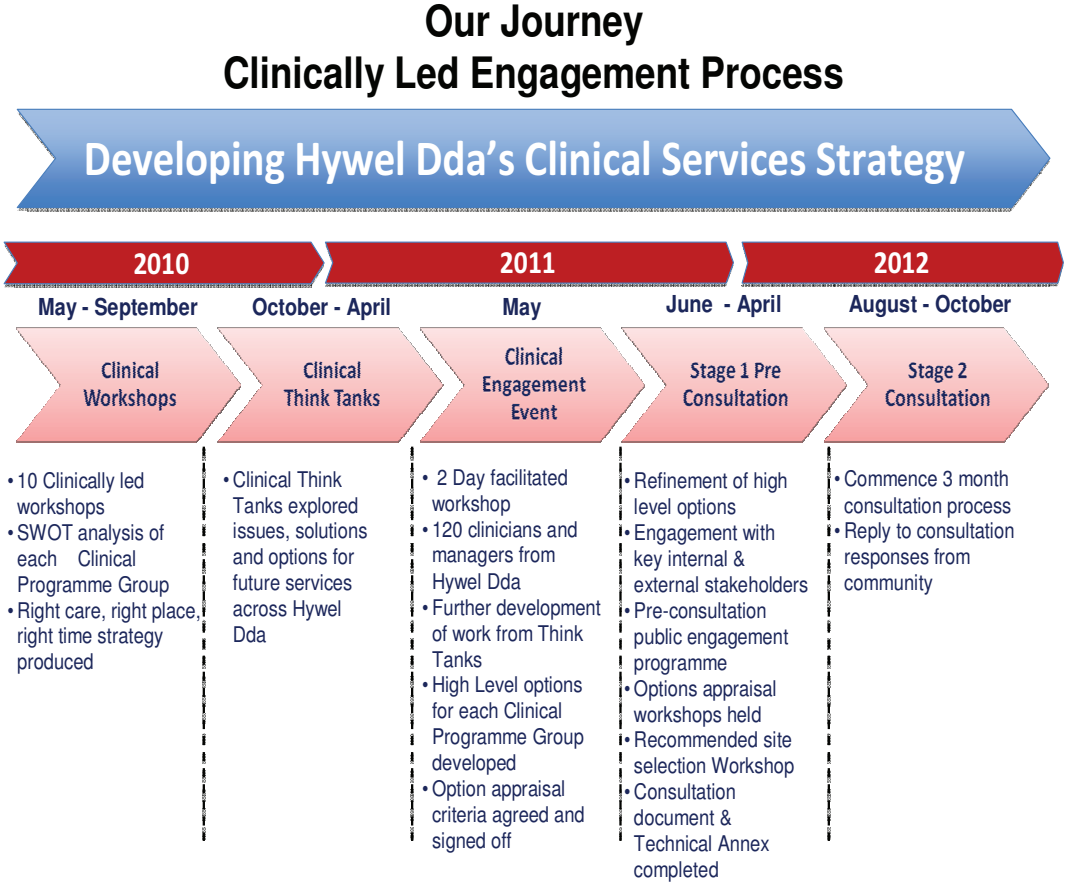
However, our vision does include the repatriation of some services, and a commitment that where patients need to travel for care they are repatriated to a local setting as soon as they are fit to travel.

Our engagement process has shown us that a significant proportion of our population support the move to more care closer to home, that quality and safety are paramount and that we make best use of the resources we have. However, there is an equal spilt in terms of supporting specialised services on fewer sites or not (see *Consultation Document: What we have done so far* section).

4. Consultation Process

We have carefully followed the Ministerial Guidance: *Guidance for Engagement and Consultation on Changes on Health Services* - issued in March 2011, which describes a two stage process for consultation and the Board has assured itself of compliance at each stage.

The diagram below describes the process of engagement and consultation undertaken between April 2010 and the launch of the consultation in August 2012.



This process has aimed to be robust, comprehensive and inclusive and the listening and engagement period and consultation plan have been assured by the Consultation Institute (recognised experts in the field of consultation). We have aimed to be innovative and have also adopted best practice, wherever possible.

4.1 Analysis of Responses

During an extended period of engagement with our citizens (December 2011 – April 2012), we invited feedback on our vision.

We commissioned an independent company – Opinion Research Services (ORS) – to collate and analyse all the feedback and publish the findings. This report and a subsequent appendix can be found at www.hywelddahb.wales.nhs.uk/consultation and the process is described in more detail in the *Consultation Document: What have we done so far (the engagement and consultation process)* section.

A similar process has been adopted for the consultation period where once again there will be independent analysis of the feedback received.

4.2 Impact on Plans

Our consultation document reflects on specific issues raised during the engagement phase. These include transport (see *Consultation Document: Addressing the issue of transport* section); a section specific to Prince Philip Hospital; and the reasons for some speciality services not being on site.

The engagement process highlighted some specific issues:

- Bronglais Hospital – the original options included a range of proposals to centralise services away from the site. As a result of the feedback received – and in recognition of its unique location and strategic importance – these options were removed from the final consultation preferred options l.
- Emergency services in Prince Philip Hospital - the options put forward for consultation were adapted to include a consultant led Emergency Medical Admissions Unit and maintain the medical take on the site, neither of which were- in the original option.

Any alternative suggestions for service configuration put forward through the consultation must be safe and sustainable, deliverable both in terms of finance and medical staffing, and supported by our own clinicians. Should such alternatives be made we would undertake a revised options appraisal process (see page 13 of the Consultation Document), which would be considered by our planners and clinical teams before making final proposals to the Board.

5. National Clinical Forum

The Health Board has presented to the National Clinical Forum on two occasions:

- December 2011 – where a number of potential issues were identified, particularly in relation to the sustainability of some medical rotas.
- June 2012 – where the Forum indicated broad support for our plans. The Forum found that the proposed options for consultation were clinically appropriate and safe, and was encouraged that our ideas had developed from the December 2011 meeting, with a significant focus being afforded to out of hospital services.

6. Next Steps

The consultation will close on 29 October 2012 and, following a period to consider the feedback and whether there are alternative solutions, the Health Board will approve the final options for implementation.

Implementation will be incremental with a robust gateway mechanism in place under the guidance of an Implementation Board, with Clinical Programme Groups (CPGs) designing the service pathways.

We will continue to involve our citizens in the development of pathways with a "Patient's Council" as an integral element of the gateway process and with members of our engagement scheme (Siarad Iechyd/Talking Health) embedded in the CPG process. (For more details of this scheme visit www.talkinghealth.wales.nhs.uk).

Our vision is predicated on elements of capital development and the associated timeline.

More detail is contained within the *Consultation Document: How we will deliver the changes* section.

Health & Social Care Committee

HSC(4)-26-12 paper 2

Health board reconfiguration plans – Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Healthcare in North Wales is Changing

1. Context

The Health and Social Care Committee has invited the University Health Board to attend a session on Thursday 11th October 2012 to allow the Health Board to present information on proposed reconfiguration plans, and to allow Members of the committee the opportunity to ask questions about the development of the proposals.

In particular the committee wish to consider the following areas:

- Key principles/criteria adopted to guide reconfiguration plans;
- The extent to which proposals are in keeping with
  - Strategic direction set by the Minister;
  - The views of local populations
- How consultation undertaken to date has taken place;
- How responses to consultation have been gathered, analysed and taken into account to date;
- How responses to consultation received to date may impact the proposals as originally presented;
- The role and relationship with the National Clinical Forum;
- Further information about the next steps for the proposals;

This briefing document is structured around these key headings.

