

Designed for North Wales

**A vision for the health community and a
plan for the major hospital services**

Consultation Document

April 2006

Designed for North Wales

Contents

Preface

1. Introduction and Summary
2. The Health Services of the Future: Our Vision for North Wales
3. The Current arrangement of Acute and Tertiary Hospital Services for North Wales.
4. The Case for Change
5. The Options and the Evaluation
6. The Satellite sites
7. The Proposal
8. Implementation
9. Consultation

Appendices

- A) Glossary
- B) “Designed for Life” - key principles and definitions
- C) The Organisation and process of the review
- D) References
- E) The work of the Clinical Groups
- F) Supporting data
 - F1 Current Activity
 - F2 Current Spend
 - F3 Current Workforce
 - F4 Demographic Growth
 - F5 Mortality
 - F6 Morbidity
 - F7 Travel Times
 - F8 Map of NHS Sites in North Wales
 - F9 Map of Multiple Deprivation in Wales

Preface

- * We are pleased to present to you the outcome of the first phase of a major review of health services in North Wales.
- * This review is needed for all the reasons set out in this document: changes in the population, the workforce, technology and the estate, all driven by the need to improve care for patients.
- * The current arrangements were put in place in the 1980s. Since that time what it is possible to do is immeasurably different and as a result what is needed from our clinicians, our buildings and our use of technology is not what was designed 20-30 years ago.
- * What has been particularly gratifying in this process has been the coming together of people involved in all aspects of the delivery of care to explore the way in which all services should be provided in the future and not only in describing what needs to happen on the major hospital sites. This process has identified a commitment across health, social care, the voluntary sector, Community Health Councils (CHCs) and patient and public involvement groups to work together in the best interest of the patient, breaking down the organisational barriers that have sometimes prevented this. We have recognised the need to respond in new ways to better meet the challenges of an ageing population and the accompanying increase in long term health problems.
- * This review is the first phase in what will be a number of reviews leading to the implementation of changes that will improve the quality of healthcare and ensure that increasing demands can be met. The first phase answers some key questions and establishes the principles upon which future changes will be decided and implemented. The proposal to move towards investment in out of hospital care and to concentrate acute activity for existing hospital based services on three sites in North Wales, supported by English Trusts on the border and Bronglais Hospital will help us to create the necessary flexibility for the future.
- * Beyond this first phase the challenge for the future is to build upon the genuine desire to develop more integration and co-operation between services, organisations and the people who make it all work and to build capacity to deliver more services in the home and community setting.
- * We commend the proposed plan to all stakeholders and look forward to receiving your views.

Chairs of

Wrexham Local Health Board

Conwy Local Health Board

Flintshire Local Health Board

Gwynedd Local Health Board

Denbighshire Local Health Board

Anglesey Local Health Board

North East Wales NHS Trust

Conwy and Denbighshire NHS Trust

North West Wales NHS Trust

1. Introduction and Summary

- 1.1 Over the past 100 years the main causes of ill health have changed. In the first part of the last century infectious diseases such as tuberculosis prevailed whilst in the second part of the century acute illnesses such as heart attacks or the effects of cancer were common. In the next fifty years it is predicted that the main causes of ill health will be due to long term health problems such as diabetes.
- 1.2 This means that the National Health Service (NHS) must change and work to support people with identified disease to ensure that they can remain as independent as possible for as long as possible.
- 1.3 Our ability to remain independent is increasing. With the introduction of more mobile clinical and supportive technology more care will be able to be provided outside of a hospital setting. This will need people with the right skills and the redirection of financial resources . The rapid development of genetics is also opening up the possibility for much more effective preventive medicine and earlier treatment.
- 1.4 **Why is a new plan for health services in North Wales needed?**
 - 1.4.1 The request for each of the three NHS regions in Wales to review how they currently provide acute care and how those services could be improved to meet changing needs came from the Welsh Assembly Government in May 2005. This document outlines the proposed plan for North Wales. It represents the work of a wide range of clinical and other stakeholder groups which met between July 2005 and March 2006.
 - 1.4.2 The proposals sit within the overall framework of the Health, Social Care and Well Being plans which have already been prepared, consulted on and adopted by the Local Health Boards (LHBs) with their local authority partners.
 - 1.4.3 “Designed for Life”, the strategic framework for the NHS in Wales 2005 - 2015, identifies the major challenges facing the NHS in Wales as follows:
 - * 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 congested services
 - * avoiding spreading resources too thinly
 - 1.4.4 The current configuration of the three main hospitals and the three other hospitals providing acute care in North Wales was designed in the 1980s in a very different climate of demands, employment legislation and technology.
 - 1.4.5 Reviews of the these six hospital sites in North Wales have identified a range of significant maintenance and fire precaution problems requiring early decisions on investment. Before we make those decisions we need to be certain that any investment reflects what is actually needed for the future.

