

Designed to Deliver

Shaping our
Acute Hospitals in
Mid and West Wales

Technical Document



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Technical Document

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Foreword

We are pleased to present to you the initial proposals which have been developed as part of a recent review of acute health services in Mid and West Wales.

Recommendations contained within the *Review of Health and Social Care in Wales* (Wanless, 2003) identified a pressing need for a review of the pattern of health and social services. The report continued by stating that radical redesign of services is critical to future success. There is a need for the range of services provided in acute hospitals to change. We need to rebalance hospital and community care with more services delivered closer to patients' homes; and the need to reduce our dependence on over-stretched hospital facilities.

In May 2005, *Designed for Life* (10 year strategy for the NHS in Wales) was published by the Welsh Assembly Government, building on the recommendations of the Wanless Review. It challenges the NHS to modernize services in line with the changing needs and expectations of the people of Wales. In response to this strategy, each of the 3 NHS Regions in Wales was commissioned to undertake a review of acute services and bring forward proposals for improvement.

The current arrangements for acute health care in the Mid and West Wales Region were essentially established in the 1960s. Since then there have been radical clinical and technological developments which have changed immeasurably what it is possible to do. Consequently it is now imperative to review how, where and from whom patients receive their services.

Within the Mid and West Wales Region there is a commitment across health and social care organizations for all to work together in the best interest of patients. It is important to break down the organizational barriers that have sometimes prevented those interests being met. We need to respond in new ways to better meet the challenges of an ageing population and the consequential increase in long term medical conditions and chronic disease.

This document places emphasis on the patient and carer experience, focusing on service networks and patient pathways. It sets out proposals for how services can be reconfigured differently, with the concept of Service Delivery Units (Hospital Networks) in each locality linking together different sites through service networks to achieve a more effective and sustainable pattern of care for the future.

The information in this paper will give you the opportunity to think about the changes we are proposing. We also welcome any alternative suggestions you may have about how we can improve services in line with our stated objectives and we hope you will take the time to attend one of the events that will be held in your local area over the next couple of months to give us your views.

Chairs of:

**Bridgend LHB
Carmarthenshire LHB
Ceredigion LHB**

**Neath Port Talbot LHB Swansea LHB
Pembrokeshire LHB
Powys LHB**

1. 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. This is what the people of Mid and West Wales deserve and is something that the health organisations in the region are determined to deliver. Whilst we recognise this is a long-term strategy, the necessary improvements cannot be achieved unless we begin changing and developing services **now** to better respond to the high expectations we all have of our health services.

This document has been prepared 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 consistent discussion 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 we intend to involve

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

Whilst this document mainly focuses on changes to general hospitals, these are taking place within the context of the exciting changes, challenges and opportunities associated with the development of care outside the hospital setting – in our communities and homes. Already we are seeing 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. This has been particularly successful in Swansea recently where new systems of working with patients and their families to better understand and manage their disease has had a direct effect in reducing admissions to hospital (**Appendix 2**)

As these treatments continue to advance and the technology develops further to enable people, wherever they may be, to be remotely assessed and monitored by highly skilled clinicians, how we use traditional hospital services will change. As a result, we must be in a position to respond in a positive manner that improves the patient experience.

The scope of this review of Acute Services does not extend to Mental Health Services. Nevertheless, the development of Mental Health Services is a high priority within NHS Wales and significant changes are already occurring, with major investment taking place. A comprehensive review of Mental Health services is in the process of being commissioned and will be closely linked to the future model of acute hospital services.

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 are committed to working with you to improve your health; to supporting local people and communities in promoting health; to maximise independence; and to involve you in the shaping of your health service for the future.

We want to break down the barriers between hospital services, primary care/community services and social services such that we deliver an integrated system of “care” to you, the user.

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 we fully recognise our responsibility in explaining how change will benefit you in the long-term.

1.2 Why do we need to change?

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 organisations and their staff need to serve communities and populations that are large enough to treat the number of patients to maintain their skills.

There are serious concerns about the sustainability of the acute services in the Mid and West Wales region, both now and in the future, because of a range of factors that are making this absolute requirement increasingly difficult to achieve:

- Patients, Carers and representative groups are better informed about health and health care than ever before, which is a good thing. The internet has opened up information channels that enable users of the health service to have clear expectations of the services they want from the NHS and to quite rightly demand the very best medical care that is possible in the 21st century.
- The effects of the European Working Time Directive (EWTD) on medical staffing legislate for a reduction in the working week for junior doctors to 48 hours by August 2009. Unless we change the way in which we deliver services, there will not be enough doctors (because by law they will all need to work less hours) to provide a safe level of care for patients across the 24 hour period. Simply employing more doctors is not the answer – not only would that be unaffordable, more fundamentally, there would not be enough patients seen to enable them to be trained effectively and maintain their skills.
- Medicine and surgery are becoming increasingly specialised. This is good news for patients - the best outcomes for people with heart attacks are achieved if they are

cared for by a specially trained Cardiologist. Bowel surgery is best conducted by a Colorectal surgeon; vascular surgery by a Vascular surgeon. At the moment this specialist expertise is spread very thinly and is not equitably available to all patients across our communities. A further problem is that outside core working hours (out of hours) patients tend to be seen either by doctors in training or those with generalist rather than specialist expertise.

- There is an increasing and often unnecessary requirement for travel on patients and their families for specialist opinion and review. Advances in diagnostic services and telecommunications technology mean that much of this travel could be avoided with patients only travelling where it is absolutely essential for specialist intervention.
- 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.

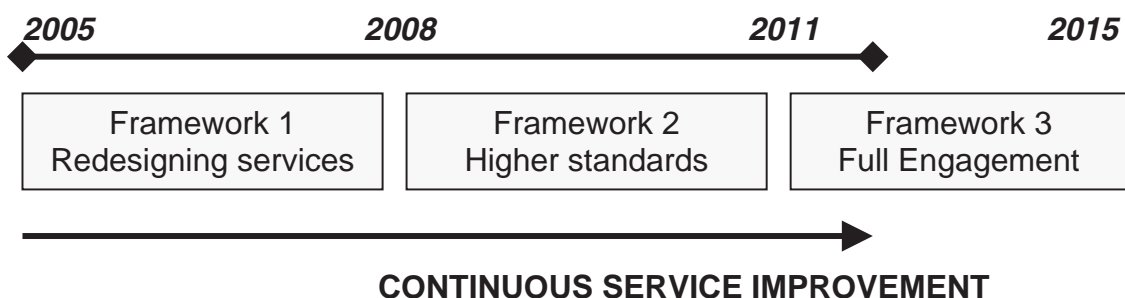
We must invest in new systems and models for primary and community care that bring outpatient and diagnostic services nearer to the patient. We need to develop better integrated urgent care services where patients can be assessed and treated in their own homes or communities; (things patients and carers keep telling us they want the NHS to deliver for them).

To do this we must transfer resources (and by that we mean people and skills as well as money) from the traditional models of hospital-based care to new systems of community and primary care. This requirement to modernise services equally applies if we are to get the best value out of future investment in services (e.g. delivering the 26 week waiting time)

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

Change needs to happen **now** 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, where improvements can be achieved through existing resources and facilities, we need to be taking action over the next 12 months to reap early benefits for patients.

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



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 pathway and not the facilities and locations in which care is delivered.
- The focus of services in the future will be on the provision of care closer to peoples' homes. This will mean that more care is delivered in the community setting and there will be less need for patients to come to hospital for routine care (e.g. outpatient 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 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 as locally as possible. (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 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 more often be the community and not the hospital setting. 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. Where Primary Care Resource Centers are identified as an integral part of the overall system of delivering care, they will contain services tailored to local circumstances from a range of options as illustrated in Appendix 1. Your Local Health Board and Local Authority will work with you over the next couple of years to ensure this process and the outcome is responsive to local need.

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 3 Acute Service Delivery Units (hospital networks) and 1 Networked Service Delivery Unit (Powys) of community and hospital services:

- **Bro Morgannwg** where acute care will be delivered across Princess of Wales Hospital and Neath Port Talbot Hospitals working as one integrated service on two sites
- **Swansea** where acute care will be improved by concentrating on a single hospital site all of the services currently provided at Morriston and Singleton Hospitals.
- **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.
- **Dyfed** where the focus of acute care will be delivered through a network that essentially works as one hospital across several sites. This will enable us to strengthen local services through clinical teams working more closely together to maintain and improve services local to the population. This will be achieved through:

EITHER: the development of a new single acute hospital in South Dyfed, located mid way between Haverfordwest and Carmarthen to replace Withybush and West Wales General Hospitals. This new hospital would be networked with Bronglais Hospital and supported by community services and Resource Centres. Key outpatient and diagnostic services would need to be strategically placed to maximise local delivery, particularly in Carmarthen and Haverfordwest.

OR: the development of West Wales General Hospital as the main acute hospital site networked with Withybush and Bronglais, both of which would operate on a linked service basis.

In both of the options described for Dyfed, the focus of subspecialty services would be on the main acute site and the networked hospitals would work on the basis of 24 hour acute assessment, stabilisation treat or transfer depending upon clinical complexity and patient need.

Neath Port Talbot Hospital and Prince Phillip Hospital, Llanelli will have an integral role to play within the hospital networks. They will continue to provide acute emergency medical services and a full range of diagnostic and outpatient services. However, they would expand to specialize in providing more elective surgery for the Region.

1.4.2 Specialist Care

Specialist services such as Cancer services, 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.

Further developments in inter-organisational multi-disciplinary team working and technology will mean that patients needing specialist treatment can have initial assessments and tests undertaken locally; initial specialist consultations undertaken remotely using telemedicine;

most specialist follow-up treatment and review undertaken locally under the supervision of the specialist teams using local skills and expertise and telemedicine technology. In summary, even though 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 in Ceredigion and further examples of where this will apply in the future are given in Section 7.8.

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 Boards and Trusts 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

- Our resources are not spread too thinly
- Clinical expertise is not misused and diluted
- We are able to attract and retain top quality professionals
- Specialist services do not become too fragmented among too many Trusts
- Services do not become increasingly congested.

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.

Designed for Life (2005) then set out the strategic framework for the NHS in Wales from 2005 to 2015, identifying the major challenges facing the NHS in Wales as:

- ensuring a safe service, by dealing with the fragmentation of specialist services amongst too many Trusts/hospitals
- attracting and retaining top quality professionals
- responding to an increasing demand on services which threatens to overwhelm the current highly congested services
- to avoid spreading resources too thinly.

Designed for Life also set out proposals for designing a health care system focused on three basic principles

- User-centered services
- Getting the most from resources
- Targeting continuous performance improvement.

Subsequently, the Welsh Assembly Government announced the requirement for reviews of acute health services provision to be undertaken in each of the three Regions in Wales, the reasons for which were further outlined in the publication “Building Safe and Sustainable Services for Mid and West Wales: the Case for Change” (2005).

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 no longer be at the centre of the health system, that primary care becomes increasingly important, that health and social services need to be integrated and that the management of chronic conditions 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. No longer will the focus be on hospitals; the emphasis will be 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.

Looking into the future our needs will change again as, 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. Several studies identify that patients in rural communities can be disadvantaged in terms of early diagnosis of cancer and that distance from the cancer centre can affect cancer survival.

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.

New communities have also developed, the age structure of the population has changed and the way disease is treated has altered so that hospital admission is no longer the best way of

tackling many conditions and often hospitals are treating patients who could be equally well looked after in another setting. 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).

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 there will 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%).

This means that the population in the Region will look quite different in less than 20 years time with fewer children, young people and economically active people and rapidly increasing numbers of older people, especially the very elderly.

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.

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. A recent conference hosted by the NHS Confederation highlighted sustainability, critical mass, changes in clinical practice and the management of illness and workforce changes as key drivers for change, referencing changes that are taking place in Manchester, Northumbria, Norfolk and Surrey, among others. A key recommendation was that most acute hospitals should plan for a future in which they will probably provide fewer services than at present, driven by the type of changes we describe here.

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. These themes correlate closely with the three strategic themes set out in *Designed for Life* to secure dramatic change in the provision of health care in Wales.

This context of integrated service provision, with a focus on the provision of safe services as locally as possible and care being provided at the point most appropriate to the needs of the patient is the one in which other local plans are being developed and consulted upon (see **Appendix 2**).

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 training at the right level and in the right volumes 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 programmes of inspections and assessments against pre-determined 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 are sometimes challenging for smaller units to achieve.

The Royal Colleges also make recommendations on Consultant staffing levels according to the critical mass needed to maintain safe and high quality services, many of which cannot be achieved other than in large hospital settings. In Dyfed for example, each of the 3 Trusts delivering separate services will not be compliant with modern professional standards. However, the reconfiguration of services into a single network could result in maintaining these professional standards. The Royal Colleges are also the accreditation body for training of medical staff and if training approval is not maintained, recruitment of medical staff will become almost impossible.

3.1.4 Quality

There are many different definitions of quality but the definition that we have used to underpin the Acute Services Review for the Mid and West Wales Region work is

“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 in a different way.

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 practice 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, even though we have employed more staff across the board, we must still change the way we work if we are 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.

Consequently, even with more doctors in training than ever before, these changes mean accommodating new ways of working.

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 creation of new roles in the delivery of 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. The development of new techniques has meant that treatment that would have required a 10-day hospital stay several years ago can now be

provided as a day case; procedures that historically were undertaken under general anaesthetic in hospital can now be conducted in the GP surgery. At present we have too much health care investment tied up in beds in hospitals and insufficient in primary and community settings or home care support. This imbalance in facilities and resources limits our ability to take full advantage of these developments in medical practice.

3.2.5 Resource Constraints

Whilst there has been significant investment in new forms and patterns of healthcare 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 utilised to prop-up unsustainable services that are costing more and more to deliver with little additional 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 traditional models of care to invest in new ways of working. All NHS organisations in the Region are already striving to deliver their Strategic Change and Efficiency Plans in order to address financial pressures but further, 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; accessible assessment and treatment; separation of elective and emergency care with not all services available on all sites; the development of clinical networks; and refocusing the role of the acute hospital.

This is achieved through the following themes which underpin the proposals set out later in this Consultation Document:

- Achieving 'critical mass' of patients and staff
- Strengthening chronic disease management programmes in the community, primary and intermediate care settings is key to reducing the pressure on emergency care in acute settings
- Managed Clinical Networks – joint working between hospitals with well developed transfer arrangements
- Innovative approach to workforce redesign and extension of staff roles
- Separation of elective and emergency cases
- Development in Information and Communications Technology (ICT) – use of telemedicine, electronic patient record and digital imaging transfer
- Maximizing the provision of care wherever possible the community setting, therefore reducing hospital admissions and attendances.

Appendix 3 lists the evidence and sources that we have used for reference in this work.

4. Why is the current service 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 (already functioning as a Local General Hospital)

A significant amount of 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 are 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 all regions of Wales and across the border into England as well as those delivered directly by Powys LHB through the existing community hospital infrastructure. All these providers work in partnership with the LHB to deliver a high quality network of accessible acute services enabling community hospitals to provide elective inpatient and day patient surgical services, endoscopy, a range of investigative services, midwifery led birthing units and admit appropriate medical emergencies 24/7.

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. (see section 8).

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.

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 suggested that the optimal catchment population for a District General Hospital is around 300,000. This in itself would suggest that there would be inefficiencies within the health care system in the Region. There is duplication of service provision, staffing and governance issues in terms of critical mass and constraints in training / development and recruitment and retention of staff.

4.3 Sustainability

The main concerns identified within this review are associated with governance (quality and safety) issues and the clinical sustainability of many services which mean that **the people of this Region are not receiving the service they deserve and** which together make a powerful argument for change.

The particular issues leading to this conclusion are slightly different in each of the Region's 4 areas (Bro Morgannwg, Swansea, Powys and Dyfed).

Bro Morgannwg

Since being established in 1999, Bro-Morgannwg has undertaken a significant proactive programme of change which has resulted in substantial realignment of services in response to changing demands (see **Appendix 2** for examples from Bro Morgannwg and other communities within the Region). Whilst there is further transformation to be achieved, the direction of travel is entirely consistent with the principles identified within Designed for Life and this acute services review.

