Designed for the Future- The Way Foward

Real Options for Real People in Rural Wales

swat
Save Withybush Action Team

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Foreword

We are pleased to present to you our proposals following the recent public consultations in Mid and West Wales.

We agree that change is inevitable and in certain areas desirable but disagree with some of the recommendations contained within ***"Designed to Deliver"***. We understand that previous reviews such as the ***Review of Health and Social Care in Wales*** (Wanless, 2003) have been used but we believe that they have been deliberately misinterpreted to meet the political requirements of the Welsh Assembly Government. We agree with Wanless that redesign of services is critical to future improvements to service provision across Wales.

It has been recognised by Wanless that the things that the NHS does well i.e. emergency services must be maintained and enhanced in the localities where they are needed. He also suggested that elective services must be improved and we have seen waiting times come down over the last few years. The new Local Health and Social Care Consortiums we are proposing must build on this and the additional funding that is being made available over the next 10 years utilized to enhance these 6 new consortiums. Responsibility for Social Care funding streams must be shared between the Local Authority and the NHS in order to reduce the Delayed Transfers of Care which can have such a deleterious effect on elective surgery and emergency admissions. This again fits into Wanless and is his second criteria for how to improve the services. All the proposed changes, according to Wanless, must not be introduced without a published evidence base and costings and evaluation criteria. This was his third criteria for improving Health and Social Care in Wales.

We agree that there is a need for the number of acute hospitals within Wales to be rationalized but again this should be done for the benefit of all the citizens of Wales and not to the detriment of those in rural areas. More importantly we believe that the main thrust of any document which is serious about change in the Health Service in Wales should firstly be looking at the reduction in costs that can be achieved by merger of Local Health Boards and NHS Trusts to create a joint commissioner/provider management structure similar to that in Scotland. The numbers of unnecessary and excessive managerial positions should be radically reduced and there should be a nationally agreed formula to determine the number of non clinical and clinical staff that hospitals are allowed to employ dependent upon the ***"real"*** catchment area that is supported by that unit. In order to do this in West Wales the Pembrokeshire and Derwen NHS Trust would have to change to the Pembrokeshire Health and Social Care Consortium. This would enable local management of Hospital and Community Services and Social Care in collaboration with the Local Authority with much reduced administrative costs. The excellent networking within Mental Health Services would be maintained but each Consortium would run this service locally for the benefit of local people. However certain administrative services could be centralized to a single unit for the whole of Mid and West Wales such as Salaries and Wages, Senior Human Resource positions and Senior Estate Management positions.

We agree that it is laudable to promote self care and health information and to improve the standard of community care provision and that some services may be delivered in Primary Care that are not presently. We do not agree that reducing the facilities in rural hospitals is safe for patients.

We believe that the document "***Designed for Life"*** (10 year strategy for the NHS in Wales) published by the Welsh Assembly Government in May 2005 was a poor document simply because it lacked clarity with regard to cost effectiveness and the impact on the population's access to emergency medical care. The "***Designed to Deliver***" document has not alleviated these concerns and once again has not added any clarity with regards to cost effectiveness or emergency care access.

If the NHS in Wales is to modernize services in line with the changing needs and expectations of the people of Wales then the people of Wales' voices need to be heeded. In response to these documents and having listened to the people of Pembrokeshire we have developed this strategy to improve acute services and bring forward proposals for improvement.

Acute health care in the West Wales Region has been provided within Pembrokeshire for over 60 years although Withybush as we know it today was not opened until 1979. Since then there have been rapid improvements in the health care provision for Pembrokeshire and surrounding areas from this ideal base. Whilst we agree that clinical and technological developments provide an opportunity to provide some services in the home this should be rolled out in a controlled and carefully costed manner to avoid the pitfalls that will inevitably occur. Consequently it is imperative to review how, where and from whom patients receive their services and whether any changes can be brought in safely and effectively and within budget.

We believe that a new era focusing on the patient and not targets is upon us. It is to this aim that we expect the Local Health and Social Care Consortiums to be managed by a Board made up from Consultants, Senior Nurses, Senior Allied Health Professionals, General Practitioners and Senior Social Service employees working in partnership. Each LHSCC will have a General Manager who reports to this board and who organises the day to day running of the LHSCC. There will be ***"real"*** and ***"valued"*** representations from the CHC and Voluntary Services. There will be **NO** Chief Executives and **NO** Trust Boards which in itself will create significant savings for the NHS in Wales.

This document focuses on the patient and the provision of safe effective and sustainable life long care. We have suggested how services can be reconfigured differently for each locality to achieve these aims for the future. These are real and viable alternatives to the proposals proffered in "***Designed to Deliver***".

Introduction and summary

1.1 The purpose of this document and who it is for

Last year, *Designed for Life* outlined a 10 year strategy to deliver world-class health services in Wales by 2015. SWAT believes that this is what the people of Mid and West Wales deserve and we are determined to assist in its development and delivery. SWAT recognises that this is a long-term strategy and this is a laudable aim however changing services without proper consultation, costing and feasibility studies, and without the will to listen is a recipe for disaster.

This document has been prepared by SWAT in response to that produced by the NHS Trusts and Local Health Boards serving Bridgend, Carmarthenshire, Ceredigion, Neath Port Talbot, Pembrokeshire, Powys and Swansea.

We outline in the pages that follow a series of proposals that we strongly believe will result in better health care for the people of Mid and West Wales. This is the first stage in a programme of change and improvement that will take place over at least the next 10 years. There will need to be real and meaningful consultation with the public to work through the detail of the proposals in the months and years ahead. This must be a thorough and wide ranging debate, and needs to involve

- The people of Mid and West Wales
- Patients
- Carers
- NHS staff
- Community Health Councils
- Community Leaders
- Voluntary sector partners
- Local Authority partners

This document mainly focuses on the patient but also on the impact to staff of the proposed changes to general hospitals contained in "***Designed to Deliver***". In particular we will be evaluating the impact on patients, their families and the staff if developments in care outside the hospital setting are not to fail. Already significant changes in the management of chronic illnesses such as diabetes, asthma and heart conditions, that mean that people can be kept well for longer and receive treatment in their own homes have been promoted but we are mindful of the failures of Mental Health Care in the Community where services have become stretched and patients have been neglected culminating in their own death or death of another. We would not want to see failures in the services to vulnerable patients in the communities happening in a similar way because of insufficient funding and with the removal of hospital based services close to the patient having already taken place. This would result in much anxiety and many unnecessary deaths of those with chronic diseases. Any reduction in admissions is too big a price to pay if the safety of these is compromised through underinvestment.

All of us who work and live in Mid and West Wales want the same things from our NHS:

• high quality, safe services delivered as close to peoples homes as possible;
• short waiting times;
• highly skilled health professionals who will be sensitive to the needs of patients and their families;
• high quality health care facilities with state of the art equipment.

We agree that the Community, Primary and Secondary Care services should be delivered as one within each locality and that the Local Health and Social Care Consortiums should collaborate with the Local Authority so that an integrated system of *"care"* can be provided to all who need it. There will be a transitional arrangement of 3 years during which time the relevant areas of social care will become more and more part of an integrated Health and Social Care strategy. This must however come properly funded and not reliant on savings from other areas of care.

We agree that this goal can only be achieved if services and organisations work more closely together which inevitably means that the way in which we organise and deliver care will change. This change must be for the better and must provide benefit for the long-term.

1.2 Why does Health Care Organisation need to be changed?

The challenge for the NHS in the 21st century is to deliver health services that are high quality, safe, sustainable, accessible, affordable and acceptable to local communities. The key issue is for the NHS to consistently deliver the best outcomes for patients, 24 hours a day, 365 days a year. For that we need doctors, nurses and other health professional staff to have the skills, experience and learning opportunities to provide the very best of care. To achieve this, organisations and their staff, need to serve communities and populations that are appropriate to maintain their skills.

We believe that sustainability of the acute services presently in Mid and West Wales region, both now and in the future, is possible but requires the political will to fund the health service properly and to use the savings which can be made from streamlining management. This is the only safe option for the population of Mid and West Wales and in particular for those in the most rural areas. It is up to the Welsh Assembly Government to be brave and take this step in order to provide a World Class Service for the whole of Wales.