Together with this briefing, a number of pieces of key evidence are embedded in Annex 1 – including:

- Our final Board paper in July 2012 summarising the review outcomes and proposals for change;
- A summary of the Board's decisions in July 2012
- Our consultation document – *"Healthcare in North Wales in Changing";*

- Our consultation questionnaire;
- Our consultation leaflet.

These formal documents are supported by a large volume of evidence and technical papers, impact assessments, strategy documents and wider documents relating to our service reviews. These documents cover the breadth of the challenges facing the NHS in North Wales as we seek to develop high quality and sustainable services. These technical documents are published in the public section of our website under each service review, via: http://www.wales.nhs.uk/sitesplus/861/page/42847

2. Background to Consultation

The Health Board entered a period of formal public consultation on 20th August 2012, and this will run until 28th October 2012. The consultation continues a process of service reviews across North Wales that has been ongoing for the three years since the Health Board was formed, and has included very extensive clinical, professional and stakeholder engagement.

The proposals under consultation are those relating to:

- Community and Locality services – proposals to implement enhanced care at home, supporting people in their own homes, avoiding hospital admission. Proposals to enhance the range of services delivered at a local level through changes to the network of community hospitals and supporting services, and;
- Older Peoples Mental Health services;
- Neonatal Intensive Care services;
- Vascular services – including complex arterial surgery;

The Health Board has also been undertaking reviews in other areas, notably Non-Elective General Surgery, Trauma and Orthopaedics, and Women's and Children and Young Peoples services. In these areas, the Board determined, with the agreement of the Community Health Council, that our proposals to change and enhance these services in a sustainable way, do not constitute substantial change that requires formal consultation. We plan to maintain these services on all three of our acute DGH sites, with stronger networking across the region. Work is ongoing with these areas to identify how professional and clinical standards will be delivered sustainably.

In all of these service areas the levels of engagement with stakeholders, patients and their representatives has been very high throughout our

discussions. Our approach to continuous engagement was presented to the Health & Social Care committee at its meetings on 17th November 2010 and again in early 2011.

The objective of our consultation is to continue the dialogue we have established with our stakeholders over the past three years, and to allow patients, staff, partners and the wider public to contribute their views on the Board's proposals for service change.

This dialogue and engagement is a meaningful process that the Health Board, as a clinically-led organisation is fully committed to. It has led to the proposals that we are consulting on

3. Key Principles

Our strategy, vision and proposals for service change are aimed at addressing a clinical case for change, and are developed in accordance with the following core principles (the Triple Aim):

i. Improving the Population Health.
ii. Improving quality, safety and the patient experience.
iii. Controlling or reducing costs.

Our clinical vision, set out in our summary board paper, and in our consultation document in Annex 1 is that:

- The local population will enjoy health, well-being and independence equal to the best;
- Supporting people to take responsibility for maintaining their own well-being in their own homes is our main aim as a practising public health organisation, with primary and community services working in close collaboration with third sector and community groups;
- Out of hospital services should be accessible and available at convenient times, which are consistent and reliable wherever patients live;
- We want to make sure that when acute hospital care is needed, our hospital services can deliver the highest quality clinical outcomes;
- When urgent or specialist care is needed, providing this safely and reliably for the whole population builds community confidence that services are consistently available, safely staffed and that quality

standards will be achieved, all in order to deliver the best outcomes for patients. Building on our three main acute hospitals, this may involve networking some services to provide a reliable response for the whole population;

- Our services will be delivered by an appropriately trained and skilled workforce, with the opportunities to maintain and improve their clinical skills, supported by the necessary infrastructure;

Our aim throughout has been to ensure that we develop services that are fit for the medium and long term – that provide the people of North Wales with affordable, high quality, safe and sustainable services. Services that are built around clinical teams and skills, rather than tied to buildings. Services that meet the needs of patients, and are capable of adapting to our changing demographic and technological profiles.

In considering our consultation, it is important to understand the extensive process of service reviews which has led to those proposals being made.

The service reviews and the proposals we are consulting on have been developed using a methodology based upon the Institute of Healthcare Improvement's 3-cycle process of service improvement. This ensures that proposals for change have a rigorous evidence base and are grounded in multiple stages of detailed stakeholder engagement, leading to successive cycles of refinement of solutions.

We have placed professional standards and clinical guidance at the core of or work, with safety our overriding principle.

Each service review has been conducted separately to ensure that the most appropriate sustainable configurations for that service were developed, before the different streams were brought together to consider the range of interdependencies that exist between and within services. Services have also been designed to reflect the differing needs of urban and rural communities in North Wales. This was critical to building sustainable solutions from the bottom-up.

Through dialogue with stakeholder groups, patients and agreement with the Community Health Council, we have developed a set of non-financial criteria against which all of our proposals are assessed:

- ✓ Quality of care, including clinical safety
- ✓ Deliverability
- ✓ Accessibility
- ✓ Sustainability

- ✓ Acceptability
- ✓ Transparency

Each of these headline criteria has a number of assessment factors which add further differentiation to consideration of the proposals.

Each of the service reviews assessed these criteria for suitability with their own local stakeholders, and in some cases these have been adapted to enable a more appropriate appraisal of proposals.

In additional to the non-financial criteria, a fundamental principle for each of the service reviews has been to develop solutions that address issues of sustainability including financial, clinical, operational and workforce sustainability.

In setting out our proposals, we have been careful to ensure we can describe them fully in terms of financial impact, capital requirements, the types of staffing rotas and training opportunities they would entail, and how they would impact upon recruitment and retention of clinical and professional staff.

A further guiding principle throughout our work has been to provide services in North Wales (or to bring services back in to North Wales) where it made clinical and economic sense to do so. This helps build the resilience and sustainability of local services, as well as reducing travelling times for many of our patients, their families and carers.

4. Strategic Fit

4.1 National Strategy

Our proposals have been developed to align with the Minister's strategic direction set out in *Together for Health: A Five Year Vision for the NHS in Wales,* as well as The Bevan Commission report, *NHS Wales: Forging a Better Future.* We also referred to the strategic direction for primary and community services as set out in *Setting the Direction*, a report by Dr Chris Jones on behalf of Welsh Government which was produced in 2010; and also, the *Rural Health Plan for Wales*, 2009.

The Health Board's strategic direction in response to national policy is set out in *Our 5 Year Plan 2010-15: Bringing Services and People Together* produced in June 2010 and embedded in Annex 1.

As well as the Welsh Government's strategic direction, we have also paid particular regard to nationally published clinical and professional standards – for example, those set out by the British Association of Perinatal Medicine, All Wales Neonatal Standards, Birth Rate Plus, All Wales Dementia Action Plan, The Provision of Services for Patients with Vascular Disease.

All of these set the foundations for our work on future service models, and have been underpinned by the evidence base and messages from the literature in relation to each of the service areas.

We have summarised our proposals' alignment with this national direction in our consultation document as:

"In North Wales we will:

- ✓ *Support you to manage your own health and wellbeing*
- ✓ *Offer planned care closer to home or in centres of excellence*
- ✓ *Offer urgent care within a safe time and within a reasonable distance"*

4.2 Local Views

We have set out some of the views we have received during our engagement with stakeholders, in our consultation document in the section "What you have told us so far". In many cases the feedback from stakeholders has been crucial in refining the proposals for change we have developed.