Swansea

The Swansea community has been debating the potential for integrating the services currently provided from Morriston and Singleton Hospitals onto one site and again, this is entirely consistent with policy and best practice guidance.

Powys

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.

Dyfed

The most complex problem in the Region is the provision of acute services in Dyfed where, sustainability issues permeate the entire area. Although there are several centres of population, much of the region is sparsely populated and the large geographical area creates unique challenges associated with balancing access and critical service mass. Concern about the quality and sustainability of services are not concerns about individual clinicians and their abilities. While we firmly believe that the proposed reconfigurations will make for a

better environment for clinicians, and for patients they do not reflect concerns about the quality of care offered by the individual Doctor, Nurse or Allied Health Professional.

The following scenarios illustrate how the current configuration of service is out of balance.

Maternity Services

Running a 24/7 service in a Consultant-led unit requires a minimum of 5 Consultants to provide adequate service cover. Many units within the Region have lower levels of activity than the average number of deliveries per Consultant, which raises questions about the ability to maintain the appropriate level of clinical skills and training for the whole clinical team. This is particularly relevant in terms of exposure to rare clinical conditions.

Developing extended Midwifery-led Maternity care with a single integrated Consultant-led service for Dyfed will address these issues. For a very small number of women who have high risk pregnancies, it may mean travelling further to deliver their baby but the safety and quality of that service can be much better assured. For the majority of women they will have higher quality midwife-led care closer to home.

Cardiology Services

A patient admitted to hospital with heart problems should have their care supervised by a Consultant Cardiologist. Where there is only one specialist in a hospital, there is no support and advice for other clinical colleagues when this individual is off duty, on holiday or on study or sick leave, other than through informal networks.

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 another centre in the network to ensure they receive the expert care they need.

Paediatric Services

The last 10 years has seen a significant change in the way we deliver Paediatric Services. The professional and parental drive to avoid overnight hospital stays for children unless absolutely necessary has meant that the 24 hour profile of paediatric care has dramatically altered. The day-time and early evening work has expanded, with more investigations and treatments delivered in the community and in day-units, and overnight work has contracted. Yet we still have traditional inpatient models of care which mean there are not enough Doctors and Nurses around during the day and often very little patient activity at night.

The way we organise Paediatric services needs to respond to the changing pattern of care. Whilst 24 hour Paediatric assessment and stabilisation services will need to continue, networks of services could reduce the number of places with overnight capacity releasing staff and resources to improve the services to patients when needed most (during the day and early evening).

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.

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 than 48 hours per week. Without changing the current working patterns this means 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. Clearly this presents a pressing need for change as even with the increase in numbers of doctors, we will not be able to close this gap. This is because simply putting additional junior doctors into the current model of service delivery would not provide them with enough patient contact and experience to allow them to meet their training requirements and develop their skills.

Failure to comply with the European Working Time Directive carries the risk of prosecution should a legal challenge be made. Change needs to happen in three key areas to improve the position. These are rotas, the development of night-time services in hospitals and, crucially, reconfiguration.

4.5 Recruitment and Retention

Recruitment and Retention of staff across a whole range of professions and specialities is becoming increasingly difficult in some parts of the Region.

This is particularly evident in the case of senior medical staff. The new Consultant, when faced with the prospect of significant choice over where he/she wants to work, is influenced by a number of factors including:

- Frequency and intensity of on-call commitment
- Balance between general and subspecialty interest clinical activity
- Availability of high quality support services
- Links with academic institutions
- Work environment (including equipment etc.)

It is therefore becoming increasingly difficult for smaller service units to compete for high quality clinical staff as the on-call commitment has a major impact on quality of life for Consultants. Historically, West Wales has attracted excellent calibre clinicians who have made specific life-style choices to work in small rural communities, many of whom are approaching retirement in the near future. This, together with the advent of the revised

Consultant Contract and the sub-specialty training programmes for medical staff, means that succession planning and recruitment is becoming increasingly difficult.

The subspecialty debate is also becoming increasingly challenging for small provider units. The generation of surgeons and physicians who received generalist training are rapidly disappearing and are being replaced by Consultants who have been through targeted specialist training programmes. The new generation of Consultants are not general physicians but Cardiologists, Respiratory Physicians, Gastro-Intestinal Physicians, Endocrinologists etc. This does not mean that they cannot deliver core emergency medicine activity but, in terms of optimal outcome, it does mean that a system and structure of sub-speciality treatment and advice networks must be developed 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.

Modern clinical practice indicates that we need to have hospital networks catering for populations of 300,000. This would provide the patient base and the requisite staffing numbers / skills distribution to deliver high quality 24 hour care. In urban populations such as Swansea, this would suggest the need for the equivalent of one acute hospital.

The challenge for Mid and West Wales is fundamentally how to organise services in sparsely populated areas. For example, the 300,000 population basis in the context of Dyfed would indicate that ideally there should be one Acute Hospital to replace Bronglais, Prince Philip, West Wales General and Withybush Hospitals. With the need to balance issues of access and critical mass it is difficult to envisage how a totally centralist model for Dyfed could be made to work, but sustaining 4 hospitals duplicating services for already small populations will be extremely difficult to achieve in the future.

In consideration of the evidence base and in listening to the views of stakeholders as part of this review process, a model for the provision of hospital services has been developed to address the issues of critical mass and access.

5.1 Development of the future acute services model for the Region

This model has been developed through a project management structure which was established after the publication of the Case for change at the end of October 2005, as set out at **Appendix 4**. Throughout all of the discussions the views of clinicians have been extremely influential and the drive has always been clinical sustainability. The thinking was also shaped by the discussions at four stakeholder events which were held in early January 2006 to broaden the debate and bring out more views to inform the future models of care and the development of options. From these events several models of service delivery emerged which identified themes and thinking that were largely compatible with models set out in Sections 6 and 7 in that they should be based on:

- A systematic approach
- A focus on patient pathways
- Strengthening diagnostic processes
- Different elements of care for different hospitals
- Graduated models of care
- Service networks.

Whilst it is acknowledged that there were concerns about the timing of the Stakeholder events and the notice given, which inevitably affected attendance, the events did establish agreement on the forces for change, introduced different degrees of knowledge and experience to the process and helped considerably to supplement the traditional approach to the development of options. Details of the Stakeholder events are attached at **Appendix 5**.

5.2 The Proposed Model for Mid and West Wales

Taking the 300,000 population size as an approximate determinant of acute health services communities, the Region can be broadly delineated as follows:

Bro Morgannwg Service Delivery Unit (Hospital Network)

Supporting the populations of Bridgend, Neath Port-Talbot and the Western parts of the Vale of Glamorgan. Total population serviced circa. 300,000.

Swansea Service Delivery Unit (Hospital Network)

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. 270,000.

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

Dyfed Service Delivery Unit (Hospital Network)

Supporting the populations of Carmarthenshire, Pembrokeshire, Ceredigion together with parts of South Gwynedd and North Powys. Total population serviced circa. 370,000.

Powys Service Delivery Network

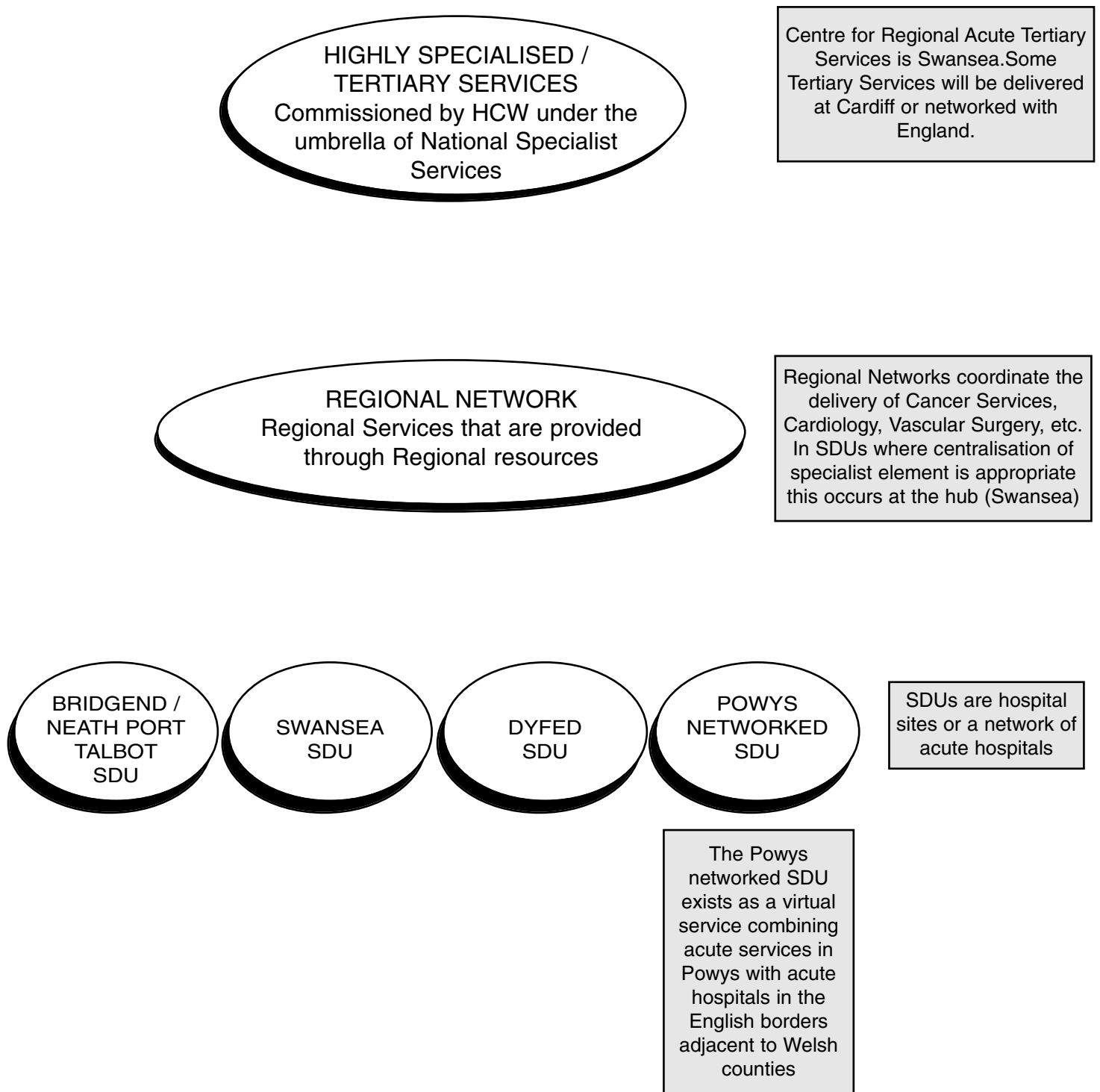
For acute hospital provision, the Powys Service Delivery Unit does not stand alone but is part of a broader network that includes the Hereford, Royal Shrewsbury, Wrexham Maelor, Bronglais, West Wales General, Swansea, North Glamorgan, Gwent (Abergavenny) and Robert Jones and Agnes Hunt hospitals . This network also provides access to a full range of dependable specialised services.

In terms of specialist hospital services, the critical mass of patients and subspecialty skills cannot even be delivered through the local service delivery unit and would require the networks to work together to create an integrated service across organisations. An example of where this is already being planned is with vascular services where Bro Morgannwg, Carmarthen and Swansea surgeons aim to link together to provide a single vascular surgical on-call rota that ensures at any one time there is a vascular surgeon available within the network to provide support and advice on clinical decision making, wherever the patient may be, and, if necessary, accept transfers for emergency specialist intervention.

When it comes to highly specialised services such as Cardiac Surgery, there is only one site in the Region providing these services, namely 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

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). Figure 1 depicts this model.

Figure 1: Revised Service Model



5.3 Structures to deliver service improvements

During the stakeholder engagement phase of this project, one of the consistent themes that emerged was the need to ensure that organisational boundaries do not get in the way of delivering high quality care for patients.

This review was set up to focus on improving health services. However, it is clear that changes to the way in which services and organisations are structured will be central to the achievement of maximum benefit in the future.

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 3 Service Delivery Units (Hospital Networks) and the Networked SDU for Powys must be the basis upon which we structure both the commissioning and delivery of secondary care services in the Region.

The proposed structural improvements to deliver this requirement can be summarised as follows:

5.3.1 Local Health Boards

A review of the present commissioning arrangements is currently underway on an all-Wales basis and will ultimately inform the overall strategic direction for the Region. However, this review has identified an absolute requirement for the secondary care commissioning function of the LHBs to be conducted on a collegiate basis in line with the SDU model.

In practice this will mean 4 collegiate commissioning arrangements in the Region as follows:

- In Powys, the networked SDU is contained within the Local Health Board with highly complex linkages to other service providers. It is not proposed that this will change.
- Swansea LHB will continue to work directly with Swansea NHS Trust for the provision of general hospital and community services
- Bridgend LHB and Neath Port Talbot LHB will be expected to develop an integrated secondary care commissioning structure building on the existing concordat with Bro Morgannwg NHS Trust. This will include working with their main service provider units to develop joint long-term agreements and strategic change and efficiency plans.
- Carmarthen LHB, Ceredigion LHB and Pembrokeshire LHB will be expected to develop a single integrated secondary care commissioning structure. This will include working with their main service provider units to develop joint long-term agreements and strategic change and efficiency plans.

There is a clear recognition of the need to retain local partnership working between LHBs, Local Authorities and both statutory and voluntary providers of health services in the delivery of the Health, Social Care and Wellbeing Strategies. Any organic organisational change that might emerge from the aggregation of commissioning functions must take account of this important requirement.

5.3.2 Trusts

For Bro Morgannwg and Swansea the proposed SDU model is consistent with current Acute Trust organisational boundaries. On that basis, there are no proposals for change.

This is not the case within Dyfed where the proposed SDU would straddle 3 existing organisations:

- Carmarthenshire NHS Trust
- Ceredigion and Mid Wales NHS Trust
- Pembrokeshire and Derwen NHS Trust

The whole of the improvement agenda in Dyfed is predicated on these 3 Trusts working together to deliver a single integrated service that allows resources and expertise to be put to best use for the whole population. In considering the necessary structures to deliver such joint working, we see no clear benefit to retaining 3 separate organisations.

It is therefore proposed that the 3 Trusts are integrated into one single provider of acute and community services for Dyfed. This will ensure that any organisational barriers to service integration are totally removed and that resources are released to focus better on front-line patient services.

The timing of the integration needs to be discussed as part of this consultation process with the options being:

- (1) Trusts amalgamating before service realignment
- (2) Trusts amalgamating at the same time as service realignment

5.4 Service descriptions

Our present pattern of Acute Hospitals was conceived through the vision outlined in Enoch Powell's Hospital Plan (1962) and the Bonham-Carter Report (1969).

It is now common for a traditional District General Hospital service to be delivered over a network of sites (e.g. Morriston and Singleton or Princess of Wales and Neath Port Talbot Hospitals) and for some hospitals to concentrate on elective (planned) surgery rather than emergency surgery (Neath Port Talbot) whilst fulfilling many of the other traditional District General Hospital roles.

There is awareness that the term '*District General Hospital*' is extremely emotive and does not at present describe the variety (or variability) of services available at the different major acute hospital sites within our region.

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. 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. Certain clinical activities (Neonatal Surgery, Paediatric Intensive Care or Complex Cancer Surgery), which were until quite

recently performed at the majority of acute hospital sites, are now concentrated on a limited number of sites in South Wales as evidence grows that concentrating on one site with one team improves outcomes. Other activities (e.g. MRI scans, Coronary Angiography, Chronic Renal Dialysis and Chemotherapy) which were once centralised are now available at some of the peripheral sites. This trend is also moving diagnostic, treatment and rehabilitation facilities from the Acute Hospital to the Community Hospital or GP Surgery.

Within a '*Service Delivery Unit*' there is the expectation that, as now, a number of acute hospital sites and other facilities will be performing different roles with potentially different emphasis on aspects of emergency and elective care, but acting in synergy to create equitable access to a high quality service which will be challenged to provide a safe service as locally as possible for each aspect of care.