The European Working Time Directive (EWTD) on medical staffing legislates for a reduction in the working week for junior doctors to 48 hours by August 2009. The UK Government has dramatically increased the number of Medical Students going through our Universities over the last few years. There are many doctors already struggling to obtain training posts in our hospitals. If there was the political will to expand the provision of these training posts then there would continue to be enough doctors to provide a safe level of care for patients across the 24 hour period in the future. Not employing more doctors is fundamentally wrong. Training is not just about how many patients a doctor sees but about the quality of the training given in order to be able to recognise and deal with conditions that may never be seen in the lifetime of our present General Practitioners. Is it right for the public purse to train all these doctors only to lose them to other countries and at the same time end up with a poorly manned NHS?

All Consultants in Medicine and Surgery are able to provide general services as well as particular areas of increased specialisation. It has always been the case that where a particular area of expertise is needed and which is not available within a particular area then colleagues at other hospitals are available for advice. This is a similar system to the National Poisons Service for A&E. Not every doctor in A&E has the answers for every type of poisoning and therefore a 24 hour hotline is available. Consultants who are specialists in certain diseases e.g. Hepatologists will only ever be concentrated in Supra-Regional or National Centres. These are also available to contact in rare out of hours emergencies which has always been good news for patients. The best outcomes for patients have always been when procedures have been carried out in a controlled manner by appropriately trained staff. It is not possible to have every subspecialty available in all District General Hospitals but this does not mean that core acute services should be removed from much needed hospitals especially in rural communities. All patients that present out of hours with unusual or life threatening symptoms have clinical input from a highly trained Consultant who will know whether he has sufficient knowledge to deal with the problem or whether to take advice from a more experienced source. This is traditional clinical networking.

It is unreasonable to expect more patients and their families to travel for acute core service provision. Advances in diagnostic services should be provided locally to avoid patients travelling in emergency situations which increase their risk.

Increasing numbers of patients with urgent but not life threatening injuries and illnesses are going to A&E departments for their care. Only a small percentage of patients need to be seen in these very specialist departments - many of these urgent care needs could be treated in local centres with GPs, Specialist Nurses and Specialist Paramedics delivering services closer to where people live. We must invest in new systems and models for primary and community care that bring outpatient and diagnostic services nearer to the patient. We need to develop better integrated urgent care services where patients can be assessed and treated in their own homes or communities; (things patients and carers keep telling us they want the NHS to deliver for them). These improvements need to be pump primed and properly funded from central government in order for them to work in synchronicity with the local acute hospital provision.

1.3 What is the vision for Mid and West Wales for the future?

Change needs to happen at an appropriate pace to protect patients and provide a safe transition to new ways of working if we are to deliver improved services. This is not always about new buildings: it is about better ways of caring for patients which can be achieved through working differently and together throughout the Region. Whilst we recognise that overall this is a 10 year programme of change and improvements can only be achieved with additional resources and management savings. It is imperative that no action is taken until it has been thoroughly researched and proven to be of benefit for patients.

Designed for Life identified 3 distinct strategic frameworks against which improved health and healthcare will be delivered.

2005	***2008***	***2011***	***2015***
Framework 1 Higher standards	Framework 2 Redesigning services	Framework 3 Full Engagement	

CONTINUOUS SERVICE IMPROVEMENT

These frameworks must underpin our vision for the future which is that:

• The same high quality of care will be provided for the residents of Mid and West Wales, irrespective of where within the Region they live and within 26 weeks from referral to treatment.

• Services will be designed around the patient.

• The focus of services in the future will be on the provision of care closer to the patient's home. This will mean that more care is delivered in the community and there will be less need for patients to come to hospital for routine care and diagnostic services.

• The increased focus on chronic disease management will help people to manage their illness and reduce the unexpected crisis that often leads to hospital admission.

• The ambulance service will be an integral part of the new model of delivery of "urgent care" with Paramedics, Nurses, GPs and hospital Doctors working as part of a team to assess and treat patients at home or in the community, significantly reducing the need for hospital admission.

• There will be a programme of development for a network of Primary Care services and Resource Centres which will take appropriate outpatient and diagnostic services out to the Community; with GPs, Hospital Consultants and Specialist Nurses / Allied Health Professionals all working together to deliver high quality accessible services locally. (This element of the overall change agenda will be subject to separate detailed planning and discussion within localities.)

• .Technology will play an increasing role in avoiding the need for travel. Telemedicine will enable remote consultation and assessment of patients which will release valuable clinical time to treat more patients more effectively. Telemonitoring will enable patients to be better supported in their communities and at home.

• For those services where care is best provided in hospital, resources and expertise will be focused on delivering maximum safety and benefit for all residents of Mid and West Wales.

• 24 hour access to assessment of acute illness will be maintained and improved. Diagnostic capability will be enhanced to assist rapid clinical decision making so that patients receive the right treatment in the right place as quickly as possible.

• Services will be organised such that routine care is not adversely affected by emergency demands.

1.4 How do we achieve that vision?

This vision will primarily be achieved through a process of improving care delivery in the most appropriate place. This will be an efficient, effective and most importantly safe mix of care in both the community and the hospital settings. This is not a new concept and there are many examples where this is already happening across Wales, the UK and Europe. However, we need to accelerate this process and engage with communities to develop the primary, community and social care infrastructures to enable this to happen. In each area the Local Health and Social Care Consortium and Local Government Authority will work in collaboration to jointly procure appropriately funded social care to effect a seamless provision of care which is responsive to each patients needs. These will become the new Local Health and Social Care Consortiums and they will provide seamless care for all.

As part of this overall modernization programme, it is proposed that the role of our hospitals will also need to change as follows:

1.4.1 General Acute Hospital Care

The Mid and West Wales Region will be configured in terms of 6 Local Heath and Social Care Consortiums

• **Bro Morgannwg** where acute care will be delivered across Princess of Wales and Neath Port Talbot Hospitals working as one integrated service on two sites.

• **Swansea** where acute care will be improved by rationalizing all of the services currently provided at Morriston and Singleton Hospitals working towards one integrated service on two sites.

• **Powys** where the existing network of hospitals (English and Welsh Acute Hospitals and Powys LHB) will work in partnership to provide an increased range of acute services within the county via the establishment of assessment and treatment centres. However a dedicated Acute Hospital may need to be developed depending on other areas reconfiguration plans.

• **Dyfed** where the focus of acute care will remain within the present hospitals but with shared management roles where this is appropriate to cut out the unnecessary duplication that presently exists. The Health and Social Care Consortiums will take on the role of Purchaser and Provider for each locality similar to the Scottish Model. Each locality will have an integrated hospital, community and primary care service for both acute and mental health services and will take on the role of the Social Care needs over time from the Local Authority. A robust networking system will be developed across the three sites and there will be joint commissioning for certain supra-regional services. This will enable local services to be strengthened through clinical teams working more closely together to maintain and improve services for the local population.

1.4.2 Supra-Regional Care

Supra-Regional Specialist services such as those for the less common Cancers, Cardiology and Vascular surgery will be run as a networked service across organisations, working to common standards, protocols and pathways of care to ensure equality irrespective of location. On-call arrangements will be synchronised to ensure that there is always a Specialist available within the Region. They will provide advice and remote expert opinion to medical and surgical teams across all hospitals throughout the 24 hour period, reducing the need to transfer patients between hospital sites.
Multi-disciplinary team working and technology will continue to allow initial assessments and tests to be undertaken locally. In some circumstances initial specialist consultations may be possible remotely using telemedicine. Most specialist follow-up treatment and review will continue to be undertaken locally under the supervision of the specialist teams using local skills and expertise and telemedicine technology.
In summary, even though these super specialist interventions will continue to need to be concentrated in a small number of centres, more and more of the care pathway will be able to be delivered locally. This is already happening to a large extent in the delivery of some specialist cancer services.