Our engagement process has identified that a significant proportion of our population support our strategic direction:

- ✓ to provide more care out of hospital settings within patients' own communities and homes.
- ✓ to provide more specialist treatment in centres of excellence if better outcomes and safer services can be demonstrated.
- ✓ to bring services back into North Wales where it makes sense to do so.

Given the geography of North Wales, we have spent considerable time with stakeholders discussing the issues of rurality and transport. Whilst not everyone agrees, we have found a broad consensus amongst patients and carers that they are prepared to travel longer distances to ensure access to high quality or specialist services. This balanced by a desire to ensure we increase the scope of services provided within local communities.

The ability of relatives and cares to visit patients is important to stakeholders, and we are working closely with Community Transport providers, as well as Local Authority partners to improve the transport networks currently in place.

Stakeholders expressed concerns about possible communications difficulties as services change, and as a result we are developing single points of contact for referrals, and information with social services as part of our proposals.

Patients on the borders of our area – for example in South Meirionnydd – have told us they have concerns between our service change proposals and those of neighbouring health boards. We have worked with Hwyel Dda and Powys LHBs to ensure that patients who live within the BCULHB area but access services from Hwyel Dda (specifically Bronglais Hospital) are fully considered in both Health Boards' proposals. Similar discussions have also been held with English providers including the Countess of Chester Foundation NHS Trust and the Robert Jones and Agnes Hunt NHS Trust.

The views of patients and residents during our engagement events for Trauma and Orthopaedics, Women's and Children and Young People services and Non-Elective General Surgery were important in shaping our proposals to network these key services across all three of our DGHs.

5. Consultation Process

Our current proposals are the product of:

- our continuous engagement work in 2009/10 that led to the development of the North Wales Clinical Services Strategy;
- our continuous engagement work in 2010-2012 in each of our service review workstreams, as well as a number of combined events across North Wales;
- our public consultation which is running until 28th October 2012.

Throughout our engagement and current consultation process, we have sought to use a variety of media to present issues and enable stakeholders and patients to give us their views:

- engagement events;
- media briefings (print, broadcast and digital);
- stakeholder briefings;
- dedicated website with all public documentation;
- Printed material sent to every household in North Wales;
- Dedicated email address;
- Telephone hotline;
- On line questionnaire;

The consultation process is being supported by an independent analysis of questionnaire responses and other feedback

5.1 Continuous Engagement

We have followed in detail the Welsh Government guidance on continuous engagement and consultation ("*Guidance for Engagement and Consultation on Changes in Health Services, 2011*"). We have engaged staff, partner organisations and other stakeholders extensively in designing our plans prior to moving to consultation. We have also worked closely with the Consultation Institute, a widely respected not-for-profit advisory body, to ensure that continued compliance and robust, meaningful engagement has been written into our consultation plans from the outset.

A wide range of individuals and community group representatives, as well as partner organisations in the third sector and statutory services were involved in the engagement work to develop the North Wales Clinical Services

Strategy. This process was independently evaluated and was found to comply with the interim guidance on consultation and engagement.

Since then we have continued to involve stakeholders in the further development of our proposals for service change. Each service review has undertaken a number of discussion events at which stakeholders have been invited to contribute their views on the area in question. This has been augmented by regular update briefings being widely disseminated, including through the media. We have established 14 locality stakeholder groups which will have shaped the planning and development of their health services, working with the Locality Leadership Teams.

We have briefed major stakeholders on a monthly basis through a "Key Issues" update and we have held a series of briefing events for AMs, MPs, Local Authorities, Third Sector, Primary Care representatives and the Community Health Council.

We have talked to our main advisory groups – the Stakeholder Reference Group, Healthcare Professional Forum and the Local Partnership Forum – on a regular basis.

A series of stakeholder events have been held on specific service areas. We have also held drop in sessions which have been targeted at particular community and patient groups where we have needed more feedback from those groups which are likely to be affected. Our work on equality impact assessment of our proposals has highlighted some of the protected characteristic groups as needing further engagement and we are working on this as part of the formal consultation exercise.

We have used existing forums such as voluntary sector networks organised by the County Voluntary Councils, and forums of town and community councils, to present the issues and discuss concerns and views of these forums.

Overall, a very wide range of representatives, patient and community groups have been able to hear about the issues we have been considering and give us their views.

An overview of the detailed engagement activities/dates undertaken by each service review is contained within the final papers present to the Health Board in July 2012: http://www.wales.nhs.uk/sitesplus/861/page/62235. It is summarised in Annex 2.

5.2 Formal Consultation

The Guidance requires Health Boards to undertake a two stage process in relation to consultation, when it appears likely that formal consultation should take place. The first stage is to undertake extensive discussions with key stakeholders to explore the issues, refine the options and agree on the approach to questions.

We have included the key stakeholders identified in this part of the guidance in our engagement processes, and included a specific formal approach under the terms of this part of the guidance. This included presentation to the Stakeholder reference Group; the Healthcare Professional Forum; the Local Partnership Forum and the Community Health Council. A presentation was made to an all-North Wales LSBs' meeting on the potential options and the approach to consultation.

The details of our consultation process are set out in our consultation document in the section "Have your say on our proposals". All of our consultation material is bilingual.

We have commissioned the Consultation Institute, an independent not for profit organisation, to undertake a compliance assessment on our consultation process. The Institute has indicated that they will sign off the scoping document, project plan and mid-consultation review for the consultation process – confirming that it complies with the Guidance and with good practice. There will be a formal final sign off at the end of the whole consultation process.

A scoping document for the consultation was presented to the Community Health Council and agreement reached on the issues to be covered. The scoping document has also been signed off by the Consultation Institute, together with the project plan.

Our consultation was launched with a media briefing (print and broadcast) that coincided with the delivery of an information leaflet to every household in North Wales.

The consultation runs from 20th August until 28th October 2012, and anyone with an interest in our proposals can have their say by:

- Attending any of our 48 formal public meetings held in 16 different locations across North Wales – the dates/locations are set out on p39 of our consultation document.
- Writing to us via our Freepost address or dedicated email address.
- Phoning our free telephone helpline

- Completing the formal questionnaire – either in print or online via our consultation website: www.bcuhbjointhedebate.wales.nhs.uk
- Contacting the Community Health Council – with whom we have worked closely in designing our consultation process.

ORS have been commissioned to undertake a number of small discussion groups and household surveys to capture more targeted feedback to complement that received directly through the Health Board's activities.

5.3 Analysis of Consultation Responses

We have commissioned Opinion Research Services (ORS), a specialist social research practice to collate, analyse and report on all of our formal consultation responses.

Responses are primarily received via the formal questionnaire. Loggists are also capturing all responses made via public meetings, letters and emails, to feed into the ORS analysis.

ORS will produce a standalone summary of the responses, as well as a full report on the consultation findings.

5.4 Impact of Responses on Plans to Date

We have set out above how feedback during our continuous engagement phases has been key in helping to shape our proposals – particularly around transport, the development of centres of excellence supported by a network of acute services across all three acute DGH sites, and the development of locality hubs.

It is too early in our formal consultation to make an assessment of responses received to date on the proposals we are considering. However, where responses have related to the presentation of material or the organisation of events, these have resulted in appropriate changes being made. Where demand has been high for public meetings we have amended our arrangements to accommodate more attendees.

Any alternative proposals that are suggested during the consultation will be considered, and subjected to the same non-financial and financial assessment criteria set out above. They will also be considered in terms of

the Triple Aim and the objectives of delivering safe, affordable, high quality and sustainable services.