5.5 Definitions

In the absence of universally agreed definitions we are using the following terms to start to differentiate the service provision at the different Acute Hospital Sites:

- District General Hospital (DGH)
- Linked District General Hospital (linked-DGH)
- Local General Hospital (LGH)
- Elective Treatment Centre (ETC)
- Powys Assessment and Treatment Centres (PATC).

There is the assumption that all the major acute hospital sites (DGH, linked-DGH, LGH) will include:

- ✓ Facilities to receive and assess Acute Medical Patients where all patients possibly requiring admission would be assessed (including direct GP referrals)
- ✓ Access to major diagnostic facilities (Radiology and Pathology)
- ✓ Primary Care Out of Hours Service supported by either Minor Injuries Unit or Accident and Emergency Department
- ✓ Day Surgery Services
- ✓ Elective inpatient services
- ✓ Comprehensive Outpatients Facilities.

In the future, when developments in Primary Care services / Resource Centres and the investment in chronic disease management and intermediate care moves some aspects of these services closer to the patient, the dependence on acute medical admissions may decrease, creating the need for further reshaping of the Acute Hospitals as appropriate.

A significant amount of work has already been undertaken to define the precise profile of the services: this will be refined in the light of public consultation. This must be considered on a service by service basis, mapping patient pathways with active involvement of clinicians and patients representatives alike. For example, should all breast cancer surgery be consolidated in one place for each Service Delivery Unit? One-stop clinics, diagnostic services; pre-operative work-up; post-operative follow-up could continue to be delivered locally but are there benefits to patients for the operative part of the pathway to be concentrated in one place to maximise the skills of the surgical teams? These specific details can only be determined in line with the key principles of the network model and with expert clinical and patient input to the decision making process. However, the hospital services portfolio can be broadly summarised as follows:

5.5.1 *District General Hospital (DGH)*

- ✓ 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
- ✓ Broad range of day-case surgery
- ✓ Full outpatient service
- ✓ Extensive diagnostic services
- ✓ Rehabilitation

5.5.2 *Linked District General Hospital (L-DGH)*

- ✓ 24 hour A & E department that accepts most patients
- ✓ Fully integrated Medical and Surgical Assessment Unit
- ✓ Broad range of inpatient services (Specialised services at DGH)
- ✓ High Dependency Care (with capacity for short-term ventilation) plus Coronary Care facility
- ✓ Emergency operating on an extended day basis 365 days per annum
- ✓ Midwifery-led maternity service
- ✓ Extended Day Paediatric investigation and treatment service
- ✓ Range of elective inpatient services
- ✓ Broad range of day-case surgery
- ✓ Full outpatient service
- ✓ Extensive Diagnostic Services

5.5.3 *Local General Hospital*

- ✓ Minor Injuries / Local Accident Centre receiving patients with minor injuries/ illnesses
- ✓ Medical Assessment Unit
- ✓ Medical inpatient services (generally non-specialist)
- ✓ High Dependency Care (with capacity for short-term ventilation) plus Coronary Care facility
- ✓ Range of elective inpatient services
- ✓ Broad range of day-case surgery
- ✓ Full outpatient service
- ✓ Extensive Diagnostic Services
- ✓ Midwifery-led maternity service and/or extended day Paediatric investigation and treatment service where locally indicated
- ✓ Diagnostic Services

5.5.4 *Local General Hospital with co-located Elective Treatment Centre*

As identified in 5.4.2 but with a broader range of elective surgical services, some of which could be specialist in nature.

5.5.5 Powys Assessment and Treatment Centres

- ✓ Receives some patients as direct admissions under protocol (non-specialist)
- ✓ Minor Injuries/Local Accident Centre receiving patients with minor injuries/ illnesses
- ✓ Protocol-driven medical assessment function
- ✓ Some non-specialist short-stay elective inpatient services
- ✓ Broad range of day-case surgery
- ✓ Midwifery-led maternity service
- ✓ Diagnostic Services

There needs to be a detailed clinical dialogue across the Region to secure agreement to the precise service components that are to be categorised as “specialist” services within this conceptual framework and would only be delivered on the DGH sites.

Whilst there are some services that clearly fall into this category, such as invasive diagnostic cardiology, interventional radiology, specialist urology surgery, specialist cancer surgery, etc., there are some services or components of services where it is not so clear. Similarly, as medicine advances, currently defined highly specialised services will become specialist over time (e.g. primary angioplasty) and will move out to the DGH provider units.

For the highly specialised services, the dialogue is much broader than this Region. Having stated quite clearly that the only place within the region where such services would be delivered is Swansea, it is for Health Commission Wales and the national review processes to determine the service disposition with respect to Cardiff and other Providers of such services outside Wales.

6. How have we defined this model?

The Acute Services Review Project has been managed according to standard Project Management processes. A Project Board, consisting of Chairs and Chief Executives of Trusts and Local Health Boards in the Region, was established to oversee the process, with Leaders and Chief Officers of Local Authorities and Health Commission Wales attending to provide advice to the overall process on links with their respective organisations and services. Discussions have also taken place with Community Health Councils at key stages in the process. The Project Board was supported by a Project Team consisting of representative Chief Executives, all Acute Trust Medical Directors, Public Health representation, LHB Medical Director representation and Regional Office finance support.

In line with the proposed model (Section 5.2) and informed by the outcome of the Stakeholder Events (**Appendix 5**) the Project Team developed a long list of options looking at all possible configurations of DGH Services, with 24 hour or linked functions, Local Hospital Services and Tertiary Services and grouped these as follows:

- Population based options based entirely on optimum population masses for the provision of Tertiary and DGH services
- Options which were part population based and part access based i.e. combining the requirements for critical mass with some attempt made to equalize access for the population
- Options which were based on pragmatism i.e. on the preservation of the majority of existing hospital sites in some form
- Options which would preserve access, although limited, in terms of local unselected medical take in existing hospitals

- Options which would preserve access to unselected acute assessment and diagnosis.

The initial brainstorming generated a long list of options that could in theory achieve the required benefits. These options were subsequently refined on the premise that all tertiary services provided within the region for the Region would be based in Swansea. Other options not considered previously were added, including an option to do nothing other than integrating the two Swansea hospitals and an option involving the deletion of one site in Dyfed. This secondary categorization process resulted in reducing the list to 16 options.

In parallel with this process, the Project Team defined the requisite objectives from the reconfiguration and developed a series of criteria against which all 16 options could be assessed. These criteria were informed by the themes that emerged from stakeholder events held in January 2006 where individuals were asked to contribute to defining the requisite parameters for change.

Each criterion was weighted according to relative priority as determined collectively by the group and then each of the options was independently scored by all members of the Project Team and validated through a second scoring exercise.

This process and the results which emerged were considered at a meeting of the Project Board at the beginning of February 2006, the result of which was agreement on the 2 options to be taken forward for public consultation. The options, scoring criteria and weightings are attached at **Appendix 6**.

A conscious decision was taken by the Project Team to defer final financial modelling until the options for consultation had been decided upon. This was on the basis that:

- Although a significant factor, finance is not the primary driver for this review and the derivation of options for consultation should be focused principally on clinical viability
- The amount of work associated with detailed financial modelling (and the inherent cost in the exercise itself) indicates the need to only conduct this level of financial analysis on the most clinically viable options
- The detailed financial modelling on the short-listed options could be undertaken in parallel with the public consultation exercise and be made available to the Project Board to assist decision making alongside the public feedback from the consultation process itself

It was therefore decided by the Project Board that no preferred option would be identified at this stage in the process and that two reconfiguration options be presented to the public for consideration.

7. How will we deliver improved services?

Section 5.2 outlines the proposed model, the essence of which means that acute hospital services will be configured around the three Service Delivery Units: Bro Morgannwg, Swansea and Dyfed. Services within Powys will be configured on the basis of a Service Delivery Unit Network with acute services provided both in-county via local assessment and treatment centres, and linked in terms of catchment populations to the appropriate Acute Services Provider Unit (refer to local consultation “Doing More, Doing Better” for further detail).

The underlying philosophy of the model is that patients will access services at the nearest point appropriate to their needs, that services will be networked between sites to allow

patients to receive as much care as possible close to their homes, recognizing that there will be a need to travel for more complex and specialist services.

7.1 The options for consultation

In both of the options being put forward for consultation, the implications for Powys, Bro Morgannwg and Swansea are the same and are based on patient demographics, population distribution and critical mass of skills. Where changes have been proposed (e.g. Swansea) travel times have been modelled using standardised reference tools. Importantly, any marginal increase in travel times for hospital care must also be balanced against the significant reduction in access times for services delivered much closer to communities through enhanced primary, community and social care services / Resource Centres.

The difference between the 2 presented options lies within the configuration of services for Dyfed. For this population the essential choice is as follows:

EITHER: Access to many routine outpatient and diagnostic services will be improved; more specialist services will be able to be brought back into Dyfed; some inpatient services will be slightly less local

OR: Keep the same good local access but to a more narrow range of services

7.2 What does this mean for Bro Morgannwg?

The Bro Morgannwg SDU will consist of Princess of Wales Hospital and Neath Port Talbot Hospital supported by a network of Primary Care services and Resource Centres, some of which are already scheduled to come on-stream in the Neath Port Talbot area over the next couple of years. Within this context, the role and function of community hospitals may be reviewed.

Acute care will be provided by the Princess of Wales and Neath Port Talbot hospitals working as one service across two sites. Princess of Wales Hospital will increasingly provide more acute care allowing Neath Port Talbot hospital to concentrate on the provision of elective care. Both hospitals will continue to provide a full range of outpatient and rehabilitation services and any changes in capacity will need to be supported through development of local facilities.

In summary, it is proposed that Bro Morgannwg will work on the basis of 1 DGH and 1 LGH working together as an integrated provider of acute hospital services for the community

7.3 What does this mean for Swansea?

A detailed plan will be developed over the next 3 years to establish a single site integrated acute hospital facility.

The hospital will provide routine acute services for the local population of Swansea and parts of Neath Port Talbot and East Carmarthenshire that currently look to Swansea for their acute care provision. The integrated facility will also be the core site for the specialist and highly specialized services for the region and its capacity will be modelled accordingly.

The Swansea LHB and Swansea Trust, in conjunction with the City and County of Swansea, are currently developing plans for the transfer of care out of acute hospitals closer to home,

across the 6 localities in Swansea. This includes chronic disease management and intermediate care and is complimented by more out-patients and specialist clinics in community settings, including local hospitals and primary care resource centres. The strategic placement of these services will need to be considered in the context of the future location of acute hospital services in Swansea. The parallel consultation and public engagement on these developments 'Better Health Services for Swansea' is being run at the same time as the Regional acute services consultation.

Patients being transferred to Swansea for highly specialized care from other hospitals within (and outside) the Region will be managed according to carefully constructed pathways that ensure they are repatriated to their nearest local facility as soon as possible to both protect access for other acutely ill patients and reduce the burden of travel on carers and families.

In summary, it is proposed that Swansea will develop a single-site acute hospital supported by strengthened primary and community services to take routine care closer to patient in their communities. . These enhanced community services will be located to compliment hospital services, securing access for patients across the city and beyond.

7.4 What does this mean for Powys?

Powys faces the challenge of providing safe acute health services in a very rural community with a widely dispersed population. A range of acute services is already provided in-county through effective partnerships with neighbouring acute provider units. Sustaining and building upon these local services can only be achieved through concentrating acute resources into shire-based assessment and treatment centres supported by a number of health and social care facilities and local care teams. Pathways of care will be refined to minimise the frequency and length of time people will need to be out of county, reducing the need to travel for patients and their families.

In summary, it is proposed that Powys delivers more *acute* services locally, in partnership with a network of acute providers, through the development of shire based assessment and treatment centres (as detailed in Doing More Doing Better).

7.5 What does this mean for Dyfed?

The two possible scenarios for Dyfed can be described as follows:

OPTION 1 *Access to many routine outpatient and diagnostic services will be improved; more specialist services will be able to be brought back into Dyfed; some inpatient services will be slightly less local*

Within this option, both West Wales General Hospital and Withybush hospital will be replaced by a single state of the art acute hospital for South Dyfed located between the existing two hospital sites. This hospital would be the main DGH within the Dyfed Service Delivery Unit providing routine acute hospital services for the populations of Pembrokeshire, Carmarthenshire and South Ceredigion and specialist hospital services in a networked arrangement with Swansea and Bro Morgannwg.

The new South Dyfed hospital would, by nature of concentration of expertise and the establishment of new facilities, allow for certain specialist work that has traditionally been provided for this local population by Swansea to be repatriated back within Dyfed. Highly specialized services would continue to be provided to this population by Swansea as currently happens.

Bronglais Hospital would function as a linked-DGH (refer section 5.4 for definitions) delivering integrated services with the South Dyfed DGH site and Prince Philip Hospital would function as a Local General Hospital (LGH) as well as being developed as a dedicated centre for elective treatment for Dyfed and parts of Swansea.

A network of strengthened Primary and Community services / Resource Centres will be developed across Pembrokeshire, Carmarthenshire and Ceredigion (in some areas replacing or building upon existing community hospital facilities), that will take outpatient, routine diagnostic services and chronic disease management closer to the communities, allowing the hospitals to function on activities that can only be delivered in a hospital setting. These Primary and Community Care services proposals will be subject to separate detailed public consultation.

OPTION 2 *Keep the same good local access but to a more narrow range of services*

Within this option, West Wales General Hospital would become the acute DGH site within the Dyfed Service Delivery Unit. Bronglais and Withybush hospitals would function as linked-DGHs (refer section 5.4 for definitions) and Prince Philip Hospital would function as a Local General Hospital (LGH) as well as being developed as a dedicated centre for elective treatment for Dyfed and parts of the Swansea population.

On the basis that the 4 existing main hospital sites would be retained within this option, there would be little opportunity for redistribution of resources to support development of a network of Primary Care services. Also the scope for repatriation of specialist activity from Swansea would be limited given split site working and inability to concentrate resources.

In summary, the options for Dyfed are:

OPTION 1 – the development of a new integrated acute hospital in South Dyfed; Bronglais Hospital as a linked-DGH; Prince Philip Hospital as a LGH and dedicated centre for elective care supporting Dyfed and Swansea; and the development of a network of enhanced Primary and community care services / Resource Centres

OR

OPTION 2 – West Wales General Hospital to become the main acute DGH site for the Dyfed SDU ; Bronglais and Withybush Hospitals as a linked-DGHs; and Prince Philip Hospital as a LGH and the dedicated centre for Dyfed for elective care

This critical choice of options is already very real within Dyfed. A recent review of Maternity Services, conducted jointly by nominees of the Royal Colleges of Obstetrics and Gynaecology, Paediatrics and Midwifery identified that the current maternity services are not sustainable.

They identified the need to consider the Dyfed service as a single integrated service which, if the existing configuration of hospitals is to be retained would mean adoption of a model in line with Option 2 above as follows:

- West Wales General Hospital would become the main Obstetrician-led Maternity Unit and the single location for neonatal beds.
- Inpatient Paediatric services for Dyfed would be focused on the West Wales General Hospital site.
- Worthybush Hospital would migrate to a Midwifery-led Maternity service with a birthing centre on site. All high risk pregnancies would transfer to Carmarthen.
- The Paediatric Service at Worthybush would change to an extended day investigation and treatment unit with inpatient services located in Carmarthen.
- Over a period of 3 – 5 years, Bronglais would migrate to a predominantly Midwifery-led Maternity service with extended day investigation and treatment services for Paediatrics.

Alternatively, if a new single acute hospital were to be developed for South Dyfed, Midwife led and Obstetrician-led services would be located together, accessed according to need and supported by a network of outreach ante-natal and post-natal services within local communities.

This particular set of expert recommendations is likely to be the first of many that will, by default, drive us to Option 2. We need to take this opportunity to shape the future of these services and either take the opportunity to adopt the more radical Option 1 or to proactively manage the otherwise almost inevitable migration to Option 2.

It is recognised both options proposed for Dyfed will have some impact on access times to acute hospitals for residents of Pembrokeshire, Carmarthenshire, Ceredigion and Powys.