1.4.3 Highly Specialised Care

Where highly specialised care is provided in the Region, it will be delivered in Swansea (e.g. plastic surgery, complex burns care, cardiac surgery, and specialised neuro-rehabilitation). Strategic planning, led by Health Commission Wales (HCW) in partnership with Local Health and Social Care Consortiums will further refine the configuration of these services over the next 2 – 3 years to ensure appropriate access and quality is sustained. Where it is more appropriate for services to be accessed outside the Region (e.g. Powys residents accessing services in Birmingham, Cardiff, etc.) this will continue. This type of care will be redesigned around patient pathways such that the need for travel is minimised where possible, making best use of technology to reduce the need for repeated hospital appointments. These redesigned highly specialised services would mean that a small percentage of the care needed has to be provided in Swansea and yet 100% of the care delivered is to the same standard with a reduced impact of travel to patients and their families. Where highly specialised care is not able to be delivered in Swansea the same design and networked principles will apply.

2. Background and Context

This section sets out the Strategic Context for this work and describes the epidemiological factors that are prompting us to review how we deliver sustainable and high quality services.

2.1 What has prompted this review of acute hospital services?

The direction of travel for the development of health care in Wales has been repeatedly and consistently stated over the last 5 years.

In February 2001 *Improving health in Wales: A Plan for the NHS with its Partners* set out an ambitious long-term programme, driving for improved health and well being, reduced inequalities, first class services for all and specifically to

- Rebuild, renew and improve the National Health Service in Wales
- Develop effective and innovative ways of improving citizens' health
- Ensure continual improvement is embedded into its services.

In 2002 *A Question of Balance* clarified the capacity problems and identified that we needed to use our hospitals in a different way. Its recommendations were taken up in the *Review of Health and Social Care*, advised by Sir Derek Wanless, *(The Wanless Review)* which confirmed the existing strategic direction but re-emphasised the need for significant and rapid change. The Wanless report confirmed that Wales' current health and social care services are not sustainable and that the present configuration of services is inherently inefficient and expensive, pointing to radical action in order to ensure that the waste within the system is removed and any savings redistributed.

Unfortunately these health inequalities still remain. For example there are wide variations in the availability of acute beds across Wales (see Tables 1 and 2). This is most acute in Mid and West Wales where the range standardized ratio of non-psychiatric beds is 0.29 against 0.37 for North Wales and 0.43 for South East Wales. In fact Pembrokeshire (0.27), Ceredigion (0.23) and Powys (0.18) have some of the lowest within our region. Apart from Swansea (0.63) all of the South East Regions have higher bed ratios with Merthyr Tydfil standing out at 1.0. This is not offset by list sizes for GP's which range from 1641 for Mid and West Wales to 1776 for South East Wales.

The 2002 "A Question of Balance" highlighted that hospitals become inefficient when bed occupancy rises above 85%. Most hospitals in Mid and West Wales are currently working at levels in excess of 90%. It is therefore imperative that the high capacity in the South East should be redistributed West. This suggests any move to reduce services and capacity in West Wales is going in the wrong direction if the aims of "Designed for Life" are to be achieved.

The Wanless Review led to the production of Local Action plans for Local Health Boards to continue the impetus for change. Alongside these Local Action Plans Health, Social Care and Well Being plans have already been prepared, consulted on and adopted by the LHBs, in conjunction with their Local Authority partners. The proposals set out in this Consultation Document sit within the overall framework of these local plans.

In 2004 *Making the Connections* challenged public sector services to demonstrate that they are responsive to the needs of individuals and communities that their services are delivered efficiently and are driven by a commitment to equality and social justice.

The proposals set out in this paper are in line with the strategic direction that has been set out for Wales and seek to accelerate their implementation to keep pace with the rest of the UK and Europe in delivering high quality care.

2.2 What do we know about this region and the health of the population?

There are a number of related issues, the understanding of which assists in determining the future health needs of our population as follows:

2.2.1 Changes in patterns of disease

Over the past century the broad picture of illness and the requirements for health care have changed significantly as a result of changes in public health, demography and developments in clinical technology. The focus on infectious disease in the first half of the twentieth century changed to a focus on acute diseases in the latter half of the last century, and to the management of chronic diseases for the early part of the twenty-first century. These changes in patterns of health mean that hospitals need to be at the centre of the health system but with improvements in primary, community and social care underpinning them in order to develop an integrated and effective system to manage chronic conditions which is key to the health of the nation.

This results in a different challenge for the health care system for the early part of the twenty-first century. There will be a much greater emphasis on the early detection of conditions such as heart disease, respiratory problems, cancer and diabetes, with targeted intervention to support people to remain as independent as possible for as long as possible without the need for repeated admission to hospital. The local hospital consultants will provide a significant role in the diagnosis and backup for these conditions. It is hoped that, with supportive technology in our homes, our ability to remain independent will be further increased. Also, the advent of mobile clinical technology will enable more diagnostic, treatment and follow-up services to be delivered outside the hospital environment. All of these factors influence the need to review the way in which our health care services are provided.

2.2.2 Health Need

Across the Mid and West Wales Region there is a general pattern of inequalities in levels of health. In general, those living in mid Wales (Powys and Ceredigion) enjoy better levels of health than those in the south. However, existing measures of deprivation are not effective for rural communities where the complex interaction between factors associated with income, social circumstances, access to services and choice are often significant determinants of health. There are many examples of care where Rural communities can be disadvantaged. In particular it is well recognised that it is essential that emergency Obstetrics services need to be present in Rural areas and also that Trauma Deaths are much higher (74% in Rural v 23% in Metropolitan) when there is no major acute A&E service available locally.

People living in the areas of old heavy industry in the south of the region (Neath Port Talbot and parts of Bridgend, Llanelli and Ystradgynlais) experience generally poorer levels of health and for some conditions, levels are among the poorest in Wales. The picture for other areas (Pembrokeshire, eastern Carmarthenshire and Swansea) is more mixed.

These inequalities in levels of health are reflected in the patterns of usage of health services. Geography and the current pattern of hospital provision also mean that there is unequal access to services. Building on the needs assessments undertaken to inform development of the Health Social Care and Wellbeing Strategies, a fundamental objective of the review of acute service provision in the Mid and West Region is the provision of services organised on the principles of equity, safety, accessibility and quality that are fast, effective, simple to understand, easy to use and responsive to changing needs.

2.2.3 Service Delivery

The current pattern of hospital services was set up in the 1960s (many small hospitals are much older even than that), however the patterns of illness and disease they cater for have changed significantly. Nevertheless the provision of local emergency services is imperative in order to provide a safe and secure service for future patients. New communities have also developed, the age structure of the population has changed and the way disease is treated has altered. It may be possible to reduce hospital admissions in the long term when appropriate changes in the community and social services have been implemented. There is evidence that up to 2 in every 5 hospital beds are occupied by patients who do not need to be in hospital, thus hospitals are prevented from focusing on what hospitals should be doing - dealing with emergency cases and providing planned treatment such as surgical operations (elective care). When the community and social care services have been improved the bed occupancy of hospitals in our region will be more manageable and enable more efficient use of local hospitals which will reduce cancelled admissions due to lack of capacity .

2.2.4 Population

The population of Mid and West Wales is estimated at just fewer than one million people: this is expected to increase by 5-6% by 2023. Within this overall growth it would be expected that there would be:

- a fall in the numbers of older children and young people up to the age of 45
- general growth in the population over the age of 45
- significant growth in the number of people over the age of 75 (varying across the Region from 44% to 65%).

However this does not take into account the increasing migration into the Three Counties and the relatively high fertility rate in Pembrokeshire (3rd highest in Wales).

The ageing population of Mid and West Wales is an important factor in planning future services. Whilst recognising that the general health of the population is improving, people over 65 still account for 40% of all emergency admissions and well over half of all hospital bed days: unplanned admissions to hospital increase with increasing age. Often these admissions are for conditions that could be managed outside an acute hospital setting and if that can be achieved, as the emerging proposals suggest, then this provides acute hospitals with a further opportunity to focus on caring for those patients who genuinely need the

support of a hospital. It is imperative that a local hospital is present within particularly rural areas to support the changes in care that are envisaged. Without a fully functioning hospital with appropriate emergency back up caring for patients in their own homes would be hazardous and would lead to unnecessary deaths and increased travel for many.