6. National Clinical Forum

The Health Board presented to the National Clinical Forum in February and June 2012.

During the February visit, the Health Board presented the clinical case for change from each review work stream, focussing on issues of safety, standards and sustainability. Particular attention was paid to the sustainability of medical staffing rotas and medical training, as well as the delivery of national clinical standards set in the local North Wales context of geography and demography.

In June 2012, the Health Board presented the draft proposals to address the issues raised in the clinical case for change. The Forum's detailed response is shown in Annex 3. Broadly, the forum were supportive of the proposals being put forward as clinically safe and appropriate responses to the case for change. They raised questions relating to the clinical interdependencies between a number of services, which were fed into our final proposals.

7. Next Steps

The consultation period closes on 28th October 2012. A period will follow to allow ORS to complete their analysis, and for service reviews and clinical teams to consider the consultation report and any alternative proposals that have been made. We will also take account of the views of the Community Health Council and any views they have heard.

The supporting technical documents will be updated and developed to reflect the outcomes of the consultation.

The Health Board will then decide, in the light of the consultation and other information gathered, whether to proceed with the proposals as set out or to amend them in light of the consultation feedback. We anticipate that this decision will be taken at a public meeting of the Health Board in December 2012.

Implementation will follow in early 2013. We will aim to have completed the changes by 2016.

Annex 1

Library of key documents to support this briefing paper:

July 2012 Board Paper

Summary of Board Decisions, 19 July 2012

Our Consultation Document

Our Consultation Questionnaire

Our Consultation leaflet – link unavailable

Our 5 Year Plan

Our Consultation website

Our Service Reviews website

Link to all of our July 2012 Board papers

Annex 2

Summary of the detailed engagement activities/dates undertaken by each service review

A: Extract from Locality & Community Services final Board Paper, July 2012:

"Particular areas of work which have supported this Review include:

- Health, Social Care and Well-Being Strategies for each county area
- The creation of 14 localities across North Wales each with a multi-agency Locality Leadership Team and Locality Stakeholder Group (see Appendix 1)
- The Llangollen Hospital project
- The Llandudno Hospital project
- North Denbighshire Project
- Meetings with GPs and hospital doctors in the evenings and at Grand Round meetings
- Presentations to Local Authority Scrutiny Committees
- Specific forums eg. Flintshire County Forum, Ffestiniog Development Group,
- Meetings with the Local Medical Committee

In addition the Chronic Conditions pathfinder work has been completed in Gwynedd and South Wrexham, as a Demonstrator site for Wales, which has also influenced our review, with evidence of engagement to support a number of priority areas.

A major conference was held in May 2011 bringing together about 120 people from our Clinical Programme Groups, Local Authorities, Voluntary Sector and Primary care contractors to identify priority themes for the development of locality working. This identified widespread support for the development of integrated community based services within localities. Participants reflected upon the learning and successes of existing service models which included the improved integration of health and social care services, delivery of intermediate care and CCM Demonstrator projects.

On the 9th November 2011 an engagement event was held with around 100 stakeholders to consider further how we prioritise the work required to deliver the model of care in our local communities. In particular the participants considered 3 key priority areas, namely prevention, enhanced care at home and moving services from acute hospitals to local communities. Comments and themes raised by participants have been recorded and where used in the development of further locality engagement meetings.

From January to June 2012 further significant engagement has been undertaken at a locality level. Locality Stakeholder Groups have been established with a wide spectrum of local representation including, locality based community staff, County, Town and Community Councillors, Hospital League of Friends representatives, local

voluntary sector groups, social services, GP practices and the Community Health Council.

A series of three meetings were held with each Locality Stakeholder Group to:

1) Present and agree the Case for Change and the 3 priority areas,

2) Present and agree a Generic Locality Model of Care

3) Present and discuss various scenarios at a local level in implementing the Locality Model of Care

Around 240 stakeholders attended each set of meetings held across North Wales, with an average of 40 people for each local meeting. The North Denbighshire stakeholders group has been in place for a longer period and have been considering the service needs of that Locality with a particular focus on the Glan Clwyd Hospital Project."

B: Extract from Older People's Mental Health Services final Board Paper, July 2012:

"Internal and external engagement commenced in July 2011 and to date the following events have been held for all stakeholders including staff:-

Date	Venue
20th September 2011	Porthmadog
22nd September 2011	Llangefni
6th October 2011	Wrexham
13th October 2011	Deeside
19th October 2011	Rhyl
24th October 2011	Llandudno Junction
3rd April 2012	Pwllheli
5th April 2012	Dolgellau
17Th April 2012	Mold
24th April 2012	Rhyl
26th April 2012	North Powys
10th April 2012	Llangefni
18th April 2012	Wrexham
25th April 2012	Colwyn Bay
16th May 2012	West, North and Central Wrexham
18th May 2012	Arfon and Anglesey
22nd May 2012	Meirionnydd and Dwfor
18th May 2012	Conwy East and West
25th May 2012	Flintshire
25th May 2012	Central and south Denbighshire
22nd May 2012	North Denbighshire

Throughout the review updates have been provided to the following:-

- Healthcare Professional Forum, Stakeholder Reference Group and Local Partnership Forum, Updates at Older Peoples Forums, Locality Leadership Meetings, GP Practice Managers Meetings"

C: Extract from Vascular Services final Board Paper, July 2012:

"The review commenced after the other acute service reviews, and internal and external engagement commenced in January 2012. To date the following actions have been undertaken:-

Internal and external briefings following key stages agreed in the project board (eg commencement of review, following the first clinical workshop, when the case for change was adopted).	Multiple dates
A clinical workshop for all clinicians involved in delivering the service.	20th March 2012.
Update to Health Professionals Forum.	11th June 2012
Update to Stakeholder Reference Group.	11th June 2012
Updates to Inter-CPG Group (multiple sessions);	May-July 2012
A dedicated CHC briefing session for the project board representative	16th April 2012.
Presentation of the case for change and service models being developed to the National Clinical Forum.	27th June 2012
Inclusion in briefings and other stakeholder events as appropriate - eg CHC briefing sessions, Town & Community Council scrutiny meetings, and the series of non-elective general surgery stakeholder events;	Multiple dates

D: Extract from Paediatric & Child Health and Maternity, Gynaecology & Neonatal Services final Board Papers, July 2012:

"Internal and external engagement commenced in July 2010 and was undertaken jointly with the Maternity, Gynaecology and Neonatal work stream. To date the following events and actions have been undertaken:-

Summary of engagement events

9th September 2010: Stakeholder Event (Llandudno)
September 2010: Interviews with service users – Paediatrics & Neonatal
27th September – 3rd October: Interview with service users – Women's
5th October 2010: Stakeholder Event (Llandudno)
2nd November 2010: Discussion Forum for GPs
1st March 2011: GP Focus Group Llandudno
2nd March 2011: GP Focus Group Holywell
18th & 19thApril 2011: Paediatric Consultant Focus Group
26th & 28TH April 2011: Women's Consultant Focus Group
8th May 2011: Drop in session YG
14th May 2011: Drop in session WMH
11th May 2011: Drop in session Central (Faenol Fawr)
19th May 2011: Young People's consultation Event
11th July 2011: BCU Drop in session (West)
19th July 2011: county stakeholder event, Porthmadog
21st July 2011: county stakeholder event, Wrexham
2nd August 2011: BCU Drop in session (East)
4th August 2011: county stakeholder event, Llangefni
9th August 2011: BCU Drop in session (Central)
11th August 2011: County stakeholder event, Mold
17th August 2011: County stakeholder event, Ruthin
18th August 2011: Local Authority and Third Sector stakeholder event, Faenol Fawr, Bodelwyddan
23rd August 2011: County stakeholder event, Colwyn Bay

2nd September 2011: Summer Briefing for AMs, CHC, on all the reviews
7th September 2011: Women's CPG Focus Group
7th November 2011: Update on Reviews
8th May 2012: BCU Drop in session (West)
14th May 2012: BCU Drop in session (East)
11th May 2012: BCU Drop in session (Central)
On line questionnaire

The above has been supported by:-

- Bi-monthly CPG drop in sessions and team meetings
- Updates to Children and Young People's Partnerships
- Local Midwifery Liaison committee
- Stakeholder Reference Group
- Health Professional Forum
- Local Partnership forum
- BCU Briefings following every project board meeting
- Monthly update to partners via the Key Issues document "

E: Extract from Non-Elective General Surgery service final Board Paper, July 2012:

"There has been significant engagement with stakeholders and particularly clinicians.