Postcode modelling on the basis of a single site option for South Dyfed located half way between Carmarthen and Haverfordwest would indicate that, based on standardised calculations, the average travel time to hospital would marginally increase overall. However, with the proposed developments in primary and community services, the number of patients needing to travel to hospital for their care should significantly reduce and the number of patients needing to travel outside Dyfed for certain aspects of specialist care should also reduce. The identification of an appropriate site for any proposed new facility would need to take into detailed consideration the access routes and times for both the public and emergency services.

Inevitably there would be some alteration in patient flows, where this would be deemed advantageous to local populations, with some South / Mid Ceredigion residents essentially shifting access to Aberystwyth and some East Carmarthenshire patients electing to travel to Swansea (depending upon the location of the new integrated hospital site). Specific consideration will also need to be given to the needs of the populations of South Meirionnydd and West Montgomeryshire in the context of the inter-relationship with the North Wales Acute Services Review. Any potential changes in patient flow would ultimately need to be factored in to the capacity modelling for the future.

7.6 How congruent are these proposals with other local and national initiatives?

In developing these proposals we have taken account of the considerable work on service improvement that is already being undertaken across Wales through other initiatives and structures, to ensure congruence in the emerging themes. Specifically, the proposals

dovetail with the work in progress in relation to achieving the Access targets for 2009, and correlates closely with service models emerging from the South West Wales Cancer network and the emergent thinking on emergency demand management.

The proposals set out in this document are congruent with the outcome of the Surgical Services review for Carmarthenshire which recommends a separation of the provision of emergency and elective services, which is now being considered by the Carmarthenshire NHS Trust and the Carmarthenshire LHB. The proposals also fit closely with the findings of the recent review of Obstetric services for Dyfed and Powys, as discussed above.

The proposals recognize the important role of local services provided in Powys and the dependence of Powys residents on District General Hospital services within and outside the Mid and West Wales Region. The implications of changes in hospital service provision for Powys residents are reflected in earlier sections of this document and crystallize the need for further work to align the interface between the services provided in all three Welsh health regions.

7.7 How do these proposals fit with the Wales Spatial Plan?

For Bro Morgannwg and Powys, the future development of Primary Care Resource Centres can be accommodated within the boundaries of Local Authority Unitary Development Plans and the Wales Spatial Plan. In Powys the proposals to develop assessment and treatment centres and health and social care facilities can similarly be accommodated.

For Swansea, the identification of an appropriate site for development of a new integrated acute hospital facility can be accommodated within the boundaries of the Wales Spatial Plan and future Primary Care Resource Centre developments can be delivered within the context of local planning requirements.

For Dyfed, the proposal for a single South Dyfed Acute Hospital development would be dependant upon identification of an appropriate site that would be consistent with the Wales Spatial Plan. Informal advice received from the Welsh Assembly Government indicates that this could potentially be accommodated but this would need to be tested further with the identification of potential sites should this become the preferred reconfiguration option.

7.8 What will all of this really mean for patient care?

In short, the way we deliver patient care will change for the better over the next 10 years.

- Chronic diseases such as diabetes, asthma etc. will mainly be managed by patients at home supported by their Primary Care teams using the best of modern technology that allows remote monitoring by health professionals who will be able to provide on-the-spot advice to prevent deterioration and the need for acute care
- Many of the outpatient services currently provided by hospital doctors in hospital clinics will be delivered by specialist GPs in Primary Care settings within your community. These GPs will have direct access to diagnostic tests and advice from hospital Consultants to aid clinical decision making.
- If you need to see a hospital Consultant, other than for highly specialised care this is most likely to be accessed through your Primary Care service within your community, either in the form of a face to face appointment or through telemedicine consultations in partnership with your GP or Specialist Nurse.
- If you become acutely ill, there will be a single contact number that you will call where specially trained practitioners will assess your needs and determine what sort of

assistance you require. These individuals will be able to provide treatment advice; arrange for you to come in to a treatment centre; book you an urgent appointment to see an appropriate health professional the same day or the next day; despatch a Paramedic, Nurse or Doctor to assess you at home; or arrange for you to be brought in to hospital for assessment.

- If you are very unwell and come to hospital, you will be quickly assessed and a decision made about your care needs drawing on the best available expertise within the service network as appropriate. If your treatment can be delivered locally it will be done so to the highest standard. If your clinical outcome would be better from being transferred to a specialist centre, this will be done in a timely and controlled manner and as soon as your specialist care needs have been met you will be brought back to your local hospital for ongoing care, rehabilitation and follow-up treatment to be delivered as close to home as possible.

This can probably be best explained through some real-life examples of how services will be delivered as follows:

Patient who finds a breast lump

A 52 year old lady presents to her General Practitioner, having found a lump in her breast the previous day. Her GP strongly suspects breast cancer and refers her to the local one-stop Breast Clinic where she is seen by the Specialist Team within ten days of referral.

After a mammogram and a biopsy, both taken on the day of the clinic, a diagnosis of breast cancer is confirmed. The test results are discussed via the Telemedicine Link with the Regional Breast Care experts and the best treatment option decided in discussion with the patient.

Elderly Lady who fractures her hip in a fall at home in the evening and is admitted to a Linked-DGH at 10pm

An 86 year old lady is admitted to A & E having sustained a fall at home. Immediate assessment by the Ambulance staff at the scene suggests a probable hip fracture. Effective pain relief and immobilisation is carried out prior to transfer to hospital. Shortly after arrival at the A & E department, further assessment by the on-call surgical team confirms the diagnosis. Further pain relief is administered and the patient is stabilised and made comfortable within the Acute Assessment Unit that is co-located with the A & E department. Her likely discharge support needs are assessed at this point in her patient journey and if required, a referral prepared for the Hospital Social Worker and Occupations Therapist who will undertake the necessary assessments within 48 hours of admission. Relatives are informed at this stage of the likely date of discharge based on the standard hip fracture pathway that is proactively managed by the Orthopaedic Specialist Nurse.

An operating theatre slot is booked for 8am and the patient is transferred directly from the Acute Assessment Unit to the operating Theatre at 7.30am. She is settled comfortably in a bed on the orthopaedic ward by lunchtime and her post-operative rehabilitation starts the same day.

Discharge is achieved within the pathway guidelines with any ongoing rehabilitation requirements being addressed within the community.

Patient sustains severe head injury in Road Traffic Accident in rural mid-Wales

Ambulance attends the scene and Paramedics make an assessment of a severe head injury. According to patient need and availability of transport, patient is either air-lifted (dependent upon weather conditions) or transferred by ambulance direct to the nearest Neurosurgical Unit.

The key priority in such scenarios is to transport the patient to the point of definitive care as quickly and safely as possible. However, there are occasions where there could be clear benefit to the patients condition in seeking further local medical assessment to stabilise the patient prior to transferring to the specialist centre.

Child with suspected Meningitis

The mother of a 7 year old girl calls the GP Out of Hours service concerned that her child has a very high temperature. A GP is despatched to the home, assesses the patient and suspects Meningitis and gives antibiotics. An ambulance is called and the child is taken direct to the DGH where the Consultant Paediatrician and Critical Care team are waiting at the A & E department to conduct an immediate assessment and instigate appropriate treatment.

Child with head injury presenting to A & E

A 4 year old boy is brought to the A & E department of a Linked DGH at 9pm having fallen and sustained a short period of unconsciousness. The child is conscious on arrival but distressed and confused. An assessment is made by the A & E team with advice from the on-call Paediatrician in the DGH who reviews the CT scan, X Rays and other test results via the PACS and telemedicine system. All vital signs are stable but the Paediatrician feels it is sensible to observe the child overnight for review by the local Paediatrician who will be on duty in the morning. The child is kept in the designated Children's cubicle within the Assessment Unit which is adjacent to the A & E department and is reviewed the following morning by the local Paediatrician who discharges him home.

62 year old man is brought by ambulance to his LGH with Chest Pain

Paramedic staff undertake an ECG which indicates a probable a heart attack. "Clot-busting" drugs are administered at the scene in line with agreed protocols. The patient is assessed on arrival at the LGH and immediate treatment administered as appropriate. Advice is sought from the Cardiologist on-call for the network regarding further immediate intervention.

Young mother with previous history of abnormal smears who has repeatedly missed her follow-up smear appointments

Having failed to attend 3 appointments at her GP surgery for follow-up smear tests, the Practice Nurse arranges a home visit to the 43 year old mother of 4 to perform the necessary procedure. The results come back within 2 weeks identifying abnormal cells and the patient goes to her local Primary Care Resource Centre for a colposcopy test which is conducted by a Specialist Nurse.

The results come back within 2 weeks identifying invasive cancer and an urgent appointment is made for the same week for the patient to see a Consultant in her local hospital. During that consultation a videolink is made with the Specialist Oncologist in the Regional Centre for the local Consultant and the patient to discuss further investigations and treatment. A date is confirmed for surgery during this consultation and the patient admitted to the Regional Centre on the morning of her surgery 10 days later. Her operation proceeds without complications and she is transferred back to her local hospital 3 days later for the remainder of her care to reduce the burden of travel for her family.

The results of the surgery are discussed with the patient via a telemedicine link before her discharge from her local hospital. The tumour has been successfully removed and there is no need for further follow-up by the Regional Centre.

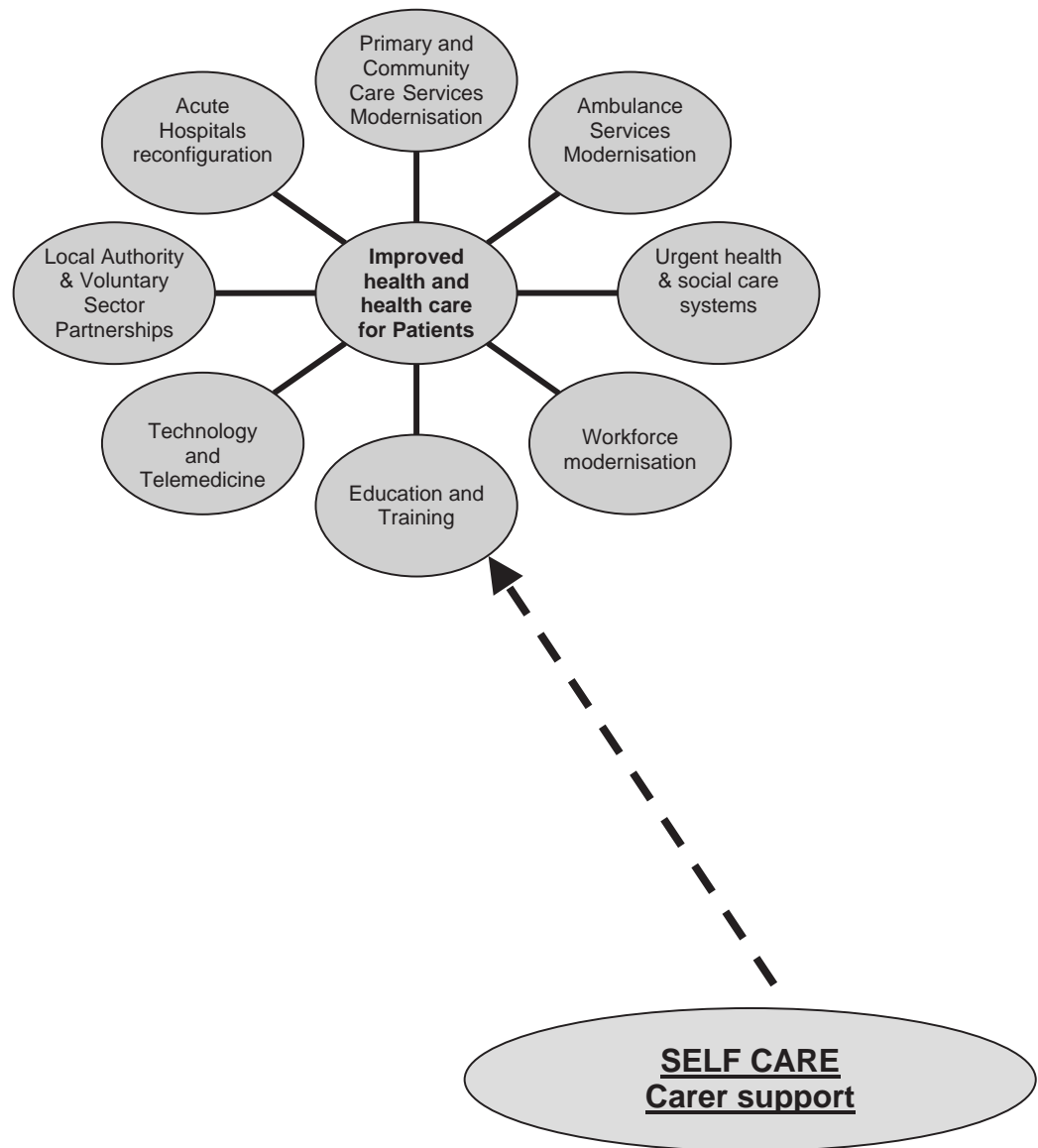
Routine follow-up is conducted by her local Consultant in her local hospital with further advice from the Regional Centre via telemedicine links if necessary.

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 alone. In many ways, the hospital dimension will have the least impact on overall health improvement and yet it is clearly the most visible in the eyes of the community. Figure 2 shows the overall context for this.

Figure 2 Context for Change



Appendix 2 provides an overview of the complementary modernization programmes and some examples of where this is already being achieved within the Region.

In summary, the key requirements are as follows:

Modernisation Category	Key Requirements	Lead Agencies
Primary and Community Care	<ul style="list-style-type: none"> • Rapid access to appropriate Primary Health Care practitioner • Proactive models for chronic disease management • Expert Patient Programmes • Focused case management according to evidence based multi-agency care pathways • Reablement services to maximize independence 	Local Health Boards
Ambulance Services	<ul style="list-style-type: none"> • Extended triage function of Ambulance Control (Hear and Treat) • Delineation of the Paramedic Assessment and Treatment function and patient transport/transfer functions • Extended range of mobile health care assessment and treatment services to reduce the numbers of patients needing to attend hospital 	Welsh Ambulance Service
Urgent Health and Social Care	<ul style="list-style-type: none"> • Integrating the modernization agendas associated with the Ambulance Service, Primary Care, NHS Direct, GP Out of Hours Services, Minor Injuries Units and A & E departments, the development of a single access point for patients for all unplanned care episodes, 24 hours a day, 365 days a year will be instrumental in development of enhanced community services 	All agencies
Workforce Modernisation	<ul style="list-style-type: none"> • Development of health care support workers who have a dual role across health and social care • Identification and development of extended practitioner roles for Nurses, AHPs and Paramedics across Primary and Secondary Care 	Trusts and Local Health Boards
Education and Training	<ul style="list-style-type: none"> • Development of network-based rotation programmes for Junior medical staff playing to the relative strengths of individual services and sites • Development of accredited training programmes for higher level support workers • Advanced Nurse Prescribing training and accreditation 	Trusts, LHBs and Education Providers
Technology and Telemedicine	<ul style="list-style-type: none"> • Investment in state of the art diagnostic facilities to support clinical decision making in all hospital sites • Broad-band access for PACS and Telemedicine • State of the art telemedicine and telemetry equipment and training to facilitate remote patient assessment • Piloting of home-based telemedicine for remote monitoring of patients with chronic disease 	Informing Health Care, Trusts and LHBs
Local Authority & Voluntary Sector Partnerships	<ul style="list-style-type: none"> • Community Strategy and HSCWB Strategy • Modernising Social Care • Education and life-long learning • Transport and infrastructure 	Local Authority Voluntary Sector partners
Self Care / Carer support	<ul style="list-style-type: none"> • Empowering the citizen to take more control of his/her own health and health care 	LHB / LA Voluntary sector/Self

9. Are these proposals affordable?

This review is not specifically driven by a need to reduce costs within the Region: it has been instigated on the basis of an absolute requirement to secure high quality, clinically sustainable services.