3. Why do we need to change?

Proposals for change in the configuration of hospital services are not unique to Mid and West Wales. Such proposals are being developed for the whole of Wales and changes are also already being implemented in many parts of England and the rest of the U.K. The focus of this work is not specifically about the configuration of hospital services and hospital buildings for the present and the immediate future. Rather it is to consider the services that will be developed over the next 10 years, with an emphasis on clinical networks and patient pathways. This will be within an overall model of integrated care which includes primary, community, acute and tertiary care and ambulance and out of hours service provision.

3.1 Clinical Sustainability

The key driver for change is the need to deliver clinically sustainable services for the Region. By this, we mean services that are able to deliver consistently safe and effective interventions with high quality outcomes for patients, with the availability of the appropriate number of high quality and appropriately trained staff 24 hours a day, 365 days a year. Sustainable services also mean that good training at the right level can be delivered as well as effective recruitment and retention of staff.

The key components of clinical sustainability in this sense are:

3.1.1 Safety

Patients have a right to require services to always be safe. This is only achieved through constant vigilance. In the last 10 years, high profile incidents such as those experienced in the Bristol Heart Enquiry and the revelations associated with the Shipman enquiry have highlighted the fact that what often appears to be high quality does not necessarily give us the assurances on safety that we would wish to have as consumers and deliverers of health care. Considerable attention has been paid to establishing systems that safeguard patients and we have seen a significant increase in programs of inspections and assessments against predetermined standards of care. Safety is as much defined by the process of care as it is by the outcome and services must be designed to ensure that resilience is built in to secure 24/7 delivery of care. Single-handed Specialists, however skilled they may be as individuals, cannot provide supervision and care around the clock and must therefore be part of broader networks to secure both ongoing quality and safety.

3.1.2 Capacity

Our challenge is to ensure that the appropriate capacity (numbers of Consultants, other health-care staff, GP clinic sessions, beds, equipment, operating theatres, outpatient appointments etc.) is in place across the whole system of delivery of acute care to meet patient demands. This is critical to enable timely access of emergency patients for assessment, diagnostic tests and treatment, without affecting the ability of the system to

provide the capacity that is required to meet the Targets for elective services outlined in *'Designed for Life',* and in particular by 2009 to have a maximum wait of 26 weeks between referral and definitive treatment for elective cases.

The appropriate capacity must also exist in all services to ensure the continued development of staff, retention of skills and ongoing recruitment to the service.

3.1.3 Evidence and Effectiveness

Over recent years considerable guidance and mandatory standards have been issued to help health care organizations in the U.K. to achieve consistently high standards. For example the National Service Frameworks and Cancer Standards have been developed which set out how specific services should be configured and provided. The National Institute of Clinical Excellence (NICE) has also developed directives which advise on clinical practice.

The Royal Colleges of Medicine and other professional bodies of clinicians are also concerned with service standards. Many Colleges have, in the past few years, published advice to guide service provision, e.g. Advice on Planning the Service in Obstetrics and Gynaecology (Royal College of Obstetricians and Gynaecologists (RCOG), July 2002) and Towards Safer Childbirth, naming the standards for the organisation of labour wards, (RCOG February 1999). Whilst both these documents are currently being revised, they already set standards which have been challenging for many units to achieve (for example Withybush Hospital is one of only 43% of hospitals across the UK that currently provide dedicated Consultant Labour Ward cover during 9-5 Monday to Friday).

The Royal College of Surgeons are currently undertaking a consultation on the appropriate levels of activity required to maintain adequate training and experience for Consultants and trainees. In their consultation document they recognise the special role of Rural Hospitals and the need to maintain sufficient numbers of generalist posts in order to man them. They also recognise that Rural Hospitals are highly likely to provide safe and high quality services. The Future Role of the Consultant (Royal College of Obstetricians and Gynaecologists (RCOG) December 2005) outlines the need to have sufficient numbers of Generalist Obstetricians.

3.1.4 Quality

"Timely access to care, high quality clinical care and high quality interpersonal care, underpinned by good management and continuous professional development"
(Roland et al, 1998)

The challenge is to continuously improve the quality of clinical care across all aspects of service provision. Quality in the health service is not a static thing - it is about ensuring health services take into account the changing needs of patients and the developing standards of care and in many ways is a sum of all of the above.

3.2 Internal and external forces

There are a number of internal and external forces that are contributing to the clinical sustainability debate and create significant drivers for change as follows:

3.2.1 Changing disease patterns

Much of the literature which we have reviewed emphasised the ageing nature of our society and the likelihood of increasing life expectancies in the next 20-30 years. With this demographic pattern, the number of people with chronic conditions is also likely to increase. One third of adults in Wales currently have at least one chronic condition (800,000 people) and it is estimated that this will rise by 12% by 2014, with a 20% rise in those aged over 65. This will place an increasing demand on health care provision and will stretch services beyond their limit unless these can be designed and provided more effectively.

3.2.2 Rising Emergency Admissions

One of the primary objectives for both patients and the NHS is to deliver as much care at home as possible and yet there has been a sharp rise in emergency admissions across the whole of the UK in recent years, placing increasing pressure on acute hospital beds. In Wales, there has been a rise of 22% in a decade with two thirds of emergency medical admissions as a result of a chronic condition. There is increasing evidence that managing patients with chronic conditions effectively in primary, community and intermediate care can prevent admissions and lead to higher levels of patient satisfaction.

3.2.3 Workforce issues

Over the last few years new employment arrangements for GPs, hospital doctors and other clinical staff have meant:
• an end to unsafe working practices such as junior doctors working long hours, causing patients to be treated by exhausted staff;
• GPs no longer have 24 hour responsibilities allowing them to provide more daytime services and develop new skills;
• that new clinical roles for nurses and other clinical professionals have been developed, allowing for more flexible, quality services;
• more doctors and nurses in training and employment than ever before.

The key objective has been to reduce the working week of all those who work in the NHS. However it will be necessary to employ more staff across the board to be able to continue to provide effective 24 hour services. For junior doctors specifically, the requirement to reduce their working week to 48 hours by 2009 is key to the maintenance of safety and quality. However, with doctors available for less time in the week, we must, therefore, re-organize those services provided outside of 9am to 5pm, Monday to Friday. Importantly, along with reducing hours, changes to training and education of doctors have taken place. This has changed the balance of how they work, with more time spent on training and less on “hands on” duties of direct patient care. It is exciting that the UK Government recognised the need for additional doctors to fill these gaps and that the increased numbers of medical students in recent years will soon be available to the work force. These additional numbers must not be wasted and allowed to leave these shores as they are the Consultants and General Practitioners of the future. On a very positive note, however, all these new arrangements create a new and exciting opportunity for cross-professional training, development and practice with flexibility hitherto unable to be achieved. Both the need and the potential for developing new ways to deliver health services have never been greater and must be seized as a significant opportunity in the overall modernisation agenda.

3.2.4 Outdated facilities

Many healthcare facilities within the region were designed to accommodate models of patient care that are no longer fit for purpose. There is a golden opportunity to use the additional resources of capital to upgrade these facilities and in particular to provide more single rooms which will go a long way to reducing the incidence of Hospital Acquired Infections. The development of new techniques has meant that treatment that would have required a 10-day hospital stay several years ago can now be facilitated within a few days as long as the appropriate back up in the community is in place. Many inpatient procedures can now be provided on a day case basis; procedures that historically were undertaken under general anaesthetic can now be conducted safely under sedation and local anaesthetic.

At present we have too much waste in the health service tied up in excessive managerial and administrative costs. There are significant duplication of managerial services at all levels and this is an area where significant reductions can be made without directly affecting front line clinical services. There have been significant reductions in the beds available in hospitals, particularly in Mid and West Wales and especially in Pembrokeshire, Ceredigion and Powys. This has caused an inefficient use of beds which are constantly occupied and with insufficient primary, community and home care support availability this has put an unreasonable strain on the acute sector. This imbalance in facilities and resources limits our ability to take full advantage of these developments in medical practice. The self care, health promotion, community care and primary care needs to be pump primed in order to redress this imbalance and improve the efficiency in the acute care facilities.