1.5 What is proposed for North Wales?

- 1.5.1 Treatment will be provided in the most appropriate setting, and the community will become the focus of the provision of care.
- 1.5.2 The provision of care will be better integrated by reducing existing barriers between primary, community, local and acute hospital, social and voluntary care. For instance, the move towards a single assessment and care plan for individual patients by the NHS and social care will help achieve this.
- 1.5.3 The plan puts forward the view that the current usage of hospitals is unnecessarily high and that the focus of services will shift to out of hospital based care as the norm. This means that some services will move closer to patients' own communities and we will no longer require patients to come to hospital for as much care as at present. This will be achieved in part by hospital based services, such as diagnostics, becoming more responsive to the needs of patients in primary and community care.
- 1.5.4 For acute health services which need to be provided in hospital, we are focusing resources to raise clinical standards and improve the hospital environment.
- 1.5.5 Acute hospital care will only be provided on the three main hospital sites - Ysbyty Gwynedd, Ysbyty Glan Clwyd and the Wrexham Maelor Hospital. These will be supported by the English Trusts on the border and by Bronglais Hospital for patients in south Gwynedd.
- 1.5.6 Highly specialised (tertiary) major surgery and medical services will continue to be performed in specified centres in the North West of England and North Wales, where viable. These services will be kept under review in the light of national and professional advice. No significant change is anticipated in the short term
- 1.5.7 The **proposed plan** is set out in more detail in Section 7. It has been designed to maintain stability whilst ensuring steady evolution and planned development. It will provide sufficient flexibility to cope with the future uncertainty that is associated with the combination of changing demand and advances in medical technology.
- 1.5.8 Implementation of the proposals will secure safe clinical environments and improve efficiency and quality, whilst maintaining good access for patients.

1.6 The Process

- 1.6.1 The proposed plan was developed with the extensive involvement of key stakeholders in North Wales. Over 250 individuals and 50 organisations have been involved in developing the proposals.
- 1.6.2 A Project Board with an independent Chair has overseen the process. A number of working groups considered options in the light of the current and future health needs of North Wales. This work, with input from a wide ranging Reference Group of stakeholders drawn from the public and the voluntary sectors, has prepared the proposal before you. The proposal has been recommended by the Project Board and adopted by the North Wales

Local Health Boards and Trusts. More details on the organisation and process are available in Appendix C.

1.6.3 The Local Health Boards and Trusts have agreed to formally consult on the proposal as set out in this document and summarised below.

1.7 **Consultation**

In this document we are consulting on:

- the balance of health services between hospitals and primary and community services for the next 20 years and
- the strategic configuration of the acute health services which are provided in the major hospitals.

In summary, it is proposed that:

- Where there is considerable scope for releasing resources currently invested in hospital beds, they will be reinvested, more effectively, in community services. This will provide better access for patients and will help manage the growing demand on health services into the future.
- After considering a range of options, we are consulting on the proposal for acute services currently provided in North Wales to be consolidated onto the current three major sites in North Wales, Ysbyty Gwynedd, Ysbyty Glan Clwyd and the Wrexham Maelor hospital.
- There will be consequential changes to the location of some services. In particular there will be some local changes which are needed for the overall improvement of services in North Wales based on clinical safety and standards.

They are:

- a) The movement of the acute services at Llandudno Hospital to the major sites.
- b) The movement of the orthopaedic services from Abergele to Glan Clwyd Hospital
- c) The movement of the ophthalmology services from HM Stanley to Glan Clwyd or alternative suitable accommodation.
- d) The movement of the stroke rehabilitation service from HM Stanley to more suitable accommodation.

On agreement though this public consultation that these services are to be moved, there will be further discussion with CHCs on the future of those sites. For some this may include closure and for some continuing use for local health service purposes.

2 The Health Services of the Future: Our Vision for North Wales

2.1 The Welsh Assembly Government’s strategy for healthcare for the next ten years is set out in “Designed for Life”. The definitions of care referred to throughout this document are based on ‘Designed for Life’ and are as follows:

- Local services – encompass minor injuries, outpatients, routine medicine, rehabilitation, family healthcare, day case and short stay routine surgery.
- Acute services – encompass major planned and emergency services many of which require the support of critical care facilities.
- Tertiary services – these are highly specialist services, including for example neurosurgery and cardiac surgery, many of which are currently delivered for the residents of North Wales in the North West of England

More detailed definitions are available in Appendix B.