A summary of the engagement events is as follows:

Date	Event
1 September 2010	Briefing for clinicians (St Asaph)
28 September 2010	Briefing for consultant surgeons and anaesthetists – open session (Bodelwyddan)
12 October 2010	Stakeholder briefing (Wrexham)
13 October 2010	Stakeholder briefing (Bangor)
14 October 2010	Stakeholder briefing (Bodelwyddan)
15 October 2010	Stakeholder workshop (St Asaph)
2 November 2010	Primary Care Discussion Forum (joint, Bodelwyddan)
3 November 2010	Discussion forum for surgeons, anaesthetists and radiologists (Bodelwyddan)
5 November 2010	Second stakeholder workshop (St Asaph)
1 April 2011	Clinical engagement, general surgery consultants
5 July 2011	Clinical engagement, general surgery consultants
18 August 2011	Clinical engagement, general surgery consultants
6 September 2011	Clinical engagement, general surgery consultants
8 November 2011	Stakeholder workshop (Colwyn Bay)
13 January 2012	Clinical engagement, general surgery consultants
14 May 2012	Stakeholder drop in session, Colwyn Bay
21 May 2012	Stakeholder drop in session, Rhyl
25 May 2012	Stakeholder drop in session, Wrexham
28 May 2012	Stakeholder drop in session, Connah's Quay
29 May 2012	Stakeholder drop in session, Caernarfon

30 May 2012	Stakeholder drop in session, Dolgellau
31 May 2012	Stakeholder drop in session, Anglesey
14 June 2012	Combined service reviews primary & secondary care session, Wrexham
19 June 2012	Combined service reviews primary & secondary care session, Bangor
20 June 2012	Combined service reviews primary & secondary care session, Bodelwyddan

Information briefings have been released to the media, to project board members and staff and their representatives and placed on the website after significant project board meetings and at key points during the project."

F: Extract from Trauma & Orthopaedic services final Board Paper, July 2012:

"The work to develop a 5 year clinical services strategy for orthopaedics commenced with a series of internal and external stakeholder briefings in summer 2010.

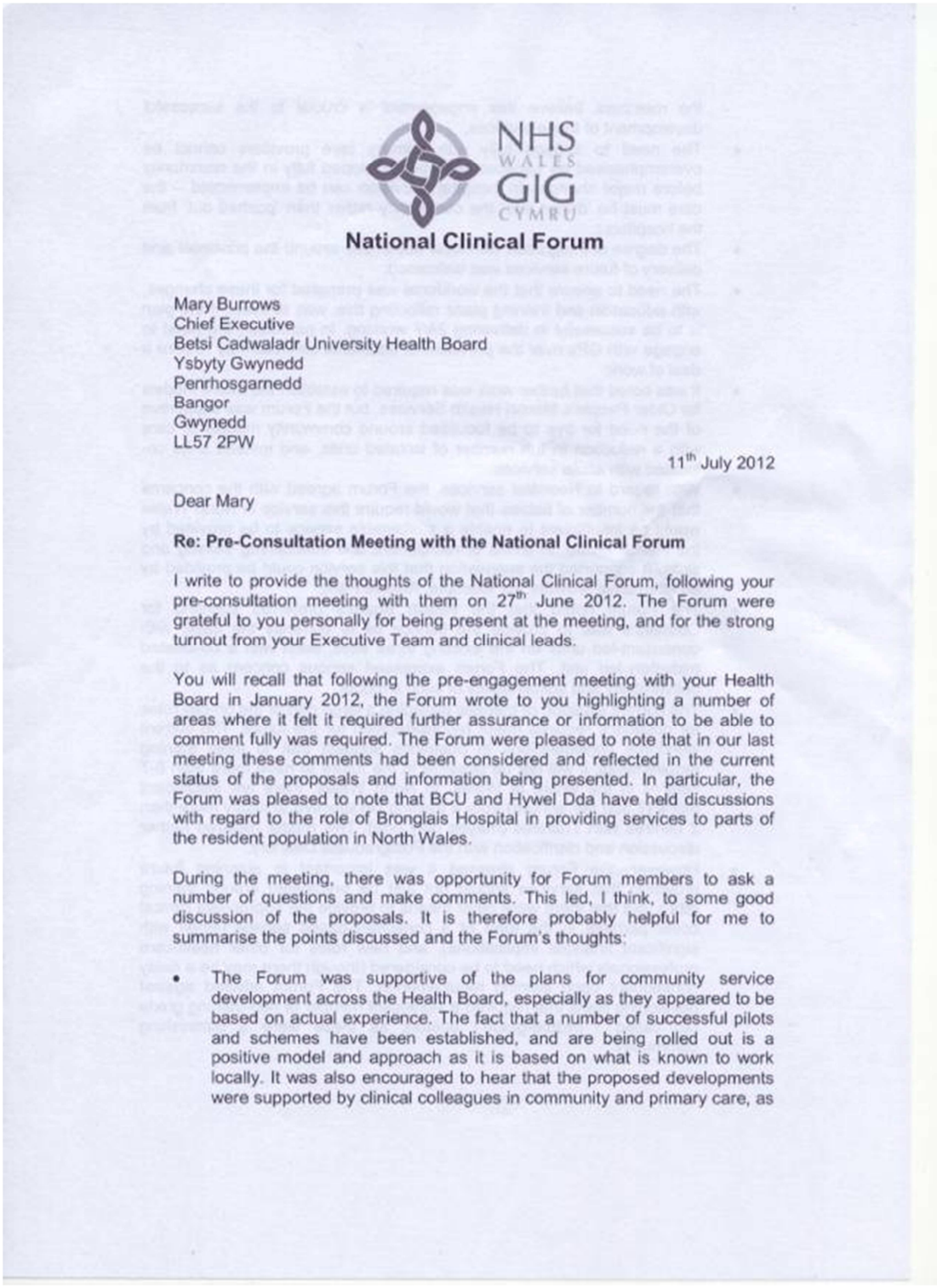
To date the following engagements events have taken place:

A series of internal and external briefings following key stages agreed in the project board (eg commencement of review, following stakeholder/clinician workshops, when the case for change was adopted by BCU Board).	Multiple dates
4 internal/external stakeholder events with attendance from approximately 300 stakeholders and partners in total – coinciding with the 3 cycles of the review and formal feedback periods on all review documentation	30th July 2010 3rd September 2010 22nd October 2010 10th November 2011
4 secondary care clinician workshops – 23/09/10, 20/10/10, 05/05/11, 20/10/11);	23rd September 2010 20th October 2010 5th May 2011 20th October 2011
A series of update briefings with other service reviews at key points during the work;	Multiple dates.
Publication on the internet/intranet, and circulation to all stakeholders of all draft project documentation with a defined formal feedback period before documents were adopted.	Ongoing.
Regular updates to Health Professionals Forum, Stakeholder Reference Group, Local Partnership Forum, and Inter-CPG Group;	Multiple dates, most recently 11th June 2012
Inclusion in briefings and other stakeholder events as appropriate – eg CHC briefing sessions, General Surgery stakeholder events;	Multiple dates throughout the review.
Presentation of the case for change and service models being developed to the National Clinical Forum in February and June 2012;	February 2012 27th June 2012

Feedback from stakeholders informally or via feedback sheets from events has been very positive about the process and levels of engagement – particularly with patients, patient representatives and carers."