3.2.5 Resource Constraints

Whilst there has been significant investment in recent years, the NHS in Wales does not have unlimited resources. The 23% funding uplift received over the past 3 years has not delivered proportional service improvement, arguably because it has been poorly managed by the Directorate of Health and Social Care in the Welsh Assembly. The two Directors are typical of the quality of management that is rife throughout the NHS. They and their counterparts throughout the organisation have frittered away the additional funding such that it has not reached the front line services it was intended to improve. This additional funding has been wasted on a myriad of government organisations which are evaluating and covering the same ground over and over again. This must be stopped immediately and better management brought in at the very top before it is too late. The cost of propping up an ever growing army of bureaucrats in the health service is monstrous and does not help to deliver any direct benefit in terms of patient care. Wholesale delivery of the new and better treatments that patients quite rightly demand can only be delivered if we release resources from these traditional models of health service management. More long-term measures are required for longer-term stability and improvement in service provision.

3.3 Learning from the best

If we are serious in our commitment to achieve world-class services for Wales, we must be prepared to learn from the best. The literature reviewed gives some very clear pointers on the way that services should be redesigned and recommends that there should be a focus on locally provided core services with access to all for both elective and emergency care and

improvement in out of hospital service provision to reduce cancellations. Clinical networking should continue and be supported with recognised time and appropriate finance.

This is achieved through the following themes which underpin the proposals set out later in this Consultation Document:
• Achieving 'appropriate mass' of patients and staff
• Strengthening chronic disease management programs in the community, primary and intermediate care settings is key to reducing the pressure on emergency care in acute settings
• Innovative approach to workforce redesign and extension of staff roles
• Separation of elective and emergency cases within the acute hospitals
• Development in Information and Communications Technology (ICT) – use of telemedicine, electronic patient record and digital imaging transfer
• Maximizing the provision of care wherever possible in the community setting, therefore reducing hospital admissions and attendances.

4. Why are the current services not sustainable?

This section considers why the current arrangements for the provision of acute health care in the Mid and West Wales Region are not sustainable in the long term.

4.1 Current configuration

The Acute Care Services within the Mid and West Wales Region are provided from eight acute hospitals, all delivering different services but mostly referred to as District General Hospitals:
• Withybush in Haverfordwest
• Bronglais in Aberystwyth
• West Wales General in Carmarthen
• Morriston and Singleton Hospitals in Swansea
• Princess of Wales Hospital in Bridgend
• Prince Phillip Hospital in Llanelli
• Neath Port Talbot Hospital

A significant amount of basic acute hospital care is also delivered through the existing community hospitals in Powys with outreach services from a number of providers surrounding the county borders.

All District General Hospitals provide a range of in-patient and outpatient services, with Swansea also providing many of the highly specialised services for the Region. There has never been an overall plan for general hospital services within Wales which means that most services provided have grown incrementally with little co-ordination or sharing of resources and expertise.

Prince Phillip and Neath Port Talbot Hospitals support the larger Hospitals with a focus mainly on elective services and twenty four-hour access for medical emergencies.
Powys does not have a District General Hospital within the boundaries of the unitary authority. The residents of Powys access acute hospital services from a number of Providers

in many regions of Wales and across the border into England as well as those delivered directly by Powys LHB through the existing community hospital infrastructure. Depending on how other areas acute hospitals are reconfigured it may be necessary to create a new DGH in Powys between Llangurig and Rhayader.

All the acute hospitals in Mid and West Wales are supported by a number of community hospitals providing more long term and intermediate care. The role and function of these hospitals, whilst vital in supporting the proposals outlined in Sections 6 and 7, is outside the scope of this review.

4.2 Hospital catchments

Within this Region, a population of just fewer than 1 million people is served, in terms of acute health care provision, by a total of eight hospitals. Even with the projected population growth of 5 – 6% over the next 15 – 20 years, the population will be less than 1.1 million. Two of these hospitals are presently linked to a bigger DGH (Llanelli and Neath/Port Talbot) which leaves 6 main DGH's. It is planned for the two hospitals in Swansea to work as one unit leaving 5 main DGH's. It is acknowledged that the populations accessing hospital services do not necessarily recognise Regional or Local Authority boundaries and certain parts of the Region experience seasonal population changes with the impact of tourism in the summer months and student populations in term time, all of which need to be taken into consideration in terms of planning access to services. It is not unreasonable for the region to maintain 5 separate DGH's serving an average population of 200,000. In fact, when seasonal variations are taken into account, only Aberystwyth would not attain that level of population to serve and the geographical isolation of this DGH more than compensates for this.

As already mentioned our Region has the lowest ratio of beds per 10,000 population when compared to North and South East Wales and it is through reconfiguration in these regions that savings can be made to reduce the inequalities in Health Service provision across Wales.

4.3 Sustainability

The main concerns identified within this review are associated with governance (quality and safety) issues and the provision of services locally which relies on a commitment by the Welsh Assembly to provide the necessary funding to maintain clinical sustainability. This would mean that the people of this Region continue to receive the service they deserve but this will only be affordable if there is appropriate changes in the way the service is run.

Bro Morgannwg

Covers an area of 251 Km² and has a population of 130,000. Also provides some services for Neath/Port Talbot (area 441 Km², population 136,000) shared with Swansea. It would be difficult to justify the existence of this hospital had Neath/Port Talbot hospital not been downgraded. Even now it would make economic sense to close this hospital and provide services from a hospital further East because of its geographical position and good road networks. The results of the South East Wales reconfiguration exercise will inform us as to whether it may be prudent to revisit this as a cost saving option.

Swansea

Covers an area of 378 Km² and has a population of 225,000. This is the major centre for Mid and West Wales. It also provides some services for Neath/Port Talbot (area 441 Km², population 136,000). The Swansea community has been debating the potential for integrating the services currently provided from Morriston and Singleton Hospitals onto one site but this is not essential in the overall strategy. In fact a single very large hospital would be cumbersome and have diseconomies of scale and inefficiencies related to its size.

Powys

Covers an area of 5181 Km² and has a population of 130,000. The unique challenge for Powys LHB, building on a long and successful history of partnership with acute service providers in England and Wales, is to further increase the quality and range of acute services that can be provided in-county. It is envisaged that reconfiguration of the community services based on 3 shire based assessment and treatment centres, supported by a number of health and social care facilities and local care teams with a focus on care pathways will deliver this key requirement. Powys LHB is conducting a parallel consultation on the detail of how this objective can be achieved ("Doing More, Doing Better") and you are encouraged to read this document to gain the fuller understanding of how the proposals will be linked.

However following any reconfiguration of services in Wales and more importantly in England along the English border (Hereford and Shrewsbury) consideration may have to be given for a new build acute hospital between Llangurig and Rhayader.

Dyfed

Covers an area of 5775 Km² and has a population of 375,000. There are several centres of population but much of the region is sparsely populated and the large geographical area creates unique challenges for the provision of safe, sustainable health and social care. It is for this reason that the changes in purchaser and provider and social care organisations into Health and Social Care Consortiums at the sites presently housing the main DGH's; Bronglais, Glangwili and Withybush are essential to improve quality, maintain sustainability and ultimately be more cost effective,

Maternity Services

Running a 24/7 service in a Consultant-led unit requires an appropriate number of Consultants to provide adequate service cover. Much is made of activity levels related to maintenance of clinical skills and training for the whole clinical team. This is offset by the fact that the numbers of doctors and trainees is comparably less than bigger units and therefore the per consultant team throughput is broadly the same whether it be in a smaller DGH or a larger DGH. Exposure to rare clinical conditions is unlikely in either setting and needs to be accommodated by maintaining appropriate levels of Continuing Professional Development and carrying out drills on a regular basis within each unit. What is certain is that isolated Midwifery-led Maternity Units and high numbers of Home Births are not as safe as Consultant led units and Birthing Centres attached to them (NICE 2006). Women who have high risk pregnancies need to be safe in the knowledge that they have a well trained team available locally.