The NHS has, in recent years, seen unprecedented growth in both capital and revenue funding and yet many parts of the Region are experiencing significant financial pressures associated with propping up unsustainable services and this cannot be overlooked when redesigning services. As a minimum requirement, proposals for change must be contained within the existing resources available to the service; in reality the proposals should release resources tied up in out-dated services and facilities to invest in more efficient and effective ways of delivering patient care and at the same time bridge the financial gaps. This is not just about investment and disinvestment, but also about addressing the financial deficits: if we do not take this opportunity for strategic change to address the financial pressures within the service, we will continue with a system of small scale cost-reduction schemes that will ultimately adversely affect patient services.

9.1 Revenue (service running costs)

The current scale of the financial challenges within the Region is starkly demonstrated by the 2005/6 projected out-turn for Trusts and LHBs which stands at £14.857m. Within this bottom-line figure, there is considerable variation with:

- Carmarthen LHB, Bridgend LHB, Pembrokeshire LHB, Neath Port Talbot LHB, and Bro Morgannwg Trust forecasting break-even
- All other LHBs and Trusts forecasting a deficit position

The Swansea community has faced increasing financial challenges over the past few years with growing demands for specialist services and the added resource burden of sustaining two separate acute hospital sites. This year, for the first time ever, both the LHB and Trust in Swansea are forecasting a deficit position.

The position in Dyfed reflects 2 successive periods of financial recovery over the past 6 years and clearly demonstrates underlying financial viability concerns. It is therefore not surprising that this financial pattern echoes the service sustainability arguments and serves to support the argument that it is within Dyfed that the reconfiguration requirements are most significant.

The significant degree of change and development that has occurred within LHBs and Trusts to reduce costs, even to the current levels of spend, should not be underestimated although it is recognised that the pace and scale is variable across the Region.

The formula that is used to distribute resources across Wales is currently being reviewed and whilst this may have some impact on the individual LHB areas, it does not alter the fact that the amount of money overall to deliver services will remain the same. Any modifications to the formula may result in individual community positions improving or worsening but this does not alter the fact that in both manpower and financial terms, the resources are spread too thinly. This clearly illustrates that failure to secure disinvestment through strategic change will not allow us to invest in the necessary improvements in services for the future.

Resource Constraints

Over the last three years there has been an increase of over 23% in funding to Local Health Boards in the Region. Whilst there has been investment in new forms and patterns of healthcare in recent years, the NHS in Wales does not have unlimited resources. Wholesale delivery of the new and better treatments that patients quite rightly demand can only be delivered if we release resources from traditional models of care to invest in new ways of working.

All NHS organisations in the Region are already striving to deliver their Strategic Change and Efficiency Plans in order to address financial pressures. This already includes a varying degree of service reconfiguration but further, strategic measures are required for longer-term stability and improvement in service provision.

There are 3 key stages to the resource mapping requirements for change on a scale such as this:

STAGE 1 Outline cost comparisons

This exercise involves a review of similar reconfiguration projects elsewhere in the U.K. to identify broadly whether the costs of proposed models are containable within existing resources.

These proposals are put forward on the basis that they will cost no more than the current configuration, based on the STAGE 1 outline cost comparisons contained within **Appendix 7**.

STAGE 2 Outline resource modelling

This exercise involves commissioning specialist expertise to model the cost base of the short-listed proposals and again make comparisons with existing service models and costs.

The STAGE 2 outline resource modelling has been commissioned by the Project Board and will be reported towards the end of the consultation period to assist the final decision making process. This information will be shared with Community Health Councils and an overview summary will be made available to members of the public on request.

STAGE 3 Detailed resource modelling

This involves detailed costing, Project by Project, of each element of the overall change programme in the context of full business case development. At this stage, the level of detail is very explicit, even down to the number, hours and grades of staff involved in delivering the services.

The STAGE 3 detailed resource modelling will only be commissioned as part of the detailed business planning for proposed developments once agreement is secured on the way forward.

9.2 Joint Funding Mechanisms and Pooled Budgets

New and more flexible ways of managing and utilising 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

Over the next 3 months, an implementation framework will be developed that brings together the various complementary change projects across the Region into a coherent programme that ensures developments are synchronised and organisations working in partnership.

This framework will need to identify the necessary skills and dedicated resources to drive this change programme forward in line with its key component requirements as follows:

- Development of new models for chronic disease management and urgent care within the context of strengthened primary, community and social services
- Development of revised patient pathways **within** Service Delivery Units for routine acute hospital care
- Development of revised patient pathways **between** Service Delivery Units for specialist acute hospital care
- Development of revised patient pathways for highly specialised patient care within and across the health Regions in Wales
- Development of business cases for new hospital developments
- Development of business cases for facilities in Powys linked to the “Doing More, Doing Better” consultation
- Development of business cases for Primary Care Resource Centres

Much of this work will be undertaken within existing organisational structures and will not require a pan-Regional approach. In advance of any potential creation of a single acute Trust for Dyfed, it is likely that there will need to be a single multi-agency change management board developed to ensure that there is effective inter-organisational collaboration for change. This arrangement would require strong leadership; professional clinical input; effective Human Resources and Finance advice; staff-side partnership and would, most

importantly need to be fully empowered by the existing Boards to act on a corporate basis to deliver improved services.

The revised pathways work 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.

Consideration will need to be given to the role of the Project Board and Project Team in the implementation phase of this process. 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.

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.

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.

However, given the serious concerns about sustainability of the current configuration (refer to Maternity Services Review – Section 7) there will inevitably need to be some early rebalancing of services prior to any new hospital developments being completed. This will mean creating integrated services in the very near future, linking together clinical teams and patient pathways across organizations. For Dyfed, the only community where the Service Delivery Unit straddles more than one organization, it is likely that there will need to be early service integration with rebalancing of work between hospitals for the benefit of patients which will almost inevitably lead to organic organizational change.

Changes will also need to take place in the interim to address the challenges of the European Working Time Directive and medical staff recruitment. Some innovative solutions to this problem are already being considered, one of which is the Hospital at Night project. In this model multidisciplinary teams work in shifts overnight to manage the clinical needs of patients at night. Whatever form reconfiguration takes, rota management and Hospital at Night are operational service delivery tools and should be in place prior to reconfiguration to facilitate compliance. Such action for a hospital such as Bronglais would constitute a significant step towards the linked-DGH concept if undertaken in collaboration with partner organisations.

It will be neither desirable nor possible to delay the introduction of new ways of working on the proviso that the future distribution of service is unknown. The timetable for reconfiguration extends beyond 2009 and with this process may alter consultant delivery of

care. For the short term nearer 2009 it is about delivering a different streamlined service for junior doctors and senior nurses.

Finally, whilst it has been clear from the outset that this acute services review is not primarily a financially driven exercise, the reality of the financial challenges within the region cannot be ignored. It will be an absolute requirement of Trusts and Local Health Boards to ensure that the Strategic Change and Efficiency Plans they prepare to deliver financial balance are consistent with the overall direction of travel. Where implementing service change, consistent with the acute services review, results in reduction of operating costs, it is expected that these will be actioned without delay.

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 you receive and create the right platform for world class services in the future, but only you can answer the question about public acceptability. Your views are critically important in helping us to make the right decisions about the future shape of health services in Mid and West Wales.

We welcome your comments on any aspects of the proposals and specifically on all or any of the consultation questions presented in the document as you see relevant to yourself and your community.

We welcome your views on the following general proposals:

1. Primary and community services will be developed to deliver more and more services locally and outside the traditional hospital setting
2. In supporting the above, we need to reshape and redesign the provision of services that can only be delivered in hospitals
3. 3 Service Delivery Units and 1 Networked Services Delivery Unit (Powys) will be developed for the Mid and West Wales Region that allows us to network services to maximise the use of specialist skills and expertise for all patients
4. Services will be redesigned around the patient pathway so that whilst it may be necessary to travel for specialist or highly specialised services we will use the best of modern technology to enable significant components of care to be delivered locally

We would also welcome your views (including your reasons for agreement or disagreement) on the following proposals:

5. **For Powys**, where clinically appropriate, more acute services will be delivered locally, in partnership with a network of acute providers, through the development of shire based assessment and treatment centres (as detailed in Doing More Doing Better)
6. **For Bro Morgannwg**, Princess of Wales Hospital and Neath Port Talbot Hospital will continue to work as one acute hospital across 2 sites and that Neath Port Talbot Hospital will be further developed as a dedicated centre for elective treatment supporting both Bridgend and Swansea communities as well as the local population
7. **For Swansea**, acute hospital services will be provided from a single integrated hospital site which will be supported by strengthened primary and community services delivering outpatients, diagnostic, minor injuries and minor treatment services closer to the communities in and around Swansea
8. **For Dyfed**, Prince Phillip Hospital, Llanelli, will retain its key function as a centre for emergency medical assessment and treatment for the local population and will be further developed as a dedicated centre for elective treatment supporting both Dyfed and Swansea

On the basis that the requirement for services to be networked to provide a virtual single-service across multiple sites for Dyfed is the best way forward, there are 2 options to consider in terms of delivering the best quality and access for all residents of Dyfed:

- (a) To replace Withybush and West Wales General Hospitals with a single new integrated hospital facility, half way between the existing 2 hospital sites to be networked with Bronglais and supported by comprehensive primary and community care services as described above?
- (b) To develop West Wales General Hospital as the main acute hospital site for Dyfed supported by Bronglais and Withybush both of which would need to function on a more restricted service basis?

We also welcome your views on the proposed changes to organisational structures that we consider of critical importance to delivering service improvements as follows:

9. Bridgend LHB and Neath Port Talbot LHB will develop joint arrangements for the commissioning of secondary care services
10. Carmarthenshire LHB, Ceredigion LHB and Pembrokeshire LHB will develop a single arrangement for the commissioning of secondary care services
11. A single Trust will be developed for Dyfed with full service and organisational integration to deliver maximum benefits for patient care. Your views are sought on the following:
 - (a) Should this single organisation be created **BEFORE** the services are integrated?
 - (b) Should this single organisation be created **AT THE SAME TIME** as services are being integrated?

Finally we would welcome any alternative proposals you may wish to be considered, in line with the key objectives outlined in both this document and Designed for Life together with the evidence and rationale underpinning your proposals.

Whilst this is a Regional plan, the consultation will be led by your Local Health Board who will organise local public events to explain the implications for your area and answer any questions you may have.

Your local Community Health Council will be an essential part of this process and they will be able to provide you with an impartial and independent perspective on these proposals and assist you in making your views known if that would be helpful to you.

This consultation will run for a period of 12 weeks from 3 April 2006 and will end on **Monday 26 June 2006**, by which time any comments you wish to make must be sent to your Local Health Board. The relevant contact details are as follows:

If you require further copies of this document, these can also be obtained via the address overleaf.

At the end of the consultation process, we will consider all the responses received from the public and specifically seek the views of the Community Health Councils within the Region who have the formal responsibility to represent the public in such matters.

If we reach agreement on the proposals, this will be confirmed at the public meetings of the Local Health Boards and we will proceed to implementation as outlined in Section 10.

If we fail to reach agreement on the proposals, the detail of the consultation and the responses may be referred to the Minister for Health and Social Care for a decision.

YOUR VIEWS ARE VERY IMPORTANT TO US.

PLEASE MAKE SURE YOU HAVE YOUR SAY!

Appendices

Appendix 1	Range of Services that will be considered for inclusion in Primary Care Resource Centres
Appendix 2	Local modernisation Programmes
Appendix 3	Evidence File
Appendix 4	Project Management Structure
Appendix 5	Stakeholder Events
Appendix 6	Options, scoring criteria and weightings
Appendix 7	Stage 1 Outline Cost Comparisons
Appendix 8	Glossary of terms

Range of Services that will be considered for inclusion in Primary Care Resource Centres

The range and nature of primary and community care delivered services will vary according to local need and access to DGH services. These will be developed by Local Health Boards and Trusts in conjunction with Local Authorities and Voluntary Sector partners over the next 12 months. Some of these services and facilities will need to be in place BEFORE the proposed hospital service changes take place if we are to achieve maximum benefit in terms of improving healthcare.

There will be no prescribed list of services to be contained within a Primary Care Resource Centre but possible services include:

- Primary care services
- Pharmacy, including minor ailment clinics
- Optometry
- Community dental service/General dental service
- Local Authority community care team
- Mental health services
- Diagnostic and X-Ray facilities
- Outpatient clinics (Consultants or nurse led)
- Phlebotomy
- Minor injury clinics
- Health Visitors
- Community Nursing
- Minor surgery services
- Contraceptive services
- Audiology
- Electro-cardiograms
- Sexual health clinics
- Chronic disease management
- Community events
- Podiatry
- Diabetology
- Physiotherapy
- Early response team
- Reablement team
- Integrated assessment teams for Older People
- Continence clinics
- Information and advice services

Local Modernisation Themes

This appendix supports section 8 of this Consultation Document. It expands on the changes that are needed in other areas of health and social care to underpin the proposed changes in acute hospital provision, and gives example of changes and innovation that is already happening within the Mid and West Wales region.

1. Changes Needed to Underpin Changes in Acute Hospital Provision

(a) Changes in the Ambulance Services

Changes in the way in which health care services are provided within the Region must be supported by different ways of working within the Ambulance Service. This service, in line with all other parts of the NHS, is already going through an unprecedented period of change and modernization to develop the role of the Ambulance Service as an integral part of the unscheduled emergency and urgent care network that can direct patients quickly to the appropriate care pathway and support other parts of the service. Key elements of the changes that are envisaged are that:

- The Ambulance Service will link the Acute Services Review with the developing Emergency Care Services (DECS) Project and the Welsh Emergency Care Access Collaborative (WECAC) with the result that the Ambulance Service will be placed at the centre of Clinical Care within unscheduled care across Wales.
- To support the changes resulting from the Acute Services Review, the Ambulance Service will introduce new methods of service delivery focused on the patient and wider community, changing the ways in which calls for emergency and urgent unscheduled care are managed, and improving the speed and quality of services provided to patients with emergency care needs. This will require
 - Working with secondary care providers to provide the most appropriate timely response
 - Introducing care pathways for common conditions according to national and local requirements.
 - Reviewing the strategy for inter hospital transfers and the need for specialist modes of transport and equipment.
- Further protocols for direct referrals to Minor Injury Facilities or other specialist units or wards will be developed to:
 - Allow patients to receive specialist attention more quickly.
 - Reduce pressure on hospital admissions
 - Reduce overall travel times for patients
 - Increase ambulance availability within localities
- New services and methods of service provision will be introduced which will have the immediate benefit of reducing the number of patients transported to District General Hospitals and A & E Departments.

- The Ambulance Service will provide and co-ordinate an increasing range of mobile health care for patients who need such care and will provide an increasing range of other services e.g. in Primary Care, Diagnostics and Health Promotion. New roles currently in operation or under development, which will provide a more rapid response whilst retaining the availability of emergency services within each locality, include:-
 - Paramedic Practitioners
 - Community Paramedics
 - Emergency Care Practitioners
 - Assess and Refer Paramedics
- By increasing the level of clinical expertise in control centres, which are the first point of access to health care for many patients, the Ambulance service will be able to
 - improve the speed, consistency and quality of call handling,
 - provide significantly more and clinical advice to callers and work in a more integrated way with partner organisations to ensure consistent telephone responses for patients who need urgent care
 - Triage patients according to clinical need
 - Provide telephone advice (Hear and Treat)
- Investment will be needed in new information technology and modern operating systems, for example, new triage software will improve diagnostic capability and “assisted technology” can monitor vulnerable patients at home.
- Patient Care Services (PCS), which deal primarily with outpatient services and hospital transfers, will be developed to add more value to this important role and further support to the Emergency Services. It will:
 - Develop new ways of working to support Acute Trust and specialist departments
 - Support Chronic Disease Management in the community
 - Develop call centres for the management and booking of patient journeys
 - Work with others including Local Authorities to optimise transport services required by local communities
 - Support EMS by adding to the first responder capability and the transportation of 999 category C patients
- The safety, quality and clinical effectiveness of the increased range of clinical services provided by the Ambulance Service to support the Acute Services review will be ensured through the process of Clinical Governance.