Annex 3

Feedback from National Clinical Forum



NHS WALES GIG CYMRU

National Clinical Forum

Mary Burrows
Chief Executive
Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Penrhosgarnedd
Bangor
Gwynedd
LL57 2PW

11th July 2012

Dear Mary

Re: Pre-Consultation Meeting with the National Clinical Forum

I write to provide the thoughts of the National Clinical Forum, following your pre-consultation meeting with them on 27th June 2012. The Forum were grateful to you personally for being present at the meeting, and for the strong turnout from your Executive Team and clinical leads.

You will recall that following the pre-engagement meeting with your Health Board in January 2012, the Forum wrote to you highlighting a number of areas where it felt it required further assurance or information to be able to comment fully was required. The Forum were pleased to note that in our last meeting these comments had been considered and reflected in the current status of the proposals and information being presented. In particular, the Forum was pleased to note that BCU and Hywel Dda have held discussions with regard to the role of Bronglais Hospital in providing services to parts of the resident population in North Wales.

During the meeting, there was opportunity for Forum members to ask a number of questions and make comments. This led, I think, to some good discussion of the proposals. It is therefore probably helpful for me to summarise the points discussed and the Forum's thoughts:

- The Forum was supportive of the plans for community service development across the Health Board, especially as they appeared to be based on actual experience. The fact that a number of successful pilots and schemes have been established, and are being rolled out is a positive model and approach as it is based on what is known to work locally. It was also encouraged to hear that the proposed developments were supported by clinical colleagues in community and primary care, as

the members believe this engagement is crucial to the successful development of these services;

- The need to engage fully with primary care providers cannot be overemphasised as services must be developed fully in the community before major changes in 'hospital' provision can be implemented – the care must be 'drawn into' the community rather than 'pushed out' from the hospitals.;
- The degree of integration with local authorities around the principals and delivery of future services was welcomed;
- The need to ensure that the workforce was prepared for these changes, with education and training plans reflecting this, was stressed if the plan is to be successful in delivering 24/7 working. In particular, the need to engage with GPs over the provision of additional services may require a deal of work;
- It was noted that further work was required to establish the future models for Older People's Mental Health Services, but the Forum was supportive of the need for this to be focussed around community models of care with a reduction in the number of isolated units, and instead units co-located with acute services;
- With regard to Neonatal services, the Forum agreed with the concerns that the number of babies that would require this service in North Wales would be insufficient to enable a sustainable service to be provided by the Health Board, in terms of recruitment and maintaining training and skills. It supported the suggestion that this service could be provided by an alternative provider, for example, Arrowe Park;
- The Forum noted that the Health Board's preferred scenario for Obstetrics was to provide the service as is currently the case, with consultant-led units on the existing three sites, each with a co-located midwifery-led unit. The Forum expressed serious concern as to the deliverability and sustainability of such a model.
- The current situation of trainees providing a large part of the on-call rotas for obstetrics requires major reconsideration for the future. The current workforce considerations in obstetrics suggest that to meet training requirements, it will not be possible in the future to have more than 6-7 centres in the whole of Wales. In North Wales, there are insufficient births (7,500 per annum) from a training perspective to justify more than 2 centres with Trainees (maybe only one). This matter required further discussion and clarification with the Postgraduate Deanery;
- However, the Forum stressed it was important in planning future provision that services should not just be predicated around training rota's, but that there were other means to provide the appropriate clinical cover perhaps in the form of a consultant-based service (albeit with significant financial implications), and new roles for other healthcare professionals which need to be considered (though there may be a delay consequent upon training requirements). The Forum advised against developing plans that required a significant number of non-training grade (so called ' middle-grade') doctors as these were a diminishing commodity;

- The Forum indicated that a service model with two main sites should be considered , perhaps with a midwifery-led unit on the third site (a '2 plus 1' option);
- The preferred scenario for Emergency paediatric services mirrors the 3 site model proposed for obstetrics. The Forum expressed concern again around the deliverability and sustainability of that model from a workforce perspective (issues virtually identical to those outlined for obstetrics). The Forum indicated that it felt an alternative model centred on 2 main sites needed to be explored, as this would be more likely to ensure sustainability. It also stressed the key clinical linkage between paediatrics and surgical services;
- A proposal for 3 full emergency departments (ED) was presented as the preferred option. The deliverability and sustainability of the workforce model was again expressed as a concern by the Forum. An alternative ED model was considered within the discussion on Emergency Surgery below;
- The Forum noted that discussions regarding Emergency Surgery were difficult, with the clinical consensus of opinion as to the future model differing markedly from the Royal College's view of what the future model might be. The three scenarios being considered therefore are 1) a 3-site model; 2) a 2-site model; 3) a 2+1 model. The Forum noted the Royal College recommended a single site based on activity and training requirements, but recognised the challenge delivering this from an access perspective due to the geography. The Forum felt that the 2-site model would be its preferred approach, but conceded that the 2+1 scenario could be delivered with careful planning and design. This model would see two sites providing full ED services, with the third requiring a selected medical intake, but with elective surgery occurring at the site. The Forum agreed that training could be delivered through a networked approach to the rotas;
- The Forum advised that the clinical interdependencies of the '+1' model would need to be considered for all the service areas (both in terms of necessity and frequency of interaction), as there would be a likely impact on all the scenarios outlined from that model;
- The Forum noted the 3-site model for delivering elective orthopaedic services, given the planned increase in activity which was required to meet demand for the service. It also recognised that the Trauma aspect of the service would need to be aligned to the plans for the Emergency Surgical model;
- In relation to Vascular services, the Forum noted the internal clinical consensus that the service needed to be provided from two sites and not the current three. The Forum felt this was reasonable, if it aligned to the proposals for Emergency Surgery, although suggested that there was potentially a need for a single site model to be considered given the activity levels.

In summary, the forum agreed with the principles presented behind the preferred options, which was predominantly for a 3 site model going forward, albeit for some specialties that would be on the basis of a '2 plus 1' arrangement. It was also appreciated that a 2 site approach was appropriate

for Emergency and elective gynaecology, and emergency surgery based on the Royal College advice. It believed that these principles and all scenarios presented could lead to clinically appropriate and safe service models, although the Forum remains concerned that the deliverability and sustainability of a 3-site model will be challenging.

The Forum believe that the clinical interdependencies of those possible 2-site models need to be considered against the 3-sites scenarios as there was scope that they could require a greater degree of change. The Forum is clear that whilst services should not be designed around training rotas, it is an important factor to consider, as well as ensuring that an alternative workforce can be sourced to provide a safe and sustainable service. The Forum also recognises the Health Boards argument that it needs to ensure it has fully tested and exhausted all opportunities to establish the sustainable workforce it requires for its preferred plan, before it definitively concludes that it can't be delivered. The Forum was pleased to hear that the implications of not being able to recruit and staff the 'preferred' models would be highlighted during the consultation and the implications for subsequent service configuration explained.