Paediatric Services

The lengths of stay for children have reduced dramatically over the last 10 years. However there is still a need for a 24/7 Paediatric service delivered locally. The ability to reduce the lengths of stay is related to the availability of inpatient beds locally. Parents need to know that there is a readily available service close at hand should the need arise when their child is allowed home without a conclusive diagnosis or with the potential for sudden deterioration.

Emergency Medicine (A & E)

To maximise the effectiveness of clinical decision-making and treatment Consultant supervision for A & E departments should be available 24/7. This is not achievable in any of the Dyfed hospitals given that each A & E department has only 1 Consultant. This is an opportunity for clinical networking to work for the good of patients across Dyfed. There could be a common rota with a consultant covering all three sites and this would ensure that as a minimum, 24 hour remote access to Consultant advice using telemedicine and telemetry technology could be made available to ensure that patients receive the right treatment in the right place at the right time according to their clinical needs. Each hospital would require the presence of acute core support emergency services for this to work safely and effectively.

Cardiology Services

A patient admitted to hospital with heart problems should have their care supervised by a Consultant Cardiologist. A formally constructed service network for cardiology would balance the service provision. Specialist Cardiology expertise could be available to general physicians, working to agreed treatment protocols, wherever they happen to be within the Region using the best available technology to provide remote advice/assessment. In the small number of cases where it is deemed appropriate, patients can be transferred in a controlled manner to Swansea where the team of Cardiologists will be based similar to the Vascular service we presently have.

We recognise that change can be very difficult for many different reasons. However services must change if we are to deliver the world-class care that people deserve and this review is only the start of a process by which we must deliver continuous improvement, not only in hospital services but in the 90% of NHS care that is delivered in the community.

4.4 European Working Time Directive

The European Working Time Directive is European law which requires that from August 2009 junior Doctors will work no more that 48 hours per week. Without proper funding of new work patterns this would mean that by 2009 only 41% of junior doctors' posts will meet the required standards. In Mid and West Wales by 2009 the total shortfall in junior doctors' hours will be 2664, equivalent to 55.5 full time junior doctor posts. It is therefore fortuitous that the UK Government was proactive in increasing the numbers of Medical Students and clearly this represents a golden opportunity to utilise this resource to close this gap.

The increase in Junior Doctors will be essential if there are to be increases in the numbers of GP's in the future to help provide more community based services. Failure to comply with the European Working Time Directive carries the risk of prosecution should a legal challenge be made.

4.5 Recruitment and Retention

Recruitment and Retention of staff across a whole range of professions and specialties is becoming increasingly difficult in some parts of the Region. This is not the case in the more rural parts of the region where there is a significant lifestyle choice component. Historically, West Wales has attracted excellent calibre clinicians who have made specific life-style choices to work in small rural communities.

The Royal Colleges have recently realised that it is essential for them to encourage more generalists and are now moving away from subspecialisation for all trainees. There are still plenty of generalist trainees with special interests who can and will fill vacancies should these be funded. It will always be necessary to have advice networks to underpin emergency care to secure optimal patient outcomes.

5. How do we create sustainability?

In creating safe, sustainable and quality services it is acknowledged that the objective is to provide the same high quality of care 24 hours a day, 365 days a year with sufficient numbers of staff and skills. Throughout the stakeholder engagement process of this review, there has been consistent acknowledgement and agreement that sustainability can only be achieved by services and organisations working together.

The challenge for Mid and West Wales is fundamentally how to organise services in sparsely populated areas. For example, the 375,000 population based in Dyfed would indicate that ideally there should be two or three Acute Hospitals to replace Bronglais, Prince Philip, West Wales General and Withybush Hospitals. However with the need to ensure equity of access it is difficult to envisage how a totally centralist model for Dyfed could be made to work.

5.1 Development of the future acute services model for the Region

Our model has been developed in response to the “Designed to Deliver” document and following the overwhelming **“NO”** to the reduction of services in Pembrokeshire contained as proposals in that document. The views of clinicians, experienced health service managers, local and county councillors, economists and the general public have been used to formulate the proposals in this document and the drive has been predominantly patient safety and affordability.

5.2 The Proposed Model for Mid and West Wales

If we accept a 125-250,000 population size to be a more reasonable determinant of rural acute health services communities, the Region can be broadly delineated as follows:

Bro Morgannwg Local Health and Social Care Consortium

Supporting the populations of Bridgend, Neath Port-Talbot and the Western parts of the Vale of Glamorgan. Total population serviced circa. 200,000.

Swansea Local Health and Social Care Consortium

Supporting the population of Swansea together with some cross-over with some parts of Neath Port-Talbot and some eastern areas of Carmarthenshire. Total population serviced circa. 300,000.

N.B for highly specialised services Swansea serves a much broader population of up to 1million.

Carmarthenshire, Pembrokeshire and Ceredigion Local Health and Social Care Consortiums

Supporting the populations of Carmarthenshire, Pembrokeshire, Ceredigion together with parts of South Powys. Total population serviced circa. 400,000. This will be split into 3 Health and Social care Consortiums based in Aberystwyth, Carmarthen and Haverfordwest. The combined purchaser and provider and social care consortiums will work closely together where services outside the local sphere are required i.e. Swansea, Cardiff and in England.

Powys Local Health and Social Care Consortium

For acute hospital provision, Powys does not stand alone but is part of a broader network that includes the Hereford, Royal Shrewsbury, Wrexham Maelor, Bronglais, West Wales General, Swansea, North Glamorgan, Gwent (Abergavenny) and Robert Jones and Agnes Hunt hospitals . This network also provides access to a full range of dependable specialised services. Nevertheless the need for an acute DGH may become apparent once reconfiguration of other areas is finalized.

In terms of highly specialist hospital services these will be based in Swansea. In the same way that the proposed model expects hospitals within the Region to work together to create virtual single services, it is expected that Swansea and Cardiff also develop networks to share skills and expertise within the concept of a single service that happens to be delivered across 2 sites in services such as renal transplantation, neurosciences and cancer treatment for children. The future configuration of these highly specialised services is outside this review and commissioned on a national basis by Health Commission Wales (HCW).

5.3 Structures to deliver service improvements

At present, there are seven LHBs, with responsibility for commissioning services from five NHS Trusts in the Region. Additionally, the LHBs also commission a range of services from a number of provider units outside the Region and in England. In future, the concept of the local Health and Social Care Consortiums will be developed. Each one of these will network seamlessly to purchase services which can only be purchased outside their local area. Powys will continue to structure both the commissioning and delivery of secondary care services as it doe now unless the reconfiguration of services in South East Wales and England removes safe alternatives for local care when a more radical solution may be required
.
The proposed structural improvements to deliver this requirement can be summarised as Follows:

5.3.1 Local Health Boards

These will be abolished and they will be subsumed within the new Local Health and Social Care Consortiums. Each LHSCC will work collaboratively with Local Authorities to bring health and social care together and provide a joint funding stream over the next 3 years.

In practice this will mean 6 Local Health and Social Care Consortiums in the Region as follows:

In Powys, the Local Health Board will be replaced with a Local Health and Social Care Consortium which will function in a similar way to before.

In Swansea the Trust and LHB will combine to form a single Health and Social Care Consortium for the provision of general hospital social care and community services.

Bridgend LHB and Neath Port Talbot LHB will merge with Bro Morgannwg NHS Trust to form a single Health and Social Care Consortium for the provision of general hospital social care and community services.

Carmarthen LHB will combine with the Trust to form a single Health and Social Care Consortium for the provision of general hospital social care and community services.

Ceredigion LHB will combine with the Trust to form a single Health and Social Care Consortium for the provision of general hospital social care and community services.

Pembrokeshire LHB will combine with the Trust to form a single Health and Social Care Consortium for the provision of general hospital social care and community services.