(b) Primary & Community Care Provision

Currently services are provided through several levels of care: primary care, Community Healthcare, Specialist Care and Highly Specialist Tertiary Care. At present 90% of the activity is provided outside hospitals but is supported by less than 50% of NHS funds received.

To support the proposals set out in sections 6 and 7 of this document connections must be made through all the levels of care available to manage patients within or as near to their home as is safely possible, to recognise the importance of self care and also to work with Local Authorities to include social care. Changes in the organisation of care must be patient

centred with well-defined access to the appropriate professional, at the appropriate time and in the appropriate care setting, as locally as is safe to do so. This will allow patients to benefit at an individual level from a seamless journey through a smoother and fluid system between primary, secondary, general and specialist care, reducing pressures in secondary care and upwards. A model of the pattern of care and the relevant linkages is set out below:



This model of integrated, joined up care requires acute, intermediate, primary and social care to work together as part of the whole health and social care system. Whilst the main body of this document focuses on the top 3 sections of this care pyramid, it must be set firmly in the context of the potential for further expansion of the non-hospital care setting to take services closer to the patient and empower citizens to maintain independent living. Fundamental principles will be:

(i) Self Care

A growing acceptance of self care, with more people taking more responsibility for their own health, as the first level of care, and seen as partners in their own healthcare, empowered to take increasing responsibility for their own health and make a positive contribution to their own well-being. This will include active management of their chronic conditions. Individuals will need access to information through supporting campaigns such as Health Challenge Wales, to ensure that they know how to maintain their health and know when it is appropriate to access healthcare.

(ii) Primary Care and Shared Professional Care

There is a need to develop capacity – workforce, skills, and infrastructure – within primary care to develop and deliver new service models. Working in partnership through the opportunities afforded through the new GMS, Pharmacy and Dental contracts, Commissioners, Trusts, Primary and Social Care will need to proactively develop services designed to respond to escalating demands, with the majority of these services co-located within GP Practices, Primary Care Resource Centres or Community Hospitals.

Primary Care would be the normal point of access for the majority of individuals and will provide initial assessment, diagnosis and treatment. Primary care professionals would help patients access other levels of care as appropriate. It would normally be at this level that individuals who have developed long-term conditions are identified. There would also be a strong focus on health promotion, primary and secondary prevention and screening and through improved, to reduce the demand for unscheduled care services.

With the right support many people can learn to be active participants in their own care, living with and managing their own conditions. For those requiring short-term care the aim, for example following surgery, would be to minimise and eventually withdraw support once the individual is fully able to manage their own care. For those with longer term needs e.g. chronic disease, support may take the form of routine assessment, reviewing self-management care plans, improving medicines use and the provision of advice and information with the aim of maintaining the individual at home.

The development of Expert patient programmes will further support individuals to effectively manage their conditions.

Care Management will occur where Multidisciplinary teams provide unified care, based on high quality evidence and through the use of defined protocols and pathways, to individuals who are experiencing difficulty in managing their condition. This would include individuals who have multiple conditions, are regular users of primary and secondary care and who are experiencing complications.

Case Management requires the identification of high risk patients often with multiple long term conditions and whose care is disproportionately complex and difficult. Their vulnerability makes simple problems a risk for unplanned hospital admissions. This is often older people but could also include children and patients with complex neurological conditions.

In all these instances, services would be co-ordinated by an appropriate professional to actively manage the care of an individual and to prevent unscheduled hospital admissions. The care plan will usually be an individualised package of care, tailored to the needs of the individual and derived from a range of services and organisations.

(iii) Integrated Care (Community Hospital Provision)

Traditionally this care has been provided by the community hospital model, where there is a step down approach (i.e. the patient does not require an acute hospital bed but still requires inpatient intervention) or a step-up approach which facilitates patients' recovery (i.e. where the patient moves from being cared for at home to requiring in patient intervention).

In reality, the boundary between health and social care has been blurred in many of our community hospitals. We find ourselves in a situation where there are patients in community hospital beds who will benefit no further from this type of care and need to be discharged home with the appropriate social care support or transferred to a Nursing/Residential home due to their level of dependence. Paradoxically there will be elderly people at home or in Nursing/Residential home care that would benefit from active "reablement" to arrest chronic disease progression and/or prevent them from becoming more dependent. The key issue with this capacity and the nursing / AHP reablement skills is to target them appropriately so the right patient is in the right place at the right time receiving the appropriate care and intervention. Current systems tend to compound loss of independence rather than arrest it which increases the burden of health and social care across the board.

2. Local Consultations Planned or Underway

The following are some of the Consultation exercises that are currently underway or planned, the underlying themes of which correspond with the themes underpinning this acute services review.

Carmarthenshire: Surgical services, community hospital services

Swansea: Community Hospital services

Ceredigion: Cardigan Hospital, Tregaron Hospital

Pembrokeshire: Unscheduled care model, South Pembrokeshire Hospital (completed), Tenby Cottage Hospital (completed)

Powys: Doing More, Doing Better

3. Examples of Where the Future Models Are Already Happening

There is a considerable amount of change already taking place within the Mid and West Wales Region that is starting to deliver the improvements in patient care referred to within this consultation document. This schedule, whilst by no means exhaustive, gives an overview of SOME of the examples where innovative and/or collaborative developments are already delivering the modernisation requirements.

3.1 Carmarthenshire (Trust and LHB)

Midwifery Led Care

Forty-nine percent of women are booked under the care of a midwife as the named professional responsible for all aspects of care throughout pregnancy and only if a departure from normal presents is the woman is referred to a Consultant Obstetrician. The numbers in the Consultant clinics have been reduced as a consequence, with only those mothers considered to be high risk attending hospital clinics. This allows the Consultant to spend more time with those women whose needs require their expertise and provides a service for women that is community based, without the need to travel to the hospital for ante-natal care.

Obstetric and Gynaecology Practitioners

A number of Obstetric and Gynaecology Practitioners have recently been appointed in order to achieve European Working Time Directive compliance at Senior House Officer (junior doctor) level. Following a three-month competency-based training programme the practitioners commenced their new roles, taking on some of the work which junior doctors have previously undertaken, and early evaluation of the efficient and effectiveness of these roles has been positive.

Specialist Nurse in Elderly Care

A Specialist Nurse in Elderly Care supports clients in their own homes by facilitating access to and referring, if required, to the Consultant, GP, Community Hospital or District Nurse services as appropriate. The aim of this specialist nurse role is to avoid hospital admission, support patients at home, and facilitate early discharge from hospital.

Community Intermediate Care Team (CICT)

The CICT provides a rehabilitation service within the client's home setting. It is a multi-disciplinary, multi-agency team which includes Social Workers, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Dieticians, Community Nurses, Community Psychiatric Nurses and Generic Support workers. The Generic Support workers

are trained on a multi-disciplinary basis, and hence can provide support in any of the above areas, and provide a 7-day service for the client, linking with the District Nursing service at weekends. The prime objective of the CICT is:

- § To avoid hospital admission
- § To facilitate early discharge
- § To reduce dependency on admission to Social and Care Homes
- § To improve the quality of life and independence for patients within Carmarthenshire

Hospital Discharge Scheme

Working in partnership with the voluntary services, Carmarthenshire NHS Trust has been able to develop hospital discharge schemes within local Communities. One such scheme is provided by the Red Cross service that facilitate safe discharge for patients living alone. The hospital discharge scheme ensures that the home environment is safe and prepared prior to discharge and, together with social support in the first few days, improves the patient's experience of going home.

Chronic Disease Management

A new model for managing patients with a chronic disease is being implemented in Carmarthenshire. A team of nurses and physiotherapists will support patients in the community to an enhanced level and thus prevent them from needing hospital admission. Patients suffering from complex problems associated with Chronic Obstructive Pulmonary Disease, heart failure and diabetes will be referred by their GP or Consultant for assessment and care from this team. It is likely that these patients would otherwise have been admitted to hospital. This new Team will provide care in primary care, in secondary care and in the patient's home as appropriate. It is expected that there will be greater continuity of care for patients as this team links with all care sectors.

Dental Services

From April 2005, Carmarthenshire LHB has established an enhanced Dental Access Scheme for unregistered patients in need of emergency or urgent treatment. Treatment sessions have been commissioned from several dental practices in the county.

Patients can access the service by contacting NHS Direct, who will triage the symptoms and if appropriate refer the patient to the Dental Services Clerk at the LHB. The clerk advises patients of the time and location of the appointments available and makes the booking on their behalf. There is a 48 hour maximum waiting time for an emergency appointment

At present the LHB commission 17 sessions of treatment sessions a week, providing appointments for up to 51 patients per week. The sessions are located across different towns in the county to increase accessibility for patients and in addition there are emergency dental sessions in Carmarthen and Llanelli on Saturdays and Sundays respectively.

During the period April to December 2005 the LHB booked 1,530 unregistered patients into dental access appointments, of whom 1,194 had their treatment completed in the one appointment

3.2 Ceredigion (Trust and LHB)

PACS

The introduction of complete digital Radiology services across the Trust in 2004/5 has significantly benefited patients via more rapid clinical decision making both within the Trust and in partnership with other Trusts where specialist opinion is sought.

Telemedicine

Telemedicine has been in use at Bronglais Hospital for over five years, linking with the Specialist Cancer Service at Singleton Hospital, Swansea, to facilitate Multi-Disciplinary Team discussion. All patients with cancer are discussed and this means fast tracking critical management decisions. It has been of undoubted benefit to patients and, in addition to speeding up referral processes, it has also reduced the need for patients and clinicians to travel long distances.

The Ceredigion Trust has installed telemedicine equipment at its two Community Hospitals at Cardigan and Tregaron. This facilitates an effective link for community staff at these Hospitals to connect with Bronglais to discuss patient management problems and provides quick and easy access to the Emergency Assessment Unit.

The Units at the Community Hospitals also link with the new Palliative Care Resource Centre at Bronglais, and this has made it possible for both staff and patients at these sites to access the Palliative Care Centre for expert opinions.

GP Out of Hours Service

When the GMS contract came into place, the Ceredigion Trust provided an Out of Hours service for Primary Care. This is based in the Accident and Emergency setting at Bronglais Hospital servicing North Ceredigion, and also at Cardigan Hospital servicing South Ceredigion. The service is provided by a mix of salaried General Practitioners employed by the Trust and local Practitioners who contract with the Trust to provide regular sessions. This innovative approach to providing Primary Care Out of Hours service has been deemed a great success, reducing A & E attendances and responding more effectively to out of hours patient demands.

Consultant Recruitment

Recent appointments in Cardiology and Obstetrics have been linked to Swansea. This has assisted recruitment, facilitated closer service networks for complex care with Consultants performing interventions on their own patients in the specialist centre and secured continuing professional development opportunities for isolated clinicians.

One Stop COPD Clinic

For 12 months, the Respiratory Physician at Bronglais has been running a One Stop COPD Clinic. Patients with COPD referred to this Clinic, in addition to having their consultation, will undergo lung function tests, cardiac assessment, exercise assessment and their oxygen requirements all on the same day. The service is greatly valued by patients as it speeds the diagnostic and assessment process and significantly reduces time and travel. This is one of several on-stop clinics that have been developed in recent years and has greatest significance in terms of patient benefit in rural areas where the burden of travel for repeat appointments is often extremely onerous.

Extended Role of Night Nurse Practitioners

For several years, the Night Nurse Practitioners at Bronglais have extended their role. They receive referrals from the Out of Hours service, are trained in phlebotomy and cannulation techniques, resuscitation and intubation procedures. This has resulted in reducing the workload of Junior Doctors during anti-social hours, at night and weekends.

Five nurses have received training in basic history taking and physical examination procedures at Liverpool in preparation for Hospital at Night.

Elderly Care Reablement

The Local Health Board and Trust are working up proposals to redesign community hospitals in line with reablement models alongside Primary Care Resource Centres. Capital money has been secured for a Primary Care Resource Centre in Aberaeron; an Integrated Resource Centre / Reablement facility in Cardigan with the potential for co-located social services facilities; a co-located social housing scheme and Primary care facility in Tregaron alongside existing elderly care beds.

3.3 Pembrokeshire (Trust and LHB)

Consultant Paramedic Practitioner

The Consultant Paramedic Practitioner post has stemmed from the demands of creating appropriate and pragmatic unscheduled health care service models. To develop and enhance with other collaborative partners, the local provision of cost effective and quality patient services. Models, which are able to incorporate Ambulance Care, Accident & Emergency Care, unplanned In Hours Primary care and Out of Hours services, providing a seamless and therefore improved patient service.

More of these services with appropriate triage could be provided in the community, and may not require the skills of a Physician. Patients always require appropriate assessment of need, to ensure they receive the right care in the right place at an appropriate time. Alternative but highly qualified healthcare professionals, with no reduction in the quality of service, and often with increased care provision may provide this type of care, saving time and valuable healthcare resources across organisational boundaries and provide a whole systems approach.

Paramedic Practitioners are experienced autonomous clinicians that understand the patient journey completely from the community into secondary care. These creative health professionals are able to provide emergency care advice or treatment, based on clinical findings and within professional scope diagnose, dispatch or refer to other suitable health professionals based on holistic patient assessment. They establish evidence based short-term treatment plans for unscheduled patients including the supply and administration of therapeutics

A Consultant Paramedic Practitioner as a further innovation would also possess the skills, experience and vision required to strategically plan, advise on service provision, organise, develop, research and educate the staff required for future healthcare roles tailored to local community requirements.

Re-provision of Services Currently Provided at Tenby Cottage Hospital

The new Tenby Cottage Hospital is nearing completion and will provide 'state of the art' health care facilities for the people in this district. It is not however only the building that will be modern. The new hospital will provide a range of Out-patient, Minor Injury and Day Care services and will also act as a base for Health and Social Care community services in this area. A Community reablement team will provide services not only within the hospital but also in people's own homes. Using the philosophy of maintaining people in their own homes wherever possible, District Nursing, Social Services and community Therapists will be based at the new hospital and will work as one team to support the surrounding community. There will be no beds in the new hospital but these will be commissioned separately from a nearby independent Sector nursing home and will provide intermediate and palliative care for the local population. The NHS Trust and Local Health Board will work as partners with the Independent Sector managers to provide training and quality assurance. The peripatetic

community rehabilitation team will also work closely with the home to ensure that patients regain their health and mobility as soon as possible following illness.

Joint Intermediate Support Team

The Philosophy of the Joint Intermediate Support Team (JIST) is to provide care, which enables people to achieve maximum independence. Advice, treatment and care are based on genuine partnership with service users and the multi-disciplinary team. This support being tailored to meet individual needs in their own home.

The JIST team consists of practitioners from both Health and Social Care agencies, working with patients/individuals and carers to provide assessment and rehabilitation. This co-ordinated care provision is aimed at to achieving maximum self-care, mobility and daily living. The service helps people remain at home wherever possible, thereby preventing admission to a care setting and enabling maximum quality of life. Earlier discharge from hospital is also facilitated. This service is provided for individuals with a Health and Social Care need, aged 50 years and over living in the Pembroke and Pembroke Dock area.

The Team was established in October 2005 with temporary funding of £24,500 made available for 2005 / 2006, from the Local Health Board from their allocation of Wanless Monies. The project has proved very successful with the customers benefiting from the joint input. All of the customers have been very appreciative that they have had the opportunity to make even a marginal improvement in the mobility/ability. Care provision has consisted of social care; exercises as instructed by physiotherapist; motivation and confidence building. Packages have been JIST only and JIST with mainstream home care.

3.4 Powys LHB

Teaching Status

Powys Local Health Board has been approved as a Teaching Local Health Board and is developing a wide range of teaching and training opportunities, particularly in Primary and Community services, which will ultimately help to reduce demands on acute hospital services.

Surgery

A full range of day case surgery is undertaken in Powys hospitals with general practitioners, consultant surgeons and anaesthetists working together to ensure that patients are provided with high quality audited outcomes. These patients undergo pre-operative assessments at the same time as their outpatient appointment so minimising the number of attendances.