The Forum will provide a public response to the proposals during the formal consultation process. It sees no reason why the current scenarios with further consideration given to the '+1' model as part of the ongoing process, cannot progress to consultation.

If you feel there is a need to clarify or discuss any aspect of this letter, then please do not hesitate to contact me. Alternatively, I would be happy to arrange a meeting with you, myself and Andrew Carruthers to discuss anything that you feel necessary arising from this.

Yours sincerely

P.P.

Professor Mike Harmer
Chair
National Clinical Forum

Health and Social Care Committee

HSC(4)-26-12 paper 3

Health Board Reconfiguration Plans – Patients Association

There are few fiercer political battlegrounds in Wales than health funding. Not surprising, given that it makes up more than 40% of all devolved spending, or more than £5bn a year.

Warnings of a cash squeeze in the NHS have been growing for many years, with pressures on services and waiting list targets combined with a sprawling, inefficient estate of buildings and huge costs for locum doctors in rural areas.

Several LHB's have reported an overspend or other financial problems including:

- Abertawe Bro Morgannwg University Heath Board (ABM) – in the four months to July, its overspend was £7.5m;
- Cardiff and Vale had an overspend for the four months to July of £12m, while it needs to hit a savings target of £72m by the end of the year;
- For the first three months to June, Betsi Cadwaladr in north Wales, had an £8.6m overspend, with £64.4m in savings to be found;
- For Cwm Taf, the overspend is £2.5m with a £23.7m saving required
- Hywel Dda in mid and west Wales has a £4m deficit and £36m in savings to find;
- Powys health board recorded an overspend of £3.8m with a savings target of £19m;

The cuts to health spending Wales (in real terms) are steeper than any other part of the UK – 11% over the next 3 years. This is compared to 2.2% by 2014/15 in Northern Ireland, 3.3% in 2011 in Scotland and in England spending was 0.9% lower in 2014/15 than in 2010/11.

The NHS is under huge financial pressure as can be seen in the cuts in real terms spending occurring not just in Wales but across the UK. Not only that, our ageing population and increased demand for services is stretching an NHS which is struggling to cope. The Patients Association work on waiting times has shown that larger numbers of patients are waiting for longer than 18 weeks in England and that patients are being denied access to services. In June, it was reported that 10,000 people a year are waiting longer than 12 hours in A&E departments in Wales. Hospitals also recorded 842 people waiting longer than 24 hours in the most recent year, according to their figures.

The majority of patients want to be treated as quickly as possible in hospital and then be back in their own homes, amongst family and loved ones. With a move to local control of health and the rise in the elderly population, we need to make sure the NHS adapts to fulfil this need. Inpatient care and local services must serve the

needs of patients so that they receive the best treatment possible and appropriate follow up community care. It may be beneficial to integrate and consolidate services into fewer sites and centres of excellence, as long as this does not restrict services available to patients. There is evidence that patients are less likely to die in the bigger, busier hospital units where surgical teams are more skilled because they do more of the operations.

We must never forget that by merging services to be provided from one site, there will be patients who may struggle to get to them because they are too far away. It is vital that services reflect the needs of the community and are available in a variety of formats including respite care and community hospitals. However, as is so often the case, political wrangling has the potential to get in the way of the changes that need to be made. We are faced with an NHS which is being forced to make cuts to services across the board. What is the point of having brand new hospital buildings if there are not enough funds to treat people in them? Politicians must not be afraid of making difficult decisions that will ultimately mean better and more efficient services for patients.

However, when changes are being planned, patients must be involved from the outset and throughout the process. If local services are to reflect the needs of local people they need real and meaningful input into the process, not simply just public consultation. We would like to see public forums, outreach programmes and direct patient participation in the decision making process. Without this type of input, we would fear that the same kind of distrust and disillusionment present in England about the NHS reforms may become more prevalent in Wales.

Patients deserve services that are relevant to them and appropriate for local needs. The only way this can happen is if patients and the public are involved in discussions and decisions about services from the outset.

Much of the Patients Association work on patient and public involvement has focused on the new, emerging health structures in England, and in particular Clinical Commissioning Groups (CCGs). In England, the public has a right to be involved in the planning and development of healthcare services and in decisions that may affect the operation of current services under the NHS Constitution. CCGs have a duty, as set out in the NHS Act 2006 to engage with the public when determining the healthcare needs of the local population and planning or designing new pathways or services.

Patient and public involvement must be proactive and not passive. . In Tower Hamlets, the PCT sought out community groups amongst the South Asian population which has a much higher incidence of long term conditions, many linked to lifestyle. They worked with community groups to look at ways of communicating with people including leaflets in other languages and using links with community groups to establish a dialogue. They have seen increased uptake courses about lifestyle choices and leaflets by ensuring that they are language tailored, culturally sensitive and well located. This is just one example of where active patient and public engagement can have a beneficial impact on patients.

As part of our work in this area, the Patients Association developed a Blueprint for patient and public involvement in CCGs which was published in December 2011. While not directly applicable to hospital reorganisation, we believe the principles that it rests upon are shared, especially given as both deal with patient involvement in the fundamental reconfiguration of health services.

Service Design and Delivery

1. CCGs should undertake active engagement with the public when determining the local public's healthcare needs and planning or designing new pathways or services. This engagement should be innovative, proactive and not passive; going out to find the public's views on specific issues, rather than waiting for the public to submit their views. CCGs should share learning and best practice with other CCGS. CCGs must continuously seek patient feedback and experiences to use as an indicator of the quality of the services they are commissioning.
2. CCGs should use effective local engagement structures and other channels to actively connect with a diversity of groups including community networks, local authorities, Healthwatch and third sector groups. This should include those who may not directly associate their concerns with health, e.g. housing associations and social groups, to ensure they engage with all members of the public, including those from traditionally ignored groups.
3. Members of the public involved in commissioning should be offered training and a role profile so that they understand the issues being discussed, the processes and procedures, and so can engage fully. The role of public representatives should be valued and as such they should be reimbursed for their time and given administrative support.

Accountability and Monitoring

4. CCGs should involve the public in the development of the CCGs' public engagement strategy. The CCGs public engagement strategy must form the basis and agenda of their wider commissioning strategy and be published in a variety of media and venues so that it is accessible to all members of the public.
5. The CCGs public engagement strategy should define Key Performance Indicators (KPI) for public engagement which must demonstrate how they support the KPIs defined for commissioning. The CCG will report every quarter regarding progress against these KPIs and publish a publically available action plan to show the public what actions they are taking to meet the KPIs, with particular reference to KPIs they are failing to meet.
6. CCGs must demonstrate how they will communicate with the local population on a regular basis to inform them of any changes to services and how they will actively gain and publish patient feedback on the services they are providing. Any action taken or not taken as a result of this feedback should be reported and justified to the public in a transparent and easily understandable format.