5.3.2 Trusts

For Bro Morgannwg and Swansea the proposed model is consistent with current Acute Trust organisational boundaries.

This is not the case within Dyfed where the proposed merger of Trust and LHBs would necessitate the reconfiguration of Mental Health services. Each Local Health and Social Care Consortium would now include the relevant portion of the former Derwen part of Pembrokeshire and Derwen NHS Trust and the three consortiums would be expected to network effectively together and with other areas in Wales and England for more specialist Services.

The Local Health and Social Care Consortiums would be;

- Carmarthenshire LHSCC
- Ceredigion and Mid Wales LHSCC
- Pembrokeshire LHSCC

5.4 Service descriptions

Changes to clinical care and improvement to standards have prompted the realisation that some elements of the traditional District General Hospital service cannot be planned, developed or delivered in isolation. Some Cancer, Cardiac and Vascular services organised on a National and Regional basis are developing standards and care pathways to improve the delivery of care. Within the Region there is the expectation that the hub of these developing networks will continue to be Swansea. A dynamic equilibrium has always existed with regards to the centralisation of certain aspects of care at the 'hub' of a network or in Tertiary Units e.g. Neonatal Surgery, Paediatric Intensive Care or Complex Cancer Surgery. Other activities (e.g. MRI scans, Coronary Angiography, Chronic Renal Dialysis and Chemotherapy) which were once centralised will now be available at the more peripheral sites.

It has been recognised by Wanless that the things that the NHS does well i.e. emergency services must be maintained and enhanced in the localities where they are needed. He also suggested that elective services must be improved and we have seen waiting times come down over the last few years. The new LHSCC's must build on this and the additional funding that is being made available over the next 10 years utilized to enhance these 6 new consortiums. Social Care must be administered jointly by the LHSCC and the Local authority over the next three years with the development of a joint funding stream in order to reduce the Delayed Transfers of Care which can have such a deleterious effect on elective surgery admissions. This again fits into Wanless and is his second criteria for how to improve the services. All the proposed changes, according to Wanless, must not be introduced without a published evidence base and costings and evaluation criteria. This was his third criteria for improving Health and Social Care in Wales.

5.5 Definitions

Local Health and Social Care Consortium.

This is defined as an all encompassing health and social care purchaser/provider unit. The provision of care for acute, community, social, primary and mental health will be organized by this one organisation to provide a seamless approach to the patient and their family.
Apart from Powys (unless changes are needed because of reconfiguration elsewhere) there will be a dedicated acute hospital with the following services;
√ 24 hour A & E Department that accepts all patients except those requiring specialist Neurosurgery, Cardiothoracic or Burns assessment that will go directly to Swansea
√ Fully integrated Medical and Surgical Assessment Unit
√ Full range of inpatient services (highly specialised at Swansea only)
√ Full Intensive Care, High Dependency Care and Coronary Care services
√ Emergency Operating 24 hours a day, 365 days a year
√ Consultant Led Maternity Service and Neonatal Unit
√ Full inpatient Paediatric Service
√ Broad range of elective inpatient surgery (including common cancers with MDT support)
√ Broad range of day-case surgery
√ Full outpatient service
√ Extensive diagnostic services
√ Rehabilitation

6. How have we defined this model?

The "Designed for the Future" Project has been managed according to standard Project Management processes. A Project Board consisting of members of SWAT was established to oversee the process. The board were influenced by other interested individuals but mostly by the overwhelming "NO" votes taken at the recent "Designed to Deliver" public meetings. These votes quite clearly gave a remit as follows;

1. There should be no merger of Trusts to form a Dyfed Super Trust.
2. Option 1 from "Designed to Deliver" should be thrown out.
3. Option 2 from "Designed to Deliver" should be thrown out.
4. A new Option 3 should be developed which would maintain and enhance services in Pembrokeshire, Carmarthenshire and Ceredigion.

The board await the detailed financial modelling which has to be available before any changes should be considered.

7. How will we deliver improved services?

Improved services can only be delivered when the appropriate finances are made available and when changes as detailed above have been implemented to reduce excessive wasted resources through poor management. This will require radical change and substantial improvements throughout management but most importantly at the top of health service management in Wales.

The proposed Local Health and Social Care Consortiums will provide value for money with reduced management costs and an improved seamless model of health and social care for the benefit of all patients and their carers and provided locally at the point of need.

This 3rd option needs to be put to the people of Mid and West Wales in a further public consultation before any decisions on the provision of health and social care for the region are made by the Health Minister.

8. What else is needed for this model to work?

There are many components to modernized health care that need to be developed in parallel to achieve the best outcomes for patients, spanning self-care; primary and community care; social care and the integral role of voluntary and statutory agencies, individuals and carers in the delivery of services. The full benefits to patients will be achieved by changing and improving all components of health and social care, not through the reconfiguration of acute hospital services.

9. Are these proposals affordable?

This is the most important question and one that has not been answered in either "Designed to Deliver" or "Designed for Life". As Wanless said in his review before any changes are contemplated there must be a published evidence base with detailed costings and evaluation criteria. The public and professionals need to see these immediately. There is a golden opportunity with the increased resources of capital available to make strategic change to

address the financial pressures within the service and not to continue with a system of small scale cost-reduction schemes that will ultimately adversely affect patient services.

9.1 Resource Constraints

Over the last three years there has been an increase of over 23% in funding to Local Health Boards in the Region. This opportunity has been wasted and very limited changes in the way services are delivered have been made. It is to this end that "Designed for the Future" is aimed at reducing the significant waste incurred over the last few years in additional management costs and poor management which have frittered away these additional funds with limited benefits to patients, and hospital trusts left in deficit across the region. This document attempts to provide answers to the funding deficiencies and the way finances should be used in order to improve Health and Social Care in Wales and make it fair, safe, equitable and future proof.

9.2 Joint Funding Mechanisms and Pooled Budgets

New and more flexible ways of managing and utilizing resources between the different agencies involved with health and social care are already emerging. These will need to be refined and become increasingly responsive to change if the benefits of integrated care are to be fully realised for patients. Partnership arrangements need to mature into systems of joint accountability where the flow of money across organisations becomes an enabler rather than a constraining factor in the delivery of service improvements.

9.3 Capital (money to build new facilities)

In March 2005, the Welsh Assembly Government outlined a new capital budget for buildings and equipment that essentially doubled the amount of money available each year from April 2007. With a capital budget that will stand in excess of £300million per annum over most of the lifetime of this programme of change, the prospect of significant investment in new healthcare facilities for Mid and West Wales has never been better. Capital will also be required to upgrade, modernise and redevelop some of those hospitals that will not be replaced.

A revised system for planning and contracting for new NHS buildings is being established within Wales which will streamline the process to accelerate capital developments. Early indications suggest that the national programme could accommodate the building programmes outlined within the acute services review proposals for Mid and West Wales, provided that the justification is sufficiently robust in terms of both service benefit and revenue consequences.

10. Implementation

The revised systems for an integrated purchaser/provider model will need to be centred on existing clinical networks (where they are in place) working to a common set of criteria which will need to be developed in advance. Patient and carer involvement in these network discussions will be essential for success as will full engagement of the ambulance service. The critical role of staff and staff-side organisations in the change process must not be underestimated and a full partnership approach to all project structures must be adopted.

Whilst it is highly likely that there will be a need to retain strategic Regional oversight of the process, increased involvement of the CHCs at this level will be an absolute requirement to ensure a patient-focused approach to the implementation framework.

11. Transitional Arrangements

It is envisaged that these changes, if accepted, will be implemented over the next ten years. Detailed business cases will need to be developed for new hospitals and Primary Care Resource Centres; there will need to be further consultation with staff regarding changes in roles; and there may need to be additional public consultation exercises around specific service issues. Based on this framework, it is therefore proposed that a detailed implementation programme is developed in partnership with staff-side organisations and Community Health Councils once agreement is secured on the future configuration of services. However as an interim arrangement the development of Local Health and Social Care Consortiums must be commenced immediately via the merger of Trusts and LHBs and with close collaboration with Local Authorities.