Examples include:

- **Local Day Case Cataract Surgery**

Powys LHB provides cataract surgery in both Brecon and Llandrindod Wells. This is a two-stop service with patients being seen by the consultant ophthalmologist and under going a full pre operative assessment on one day. They agree a date for surgery and follow up is undertaken by a local optometrist. This service provides local access to surgery which has traditionally been provided in an acute hospital setting, reduces demand on acute services and improves access for patients and their carers.

- **GP Provided Services**

A number of General Practitioners have extended their roles and now provide the following specialised services with benefits in terms of improved access in terms of both time and distance and reduced demand on acute hospital services:

- Hernia surgery
- Carpal tunnel surgery
- Endoscopy, including colonoscopy
- Rheumatology
- Gynaecology

- **Orthopaedic Triage**

Orthopaedic patients referred to an orthopaedic surgeon are triaged and some are seen by other members of the multi-disciplinary team. The consultant only sees those patients who need a consultant opinion.

Care in community hospitals

General practitioners assess patients in the community, and in minor injury departments. They are able to admit patients directly to the community hospitals in Powys for medical care. This decreases considerably the pressure on District General Hospitals and A&E Departments.

Likewise, Consultants in Health Care of the Elderly assess patients and are able to admit these patients into community hospitals, providing a full inpatient service to those patients who do not need the extra facilities of a District General Hospital.

Chronic Disease Management

Work is going on within Primary Care Teams to expand the range of chronic disease management being undertaken through the use of local enhanced services for the frail and the elderly, those with osteoporosis, coronary heart disease and diabetes. The Primary Care Teams will be enhanced by ensuring that they are a multi-disciplinary teams including community services and such services as physiotherapy and podiatry.

Unscheduled Care

Powys is a pilot site for unscheduled care as part of the Welsh Assembly Government Unscheduled Care Project. The first stage in the project is that of triaging 999 calls to Powys minor injury departments in order to decrease the level of emergency admissions and A&E attendances at District General Hospitals.

3.5 Swansea (Trust and LHB)

Chronic Disease Management

The Swansea Chronic Disease Management pilot in 5 practices has made a huge difference to patients' lives. Targeting frail patients and those with multiple chronic diseases, experienced clinicians have been supporting the co-ordination and management of their care enabling patients and their carers to understand and help manage their disease better. This has significantly reduced emergency admissions in these practices and both patients and their carers and other members of the primary health care team are very satisfied with the results. Both GPs and patients in the other Swansea practices are looking forward to the introduction of this service right across the LHB during 2006/7.

Electronic Advice Line for Primary Care Practitioners

GPs in Swansea now access consultants directly for advice in order to better manage patients through the new electronic advice line set up between general practice and the Swansea Trust in a number of specialties. This enables GPs to take advice from consultants in order to better manage their patients in the community rather than only having the option to refer for an outpatient appointment. GPs and consultants have also been jointly producing structured referral and protocols which ensure patients are seen in the right place and all of the necessary information is available. GPs in the Swansea Out of Hours Service have been working closely with colleagues in emergency care to help treat those who arrive in A & E but only need primary care treatment. This has included GPs running sessions in Morrision A & E at busy times and patients arriving in casualty in Singleton being redirected to the primary care centre run by SOS just down the corridor. A district nurse working in A&E has also helped to co-ordinate the discharge of patients back to home where they do not need acute emergency admission.

Specialist Services in Primary Care

Two GPs in Swansea with particular training and expertise in musculoskeletal conditions are now running specialist clinics in the community working closely with physiotherapists. This has helped reduce the waiting time for a number of patients with appropriate musculoskeletal conditions. The clinical outcomes for patients have been good including direct access to the orthopaedics team at the Trust where necessary. This is part of a wider programme in Swansea to enable assessment and where appropriate treatment in the community rather than referring to hospital.

Primary Care Resource Centre Development

Plans are underway for the development of a substantial new primary care resource centre being built on the new SA1 site. Partnership between several GP practices and the LHB together with the Swansea Trust and other parties in Swansea envisage high quality, modern primary care facilities and the opportunity to base and deliver a wide range of community services within the same building. This will include specialist clinics, area wide services and facilities which have previously only been available in Morrision or Singleton hospitals. This will mean much closer access to services for thousands of people in the eastern centre of Swansea City.

3.6 Bro Morgannwg NHS Trust

The following is a schedule of the modernisation that has taken place within the Bro Morgannwg NHS Trust since it was established in 1999, demonstrating a pattern of continuous change, improvement and innovation which has allowed the Trust to treat more patients, with shorter waits, improved quality and at lower costs, improving access and quality of care for patients and aiming to reduce the demand for acute hospital services. It also shows examples where the management and provision of services have been relinquished to other providers, where this is considered to be in the best interests of patients. These changes reflect the well developed joint working between the Trust and partner organisations and with staff.

- 1999/2000** Merger - all new Consultant contracts Trust wide.
- Executive Team focussed on clinical engagement and delivering PFI deal.
- Signed PFI Deal for Neath Port Talbot Hospital.
- Approved Information Strategy, harmonised A&E, Pharmacy and financial management information systems across sites, including introduction of single E mail system with common standards introduced for electronic working.
- 2000/2001** Organisational Development for Clinical Directors commenced using Dearden's Management Consultants.
- PACS implemented in Princess of Wales Hospital's Radiology Department.
- 2001/2002** Procured Trust wide Theatre Management system. Rolled PACS out to A&E and Orthopaedic Clinic, Princess of Wales Hospital. Harmonised Radiology system across all Trust sites.
- Implemented Incident reporting and Risk Management system.
- 2002/2003** Commissioned Neath Port Talbot Hospital introducing a new "Local General Hospital" model including transferring all major trauma and emergency surgery to Swansea Trust, retaining unselected medical intake, elective surgery, including orthopaedics and full OPD and rehabilitation services at Neath Port Talbot Hospital. This Local General Hospital represents an adapted model of service, recognising the needs of the local community particularly around emergency medical admissions, but also recognising that, mainly for reasons of critical mass, it is not possible to operate a traditional DGH model.
- Began to develop the concept of "one hospital two sites" for Neath Port Talbot and Princess of Wales Hospitals.
- Introduced Fast Track Unit, Princess of Wales Hospital and reduced medical admissions by 10%.
- PACS implemented in Neath Port Talbot Hospital.
- Reviewed Local Accident Centre model – nurse led service from 10.00 p.m. to 8.00 a.m.

Trust-wide Acute Services Blue Skies thinking.

New state of the art network infrastructure at Princess of Wales Hospital and Neath Port Talbot Hospital and links to new IPVPN All Wales Networks.

Video Conferencing first introduced.

Partial Booking implemented.

Health Records Accreditation for 2 years from 2002.

Opening of Children's Centre at Neath Port Talbot Hospital.

PICU in Coity Clinic, Princess of Wales Hospital.

Patient Discharge Lounge established in Princess of Wales January 2003.

MRI Scanner installed permanently.

2003/2004

Maternity Services Review resulting in Neath Port Talbot Hospital having a Midwifery led service, supported by Singleton and Princess of Wales Hospital providing Consultant led obstetric services and neonatal care.

No patient referred to Second Offer Scheme.

Full PACS roll-out Neath Port Talbot Hospital – filmless hospital.

Trust-wide PACS system and investment in Digital Technology.

Extensive use of Benchmarking to drive improvement and innovation and Performance Management.

First entry as CHKS Top 40 Trust.

Trust-wide Cardiology Service implemented.

Waiting Times Targets achieved.

2004/2005

Concordat agreed with Neath Port Talbot, Bridgend and Vale of Glamorgan LHBs to reduce duplication of acute services between two sites and acceptance of "one hospital, two sites" model. Early examples include, breast surgery, cold orthopaedics.

Board approved 5 year Strategic Plan for 2005/06 and beyond.

No patient referred to Second Offer Scheme.

Compliance with European Working Time Directive. Action included Remodelling Oral Maxfacial and Ophthalmology Services, linking in to networks hosted by neighbouring Trusts.

CHKS Top 40 Retained.

First dedicated District General Hospital Catheter Laboratory opened in the Princess of Wales Hospital.

Waiting Times Targets achieved

Neath Port Talbot Hospital awarded Best UK Operating PFI Scheme.

Agreement in principle with Swansea Trust to amalgamate Pathology Services.

Formal Review of visiting consultants' job plans with Swansea Trust.

Cardiology PACS implemented.

Modernised Audiology Service.

Waiting Times Targets achieved.

2005/2006

Clinical Decision Unit approved for Princess of Wales Hospital and plans to develop similar solution for Neath Port Talbot Hospital.

Implementation of 5-day gynaecology ward at Neath Port Talbot Hospital.

Developing networks with Swansea Trust in key areas, including vascular and urology.

Neath Port Talbot, Bridgend and Vale of Glamorgan LHBs and Local Authorities to join with Trust in developing an integrated, health, primary care and social model to address chronic diseases.

No patient referred to Second Offer Scheme.

3.7 Bridgend LHB

Diabetes Management.

Historically the Diabetes service was hospital focused and somewhat out-dated. In partnership with the Trust and Primary Care colleagues, the LHB has facilitated the transfer of care for appropriate patients from secondary care to the primary care sector where they will receive ongoing management of their chronic condition.

In order to ensure this safe patient transfer, the LHB worked in partnership with Primary Care colleagues to fund the training of GPs and Practice Nurses to ensure appropriate skills and expertise were in place to provide the best quality patient care. In addition, the LHB agreed with the Trust a replacement Diabetologist and a new consultant Diabetologists with both posts having time allocated to work with Primary Care partners in the community.

This new model of care has provided a basis for the LHB's Modernisation Framework which will be used for management of all long term conditions. Further more, the LHB has shared

this approach with its neighbouring LHBs of Neath Port Talbot and The Vale of Glamorgan with a view to adopting a similar approach across all three organizations, which would allow arrangements within the trust to be standardised.

The benefit of managing more of the less complex diabetics in the Primary Care setting is that from the patients' perspective, they will have improved continuity of care, the Primary Care Team is better informed about the patient's condition and ongoing treatment and additional capacity is generated in the secondary care system. With better management of their condition, it is anticipated that fewer patients will have exacerbations of their symptoms and emergency re-admissions to hospital.

GPs and Primary Care Teams have been closely involved from the outset and partnership working with Trust colleagues, Social Services colleagues, the voluntary sector and patient representatives has also been an integral part of the success of this project.

3.8 Neath Port Talbot LHB

Primary Care Centres

Neath Port Talbot LHB has received early approval for its Primary Care Estates Strategy, including plans to develop GP practices into new primary care centres and primary care resource centres. The former are predominantly replacement facilities with some enhancement of accommodation to allow other services to co-locate e.g. Trust staff, dentistry and pharmacy. The Resource Centre concept is far more innovative as these larger establishments will bring together a number of existing separate GP practices into one location, whilst also co-locating Trust, dentistry, social services and voluntary sector staff and services, including the concept of a social enterprise. With approval it is hoped that the Port Talbot Resource Centre will be completed by end of 2007 to provide a different local service model, demonstrating that more services can be accessed away from the hospital environment, in line with the principles of *Designed for Life*.

Delivering Integrated Services

With Bro Morgannwg NHS Trust and LHB, Local Authority and Voluntary sector partners in Neath Port Talbot, Bridgend and the Vale of Glamorgan Neath Port Talbot LHB is leading a project for "Delivering Integrated Services" to shift services and resources into the primary, community and social care environment. The stages of the Project include mapping of existing services and best practice, early implementation of good practice and modelling new care models, drawing on national and international evidence for local implementation. Specifically, it will also focus on using new technology and information technology to allow patients to avoid a hospital experience, in the alternative environments described in *Designed for Life*.

Alternatives to Hospital Care

Neath Port Talbot LHB has already introduced a range of initiatives which are impacting on local services and providing alternatives to hospital care:

- The early response service has been in place since September 2005, and has already had an impact on hospital admissions over recent weeks. It has a high satisfaction with GPs and the patients themselves.
- The Community reablement service has been in place for the last three years and has been expanded in terms of targeted intermediate care needs and drawing users away from hospital models.

- Referrals management, based on clinical protocols and use of alternative practitioners to limit referral and target appropriate services. This has commenced in orthopaedics and will be extended to other specialties.
- The Expert Patient Programme has been very successfully locally in promoting independence and self-care and delivering these training programmes in local communities, rather than drawing people into hospital environment. It has also led to fewer admissions for the patients involved in the programme.
- A physiotherapy direct service has been introduced to direct patients away from traditional hospital consultant referral.
- There is a diabetes education programme in place to promote self-care and independence and reduce reliance on hospital services.

Evidence File

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Project Management Structure

Following the launch of the Case for Change on 20 October 2005, the following project management arrangements were established to take forward the work of the Acute Service Review:

1. Key Personnel

Project Sponsor	Geraint Martin (Head of Strategy, Welsh Assembly Government)
Project Chair	Chris Martin (Chairman, Pembrokeshire LHB)
Project Manager	Allison Williams (Chief Executive, Ceredigion & Mid Wales NHST)
Project Support Manager	Barbara Bowness (National Leadership and Innovation Agency for Healthcare)

2. Project Board

Chair: Chris Martin

Membership

Chairs and Chief Executives - LHBs & Trusts within the Region
 Leaders & CEOs – Local Authorities within the Region
 Acting Regional Director – Mid and West Wales Region
 Geraint Martin – Head of Strategy, Welsh Assembly Government
 Health Commission Wales representative
 Project Team members

(There has also been a standing invitation for a representatives of the Regional CHCs to attend)

Function

- To agree the Project Plan
- To oversee the implementation of the Project Plan by the Project Team
- To approve the proposals generated by the Project Team for public consultation
- Following public consultation, to approve the reconfiguration proposals to be presented to the Welsh Assembly Government

Members of the Project Board were also expected to:

- participate in the stakeholder engagement events (see Appendix 5)
- ensure that the Boards of the organisations represented are kept apprised of the progress of the Acute Services Review.
- ensure that the Boards of NHS Trusts and LHBs commit to the key principles underpinning the review.

Meetings

Meetings of the Project Board were held on 19 December 2005, 6 February, 27 February and 27 March 2006, and will continue throughout the Consultation period

3. Project Team:

Chair Allison Williams

Membership

Jane Perrin, Chief Executive, Swansea NHS Trust
Bernardine Rees, Chief Executive, Pembrokeshire LHB
Sue Heatherington, Chief Executive, Swansea LHB
Bruce Ferguson, Medical Director, Bro Morgannwg NHS Trust
Alan Axford, Medical Director, Ceredigion & Mid Wales NHS Trust
Peter Thomas, Medical Director, Carmarthenshire NHS Trust
Charles Merrill, Medical Director, Pembrokeshire and Derwen NHS Trust
John Calvert, Medical Director, Swansea NHS Trust
Gill Todd, Medical Director, Powys LHB
Liz Bolton, Head of Finance Mid and West Wales Regional Office
Dr Judith Greenacre, National Public Health Service
Dr Terry Davies, Medical Director, Carmarthenshire LHB
Barbara Bowness, Project Support Manager
Rob Jeffery, Wales Ambulance Trust

Function

To develop and deliver the Project plan in line with the nationally determined timetable including:

- Confirmation of the financial requirements of the Acute Services Review
- Confirmation of the interrelationship with related projects
- Identification, agreement and provision of the information requirements to underpin the service analysis
- Identification of best practice service models
- Development of a comprehensive stakeholder engagement plan to inform the option appraisal
- Development of options for change based on best practice evidence, current service information and the outcome of the stakeholder events
- Facilitate communication of progress with Project Board members

Meetings

Meetings of the Project Team were held on 15 November, 2 and 16 December 2005, 13 and 26 January, 2 14 and 23 February, and 8, 16 and 24 March. Meetings will continue throughout the Consultation period.