7. There must be public representation at every level of the commissioning process within the CCG. There must be a two-way flow of information between public representatives at every levels of the CCG, from the Board to the individual practice and every level in between.
8. There must be a clear accountability structure for public engagement within the CCG and this must be defined in the CCG's Governance. The responsibility for public involvement ultimately rests with the CCG Board. There should be:
    a. On the Board – a nominated public involvement Governance lead who is a paid member of staff.
    b. On the Board – a public involvement champion who is responsible for promoting public involvement.
    c. Within the CCG structure – a person whose role it is to manage public involvement on a day to day basis and ensures that services meet the reasonable needs of service users.
9. CCGs must be transparent; keeping accurate records of previous actions, publishing their findings and reporting back to patients how they have decided to action feedback or recommendations and clearly outline the reasons behind this.
10. CCGs are accountable to the NHS Commissioning Board, HealthWatch and Health and Wellbeing Boards. They must establish and maintain relationships with these organisations as well as other key health stakeholders in the local health economy. They must report on locally agreed measures, and report on how patient engagement has influenced commissioning services. CCGs should also ask the NHS Commissioning Board for examples of best practice from other CCGs when developing their public engagement strategies.

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Thursday, 27 September 2012**
Meeting time:	**09:01 - 15:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_27_09_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Gwyn R Price** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Lesley Griffiths, Minister for Health and Social Services** **Christopher Brereton, Welsh Government** **Christopher Humphreys, Welsh Government**
Committee Staff:	**Fay Buckle (Clerk)** **Llinos Dafydd (Clerk)** **Claire Griffiths (Deputy Clerk)** **Catherine Hunt (Deputy Clerk)** **Lisa Salkeld (Legal Advisor)**

1. Introductions, apologies and substitutions

1.1 Apologies were received from Mick Antoniw for the morning session and from Lindsay Whittle for the afternoon session. Gwyn Price substituted for Mick Antoniw.

2. Food Hygiene Rating (Wales) Bill: Stage 1 - Evidence Session 5

2.1 The Committee took evidence from the Minister for Health and Social Services.

3. Papers to note

3.1 The Committee noted the papers and the minutes of the meetings held on 12 and 18 July 2012.

4. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

4.1 The Committee agreed the motion.

5. Food Hygiene Rating (Wales) Bill: Stage 1 – Consideration of the draft report

5.1 The draft report was agreed subject to slight amendment following the evidence session with the Minister for Health and Social Services earlier.

5.2 The Committee adjourned from 10.44 to 13.00.

6. Preparation for Draft Budget 2013-14

6.1 The Committee held a discussion with representatives from Cardiff & Vale University Health Board and Powys Teaching Health Board in preparation for scrutinising the Welsh Government's draft budget for 2013-14.

TRANSCRIPT

View the meeting transcript.

Health & Social Care Committee

HSC(4)-26-12 paper 4

Health board reconfiguration plans – Letter from the Older People's Commissioner for Wales

Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

☎ 08442 64 06 70
🖷 08442 64 06 80
www.olderpeoplewales.com

Cambrian Buildings
Mount Stuart Square
Cardiff CF10 5FL

Adeiladau Cambrian
Sgwar Mount Stuart
Caerdydd CF10 5FL

By email

25 September 2012

Dear

NHS Reconfiguration Plans

I write this letter with a strong understanding of the challenges that Local Health Boards face in the current financial climate. There are decisions that are required to be taken about service delivery and prioritisation of spending, and I know that each Health Board faces its own particular challenges. I also recognise the desire of Health Boards to develop new models of care that meet the needs of Welsh people.

Health services and their delivery are often sensitive and emotive subjects. This means it is especially important that decision making is seen to be - and experienced as being – fair, transparent and carried out with due consideration of the rights and needs of those who are directly affected.

People, and older people in particular because they are the majority users of health services in Wales, must be at the heart of the decision-making process. Older people have raised with me concerns about some of the changes proposed by some Health Boards. As a result, I am writing to

outline my expectations of Health Boards when they are considering changes to services or the possible closure of medical facilities or care homes.

As Commissioner I have three particular issues in which I take a close interest. These are:

1. The extent to which older people are involved in discussion about decisions being made. I expect their involvement to be at an early stage, and will look for evidence that their views are taken seriously. I want to know that they have been listened to and that their views have been taken into account when making changes to services.

2. Where changes to services are proposed, I will look to see what the impact of the change will be upon the older person. Where the change is necessary, I will want to be assured that appropriate and effective alternative support is not only made available but that there is evidence of it being used by the older people affected.

3. Where services have been changed or withdrawn as a result of wider financial pressures, I want to see evidence that older people have not been disproportionately affected.

Securing the human rights of older people and compliance with the Equality Act 2010

Health Boards must act in a way that protects the human rights of those they serve. Older people have a legal right to be treated fairly and to have their voices heard. Their dignity, beliefs, needs and privacy should be respected, as well as their right to make informed and effective decisions about their care, treatment and wellbeing.

The specific duties under the Equality Act general public sector equality duty require Health Boards to assess the impact of policies and proposed policies on those with protected characteristics. When considering changes to services or the possible closure of medical facilities or care homes, Health Boards should – with Local Authorities where appropriate - assess the impact of the options it proposes in the consultation document and should publish the findings as part of that document. The impact assessment process should not be carried out just once – it should be

repeated wherever there is a proposed change of direction or a change of circumstances.

Boards should consider the findings thoroughly and act upon them to ensure that no-one with a protected characteristic is treated unfairly as a result of a policy or decision.

As Commissioner, I am able to support and assist older people to make complaints or take legal action in respect of services provided by Local Health Boards, for example to challenge age discrimination or to secure their human rights. I will also, at a future date, be reviewing the equality objectives of all Health Boards in respect of older people.

Meaningful consultation and engagement

I specifically draw your attention to the NHS Wales 'Guidance on Engagement and Consultation on Changes to Health Services' and also to s.183 of the National Health Services (Wales) Act 2006, which requires Health Boards to involve and consult citizens with regard to services they provide or procure.

Older people and their families should be consulted with in a meaningful way at a time when proposals for change are still at a formative stage. The consultation should give enough information, in plain language and in various formats, to allow people to be fully informed. There should be sufficient time to weigh up the information and respond to it. The responses that older people and their families give should be carefully and open-mindedly analysed by the Local Health Board, and the results should be made widely available. The Board should publish the views expressed and the reasons for the decisions it has finally taken. The responses should also be fed into an ongoing impact assessment process (see above).

The various stages of the consultation process must be made clear to older people and their families and there must be a key point of contact available who can be contacted to answer any questions about the consultation.

Provision of advocacy when facilities are closing

Older people must be able to express their own wishes or concerns when facing a transfer of care as a result of a service closure. Some will not be able to do this without the help of an independent advocate. Where an older person facing a change of residence lacks capacity and there is no relative or friend to represent them, an Independent Mental Capacity Advocate *must* be appointed since it is a legal requirement to appoint one when such decisions are being made.

At the earliest stage, older people should be made aware of advocacy services available to them; even though a person has capacity, he or she may feel they need the support of an independent person to represent their wishes or concerns. The voluntary sector can play a key role in providing such support and should be used to do so.

Whilst they may have a vital role in assisting and informing older people, nurses, care home managers and social workers are not independent advocates.

Yesterday I published wider recommendations on independent advocacy and would very much welcome your engagement in the debate which will now take place. Next year I will be publishing formal guidance, under s.12 of the Commissioner for Older People (Wales) Act 2006, on the provision of independent advocacy for older people.

I would be grateful if you could send a copy of your consultation plan and engagement strategy in respect of current reconfiguration and/or closure plans. I will be taking a close interest in the way that Health Boards make decisions so that older people's rights are upheld and will, where appropriate, correspond with you further.

Yours sincerely,

Sarah Rochira
Older People's Commissioner for Wales