12. Consultation timetable and process

At the beginning of this document we identified the need to deliver health services that are high quality, safe, sustainable, accessible, affordable and acceptable to patients. We strongly believe that the proposals outlined in this document will improve the care for patients across the region. This new proposal must be put before the people of Mid and West Wales immediately.

Appendix 1

Evidence File

In preparing the content of this Consultation Document, the Project Team has referred to the following policy guidance and evidence of good practice:

1. Welsh Assembly Government (2005) Designed for Life: Creating world class Health and Social Care for Wales in the 21st Century. Available from: www.wales.nhs.uk/documents/31672.pdf

2. NHS Wales (2005) Building local, safe and sustainable services for Mid and West Wales: The Case for Change. Available from: http://www.healthchallengepembrokeshire.co.uk/objview.asp?object_id=17

3. Wanless, D (2003) The review of Health and Social Care in Wales. The report of the Project Team advised by Derek Wanless Available from:http://www.wales.gov.uk/subieconomics/content/hsc/review-e.pdf

4. Department of Health (2003) Keeping the NHS Local: A New Direction of Travel. Available from: http://www.dh.gov.uk/assetRoot/04/08/59/47/04085947.pdf

5. NHS Scotland (2005) A National Framework for Service Change in the NHS in Scotland: Building a Health Service Fit for the Future. Available from: www.scotland.gov.uk/Publications/2005/05/23141307/13104

6. Darzi, A (2005) Acute Services Review – Hartlepool and Teesside. http://www.northteespct.nhs.uk/publications/acuteservicereview/

7. Joint Consultants Committee (1999) Organisation of Acute General Hospital Services. London: Joint Consultants Committee; 1999.

8. Academy of Medical Royal Colleges. Rural Access Working Group. Centralisation and specialisation of hospital services: bigger is not necessarily better for rural and remote communities. 2005. ARCW(05)14 The trend towards centralisation of hospital services2005oct final.doc

9. NHS Scotland National Advisory Group (2005) A framework for the sustainable provision of unscheduled care. Available from: http://www.show.scot.nhs.uk/sehd/nationalframework/Documents/unschedcare/UnschedCare240505.pdf

10. Royal College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow. Scottish Intercollegiate Working Party on Acute Medical Admissions and the Future of General Medicine. A review of professional practices in Scotland with recommendations for debate and action. Edinburgh: Royal College of Physicians of Edinburgh; 1998.

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12. National Public Health Service, Welsh Assembly Government. Overview of the evidence on effective service models in chronic disease management (Draft). Cardiff: NPHS; 2005.

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14. National Public Health Service for Wales. Drivers to services. Cardiff: NPHS; 2005. Available from: http://www2.nphs.wales.nhs.uk:8080/Designedforlifedocs.nsf/Main%20Frameset?OpenFrameSet&Frame=Right&Src=%2FDesignedforlifedocs.nsf%2F61c1e930f9121fd080256f2a004937ed%2F8025706f003aabe6802570d1003fc662%3FOpenDocument%26AutoFramed

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Appendix 2

Project Management Structure

Key Personnel

Project Board

Chris Overton (Consultant Obstetrician and Chairman, SWAT)
Peter Milewski (Consultant Surgeon and member of SWAT)
Bill Philpin (County Councilor and member of SWAT)
John Gossage (Economist and Public member of SWAT)

Project Team

Cherie Harvey (Town Councilor and Secretary, SWAT)
Anthony Miles (Town Councilor and Treasurer, SWAT)
Elisabeth David (Retired GP and Trustee, SWAT)
V Vipulendran (Consultant Paediatrician and member of SWAT)
Gustavo Vas Falcao (Consultant Paediatrician and member of SWAT)
Ken Harries (Consultant Surgeon and member of SWAT)
Glan Phillips (Consultant Orthopaedic Surgeon and member of SWAT)
David Williams (IT expert and Public member of SWAT)
Maureen Molyneux (Town Councilor and member of SWAT)
John Phillips (Retired Consultant Obstetrician and member of SWAT)

Function

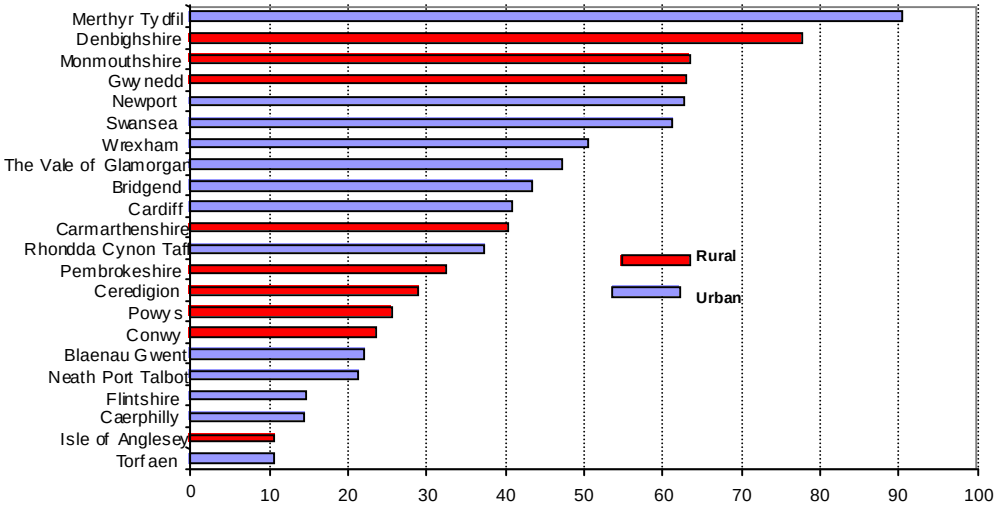
• To agree the Project Plan
• To present the Project Plan to the CHC, the Public and the "Designed to Deliver "Team

Meetings

Meetings of the Project Board were held on 6th and 18th June 2006

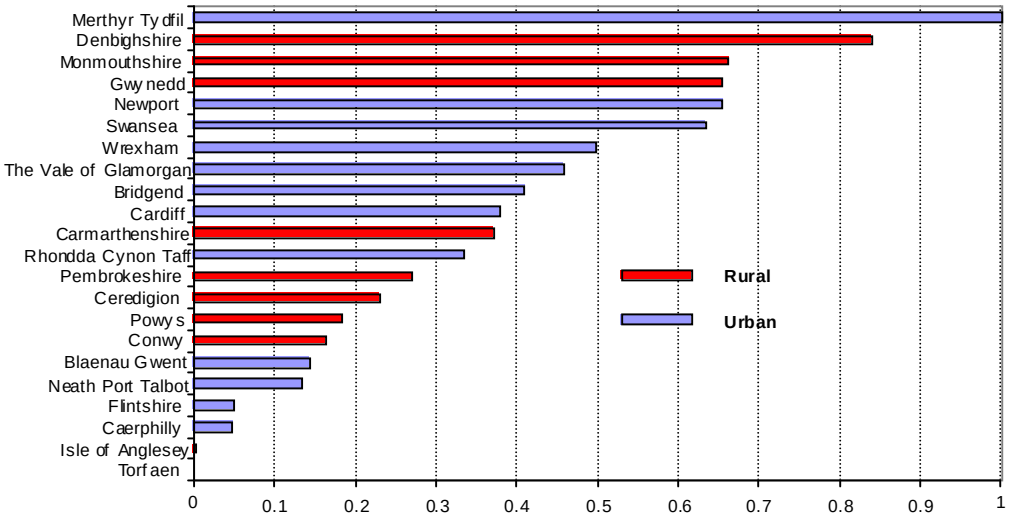
TABLES 1 & 2

Non-psychiatric hospital beds per 10,000 residents in 2002/3



Source: Digest of Welsh Area Statistics 2004 Table 2.9 NAW

Range standardised ratio of non psychiatric beds to resident population



Source: Digest of Welsh Local Area Statistics 2004 Table 2.9 NAW, calculations by SWAT

The Mid and West Wales NHS region accounts for more than half the land mass of Wales yet it has the lowest ratio of beds to population of the three regions.