Stakeholder Events

1. Aims

The brief of the Project Team includes the requirement to develop a comprehensive stakeholder engagement plan to inform the option appraisal (see Appendix 4). In support of this aim four stakeholder events were held in early January 2006 with the aims to:

- Generate awareness about the Case for Change and its potential impact within the Region and to restate the drivers for change
- Build realism and stakeholders' views into the change management process and consultation machinery and to explore with stakeholders their views on key parameters for change and acceptability thresholds
- Explore with stakeholders their views on what hospital networks might look like in the future
- Explore areas of resistance and opportunities which facilitate service transformation to generate some consensus around the parameters for change
- Explore with stakeholders their views on future models of care
- Develop an ambassadorial role in the consultation and change process

2. Facilitation and Setting

The Creative Leadership Foundation was commissioned to facilitate the events which were held at the National Botanic Garden of Wales on 5, 6, 9, and 10 January 2006. This setting was important in order to set a context for a World Class service, to demonstrate neutrality and to avoid the connotations which may be associated with an NHS setting.

3. Attendance

Stakeholders nominated by Trusts and Local Health Boards were invited, with the attendance on each day configured to ensure a diverse mix professional and geographical representation. The Stakeholder representatives included:

- Trust and LHB Chairs
- Trust and LHB Chief Executives
- Trust and LHB Medical Directors
- Trust and LHB Clinical Directors and Key Clinicians
- Key Trust and LHB Board Members
- Local Negotiating Committee Chair
- Medical Staff Committee Chair
- Staff Side Representative
- Local Authority Leader

- Local Authority Chief Executive
- Voluntary Sector Representatives
- Local Stakeholders
- Community Health Council Chair
- Community Health Council Chief Officer
- NHS Confederation
- Ambulance Trust Representatives
- Medical Staff Committee Chair

A total of 128 individuals participated in the process over the 4 days.

4. **Structure**

The structure was common to all four days and was based on a series of conversations based on the following questions:

1. 'What does your presence in this room denote in relation to the acute services challenges in the Mid and West Region?'
2. 'What is the significance of the chairs, those that are full and those that are empty?'
3. 'What are the key drivers for change as you see them personally?'
4. 'What are the 'unique opportunities' to create World Class services that are presenting at this time?'
5. 'What are the bridges we are already crossing on our journey and where are the drawbridges very firmly pulled up? 'What does a viable future model of care for acute services look like for this region?'
6. 'What does a viable future model of care for acute services look like for this region?'
7. 'How do you see a hospital network system helping to create World Class services across the region?'

The questions and process were deliberately constructed so that:

- New and different conversations amongst participants could be stimulated
- Issues of status, power and authority could be equalized
- Every stakeholder had an opportunity to find his/her voice and contribute to the discussions
- Perspectives between individual stakeholders, organisations and professions would be shared and listened to
- The diversity of experience, perspective and views could be captured to enrich dialogue
- Issues of personal and collective responsibility could be considered

5. Outputs

The key messages on the future model of care emerged as:

- The model must take a whole system approach
- The need to have clear clinical pathways and patient protocols in place, both for emergency and unscheduled care and planned care episodes
- Diagnostic and assessment services need to be strengthened on a local basis
- That organizational boundaries must not get in the way of patient flows
- The need to build up primary and community services whilst the acute model is worked up and for a short term dual investment to make it happen
- The need for clear referral and admission pathways to access self care; community services; secondary services and specialist and tertiary services
- Acceptance that not 'one size fits all' and of urban and rural differences
- That any model must comply with known regulatory standards; clinical safety etc
- The model should focus on pathways of patient care and not institutional boundaries
- The need to develop regional teams within and across specialties
- The need for 'mobile' practitioners across health system

6. Summary

It is acknowledged that there has been criticism of the timing of and notice for the events which did affect attendance, particularly that of clinical staff. However it is important to understand that when these events were arranged the original timetable was for the reconfiguration work to have been completed by the end of January. This timescale was subsequently extended but the Project Team took the view that to rearrange the stakeholder events at that stage would cause confusion and discontinuity and agreed that the dates already identified should stand.

The events introduced different degrees of knowledge and experience to the process and helped to supplement the traditional approach to the development of options. Key messages which emerged included:

- The significance of those who took part in the events and those who were invited but did not participate
- That there was agreement on the forces for change
- That there was both a unique opportunity and a unique challenge to take this work forward in the Region
- The absence of any real sense of the Region
- A fair degree of resistance to change
- Considerable consistency in the models that emerged, in that they should be based on

- √ A systematic approach
- √ A focus on patient pathways
- √ Strengthening diagnostic processes
- √ Different models of care for different hospitals
- √ Graduated models of care
- √ Clinical networks

These themes were consistent with the thinking of the Project Team and Project Board, and were taken into account in the process for developing the options and the evaluation criteria (see Appendix 6).

Options, Scoring Criteria and Weightings

To support and structure the process of developing and ranking the options to be considered in Public Consultation, the Project Team developed a range of strategic objectives and operational criteria, which were then allocated a weighting, based on the collective views of the members of the Project Team. The 16 short-listed options (refer to Section 6) were then considered against these criteria and overall scores determined by calculating the scores allocated to each option by each member of the Project Team against each of the weighted criteria. This process was finalised at the meeting of the Project Team on 2 February 2006 and endorsed by and following the Project Board meeting on 6 February. The elements of this process are discussed below.

1. Strategic Objectives of Reconfiguration

- √ Rebuilding, renewal and improvement of the NHS in Mid and West Wales to deliver a world class health service
- √ Ensure continual improvement is embedded into the service, providing quality assured clinical treatment and care appropriate to need and based on evidence
- √ 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.
- √ Ensuring the best return from investment
- √ Promotion of independence, service user involvement and clinical and professional leadership.
- √ Networked clinical services with specialised and critical care cases focussed in fewer major centres, fully coordinated with local services and local hospitals as the “front door”, providing easy access to high quality, well-organised, frequently-used local services.

2. Operational Criteria for Reconfiguration

2.1 Improved quality and level of service

- Provision of a range of services to patients
- Provision of high quality services to patients
- Clinical governance – clinical risks addressed and evidence-based best practice introduced
- Implementation of Clinical Networks on a regional and sub-regional basis
- Fit for purpose settings for care
- Safe environment for care
- Promotes the best configuration of services

2.2 Sustainability

- Future Proofing of Services
- Flexibility and viability of infrastructure in medium/long term
- Ability to respond to changes in clinical practice
- Relationship with “Making the Connections”
- Promotes professional training
- Impact on the environment

2.3 Integration of Clinical Services

- Provision of effective co-ordination and links between services
- Facilitates efficient and appropriate links between specialist, tertiary, secondary, community and primary care
- Delivery of care based on model of managed clinical networks
- Links between clinical, training/education and academic services improved

2.4 Accessibility

- Provision of geographically accessible services for patients and visitors
- Equitable access to a comprehensive range of secondary care services
- Provision of 24/7 services where appropriate
- Links with transport services
- Impact on travel time

2.5 Efficiency

- Ability to meet performance and access targets
- Avoids duplication or waste of resources
- Effective utilisation of staff and resources
- Focuses the role of secondary care services appropriately
- Efficient utilisation of the estate and capital equipment

2.6 Acceptability

- Acceptable to patients, staff and visitors
- Acceptable to partner organisations

2.7 Implementation

- Minimal disruption and dislocation of services
- Doability

2.8 Workforce

- Supports restructuring of the workforce
- Optimises EWTD compliance
- Promotes changes in clinical practice
- Optimises recruitment and retention potential
- Optimises career development
- Optimizes the potential for new clinical and managerial cultures to evolve

3. Weighting

The operational criteria were weighted as follows:

Criteria	Rank	Weight
Service quality	1	33
Sustainability	2	31
Integration	3	28
Accessibility	5	25
Efficiency	4	27
Acceptability	7	17
Implementation	8	15
Workforce	6	23

4. Options

The following 16 options were considered against the above weighted criteria

1	<p>CENTRALIST MODEL 1</p> <p>1 DGH in West of Region 1 DGH in East of Region</p> <p>2 Elective Treatment Centres co-located with the 2 DGH sites</p>
2	<p>HYBRID MODEL 2</p> <p>1 DGH in Carmarthen 1 DGH in Swansea 1 DGH in Bridgend</p> <p>3 Elective Treatment Centres co-located with the 3 DGH sites</p>
3	<p>HYBRID MODEL 3</p> <p>1 DGH in South Dyfed (to replace both WWGH and Witybush) 1 DGH in Swansea 1 DGH in Bridgend</p> <p>3 Elective Treatment Centres co-located with the 3 DGH sites</p>

4	<p>HYBRID MODEL 5</p> <p>1 DGH in South Dyfed (to replace both WWGH and Withybush) 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 Elective Treatment Centre in West of Region (? Llanelli) 1 Elective Treatment Centre in East of Region (?NPT)</p>
5	<p>HYBRID MODEL 6</p> <p>1 DGH in Carmarthen 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 Elective Treatment Centre in West of Region (? Llanelli) 1 Elective Treatment Centre in East of Region (?NPT)</p>
6	<p>PRAGMATIC MODEL 1</p> <p>1 Dyfed DGH (concept of single provider unit) based on 3 existing sites:</p> <ul style="list-style-type: none"> • WWGH • Withybush • Bronglais <p>1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>
7	<p>PRAGMATIC MODEL 2</p> <p>1 Dyfed DGH (concept of single provider unit) based on 2 sites:</p> <ul style="list-style-type: none"> • South Dyfed new build to replace WWGH and Withybush Hospital • Bronglais <p>1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>

8	<p>PRAGMATIC MODEL 3</p> <p>1 DGH in Carmarthen 1 DGH in Haverfordwest 1 DGH in Aberystwyth 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>
9	<p>LIMITED ACCESS MODEL 1</p> <p>1 Dyfed DGH (concept of single provider unit) based on 3 sites: <ul style="list-style-type: none"> • WWGH • Withybush • Bronglais </p> <p>1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 LGH in Llanelli</p> <p>1 LGH in Neath Port Talbot</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>
10	<p>LIMITED ACCESS MODEL 2</p> <p>1 DGH in Carmarthen 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 LGH in Aberystwyth 1 LGH in Haverfordwest 1 LGH in Llanelli 1 LGH in Neath Port-Talbot</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>

11	<p>LIMITED ACCESS MODEL 3</p> <p>1 DGH in South Dyfed (to replace both WWGH and Withybush) 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 LGH in Aberystwyth 1 LGH in Llanelli 1 LGH in Neath Port-Talbot</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>
12	<p>LIMITED ACCESS MODEL 4</p> <p>1 Dyfed DGH (concept of single provider unit) based on 3 sites: <ul style="list-style-type: none"> • WWGH • Withybush • Bronglais 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 LGH in Neath Port Talbot 1 Elective Treatment Centre in Neath Port Talbot</p>
13	<p>ACCESS PRESERVATION MODEL 1 (Do nothing – except Swansea integration)</p> <p>1 DGH in Swansea 1 DGH in Bridgend 1 DGH in Carmarthen 1 DGH in Haverfordwest 1 DGH in Aberystwyth</p> <p>1 LGH in Neath Port Talbot 1 LGH+ in Llanelli (as per LGH only retaining daytime emergency surgical intake, subject to the recommendations of the Surgical Services review, and A & E with middle grade cover 8-6 and ENP cover out of hours)</p>
14	<p>ACCESS PRESERVATION MODEL 2</p> <p>1 Dyfed DGH (concept of single provider unit) based on 3 sites where: <ul style="list-style-type: none"> • WWGH retains full 24 hour services • Withybush operates on a RDGH basis • Bronglais operates on a RDGH basis 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 LGH in Llanelli 1 Elective Treatment Centre in Llanelli 1 LGH in Neath PortTalbot 1 Elective Treatment Centre in Neath Port Talbot</p>

15	<p>ACCESS PRESERVATION MODEL 3</p> <p>1 DGH in Carmarthen 1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 linked DGH in Aberystwyth 1 linked DGH in Haverfordwest</p> <p>1 LGH in Llanelli 1 LGH in Neath Port Talbot</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>
16	<p>ACCESS PRESERVATION MODEL 4</p> <p>1 Dyfed DGH (concept of single provider unit) based on 2 sites where:</p> <ul style="list-style-type: none"> • New South Dyfed Hospital to replace WWGH and Withybush which retains full 24 hour services • Bronglais operates on a RDGH basis <p>1 DGH in Swansea 1 DGH in Bridgend</p> <p>1 LGH in Llanelli 1 LGH in Neath Port Talbot</p> <p>1 Elective Treatment Centre in Llanelli 1 Elective Treatment Centre in Neath Port Talbot</p>

5. Results

Ranking	Option
1	16
2	7
3	15
4	11
5	14
6	6
7	9
8	12

Following the Project Board on 6 February it was decided to proceed to consultation only on 16 and 15, on the basis that option 7 is a future refinement of option 16.

Stage 1 Outline Cost Comparisons

The proposals set out in Section 7 are put forward on the premise that they will cost no more than the current configuration, based on outline cost comparisons with similar reconfiguration projects elsewhere in the UK

Example One

A Strategic Health Authority with a population of 1.7m and 6 acute sites has developed a strategic outline case to support the development of a whole system model of care. The main contributors to the improvement in reference costs will be:

- Rationalisation of activity from 6 Major acute sites to 4 and the rationalisation of specialist care.
- Efficiency which comes from the separation of elective and unplanned care.
- Improved treatment of patients to deliver short lengths of stay and recuperation closer to home.

An overall affordability assessment covering acute care, primary and community care, and other services across the Health Authority indicates savings of between £13m to £24m would be available for reinvestment in health services once these changes take place.

Example Two

Southern Derbyshire Acute Hospital NHS Trust Full Business Case for Reshaping Health Services indicates that by building a new hospital to replace two acute hospitals and bringing together all specialist services savings in the region of £20m could be released.

This is an indication of the level of savings that could be realised from Swansea Trust and then used to offset investment in community and primary care to ensure the infrastructure is in place to provide alternative service models.

GLOSSARY OF TERMS

Acute	Describes a disorder or symptom that comes on suddenly and needs urgent treatment. It is not necessarily severe and is often of short duration. Acute is also used to describe hospitals where treatment for such conditions is available.
Admitted Care	The care a patient receives in hospital.
Care Pathways/ Patient pathway	A plan that illustrates a pathway of care for an individual care based on their assessed need.
Clinical	Involving the care, treatment or study of patients. Clinical care is usually provided in hospitals and clinics.
Clinical network	A chain of interconnected clinicians with like interests working together to plan services for large areas, e.g. several counties
Community Care	Health or social care and treatment outside of hospital. It can take place in clinics, in people's homes or in other settings.
Community Hospital	A hospital in the community setting
Diagnostics	The branch of medicine concerned with identifying the nature of a medical condition, determining whether a specified disease or disease process is present in a living organism.
Domiciliary Care	Personal and practical care provided to support an individual living in their own home, either alone or with a relative or other carer.
Emergency care practitioner	A highly trained non-medical professional who provides emergency care, e.g. nurse or paramedic
GMS	General Medical Services
Midwife-led maternity service	A maternity service that is led by midwives rather than a doctor
National Service Frameworks	National service frameworks (NSFs) are long term strategies for improving specific areas of care. They set measurable goals within set time frames.
Paediatric	Child Health Services.

Paramedic	A well-trained person who supplements medical cover and can provide treatment autonomously within defined protocol, eg Ambulance Paramedics
Primary care	The first stage of treatment when you are ill and usually provided by your GP or at a community clinic.
Primary Care Resource Centre	A community building providing a range of primary and acute NHS services and sometimes local authority and voluntary sector services
Providers	Organisation that provides services, e.g. NHS Trusts
Secondary care	The second stage of treatment when you are ill and usually provided by a hospital (outpatient and inpatient services).
Service Delivery Unit	Group of health services (and hospitals) that work together to share expertise and resources to benefit a wider population
Specialist Care	Care requiring major planned or emergency treatment, often requiring the support of critical care facilities.
Strategic change and Efficiency plans	Costed plans used to help implement strategic changes to services with a view to greater efficiency of resources used
Sub-specialty	A branch of a main clinical speciality
Telemedicine	Telemedicine is a technology which can be used for achieving rapid access to shared and remote medical expertise by means of telecommunication and information technologies, no matter where the patient or the relevant information is located
Tertiary care	The third and highly specialised stage of treatment, usually provided in a hospital centre which may not be local. Treatment of patients with complex conditions who have usually been referred by other hospitals or specialist doctors.