2.1.1 Designed for Life aims to deliver a world class health service for Wales through the introduction of new systems that move the present uncertain and uneven delivery of care towards one that, whilst ensuring access to hospital care when appropriate, delivers high quality care as close to people’s homes as is possible

2.2 Within North Wales each of the six Local Health Boards has produced, in partnership with the Local Authorities, Health, Social Care & Wellbeing Strategies which describe the needs of each population and identify specific and targeted priorities for the future.

2.3 Together these set the context for these proposals.

2.4 Healthcare in North Wales will in the future reflect the changing face of technology and changing patterns of work, allowing for the focus of care to shift to domiciliary and community settings. The ability to transfer images easily between healthcare locations is already allowing changes in services such as dermatology

Where the future is already happening:

Treating skin cancer patients closer to home

Telemedicine in north-west Wales now allows patients to access a wide range of services from their local community hospital. Hospitals at Dolgellau, Tywyn, Blaenau Ffestiniog, Bron y Garth and Bryn Beryl all now have ‘telemedicine’ facilities, reducing the need for patients to travel to Bangor. Staff can send digital pictures and images to colleagues at another hospital, and patients can have a live consultation with a doctor working at another hospital.

Dr Dennis Williams, Clinical Director for Community Hospitals with the North West Wales NHS Trust and a GP from Pwllheli explained “For example if we suspect that a patient might have a condition such as skin cancer we could send images and associated patient notes straight to the dermatologist at Ysbyty Gwynedd. This helps us to identify problems earlier, which is essential in the treatment of cancers.”

- 2.4.1 The move to develop and extend what is done ‘out of hospital’ will require a significant change to the way in which we currently deliver care. Reducing the reliance on bed-based care will release staff to work in the community, allowing more patients with long term health problems to be cared for in the community. This will include community based consultants posts as well as nurses and therapists. Community based consultants are already in place elsewhere in the UK in services such as diabetes. Staff in the community will be developed to deliver more care within the home and in new facilities in community health settings such as GP surgeries, health and social care centres and community clinics.

Trefor’s Story

My name is Trefor and I have a 12 year old daughter called Cerys who is diabetic. We are in regular contact with the integrated diabetes team.

The vast majority of this contact takes place at our local health and social care centre and all care is co-ordinated by the integrated diabetes team.

On the occasions when we have to visit the general hospital, up to date information relating to my daughter’s care is available via the shared diabetes register. We have full access to the information held on the register and participate fully in the creation of Cerys’ care plan.

The integration of team members and information means that we are no longer asked the same questions repeatedly at each attendance and there is less risk of unnecessary actions or important items being missed.

- 2.4.2 Services that would have been seen as part of hospital care in the past should now be seen as core community provision. To support this shift in delivery of care a commensurate shift in the investment in out of hospital care has to and will be achieved.

Where the future is already happening:

Chemotherapy at home

A nurse led service has been set up in Conwy and Denbighshire that allows cancer patients to be cared for in their own community rather than having to travel to hospital for treatment.

In the last two years 468 patients have had their central lines effectively cared for in the community. This new services saves some 1400 hospital appointments annually. 70 patients a month have their chemotherapy pumps removed in the community, saving some 840 hospital appointments annually.

This service now provides a viable alternative to hospital care.

- 2.4.3 The acute hospital provision will be designed to shorten the patients stay. An occupancy level of 85%, will be planned, removing the need to move people between wards for non clinical reasons. The separation of planned facilities from those for unplanned care will ensure planned surgery is no longer cancelled at short notice and waiting times are reduced. Current day case rates across North Wales will be raised, reducing the time spent in hospital for routine surgery.
- 2.4.4 Whilst many hospital based services will be common to the three acute sites, some will be restricted to one or two sites allowing for the development of centres of excellence where low volume but more highly specialist care can be focused.
- 2.4.5 This process has already started with the focusing of some surgical cancer services on one site. A programme of work to achieve the best possible standards of care in other surgical service such as urology and ENT has begun. More diagnostic tests, pre assessments and follow up clinics will be delivered in community settings. Although some patients may have to travel further for their operation, looking at the whole care pathway many other contacts will be more local. This shape of service will require consultants and other staff to network across North Wales in order to continue to provide the highest possible level of care as medical knowledge and capacity becomes ever more specialised.
- 2.4.6 Wherever it is to the benefit of patients in North Wales capacity will be made available to provide planned work in North Wales.
- 2.4.7 For tertiary (highly specialised) services North Wales will continue to use the well established links with the hospitals in the North West of England and beyond.
- 2.4.8 The artificial divisions between primary and secondary care will disappear. Health, social and voluntary care will be integrated to improve services through the reduction of unnecessary duplication (e.g. multiple assessments), better use of scarce skills and the simplification of the pathway of care. Joint management of staff and the pooling of budgets will help achieve this. This will also help patients become more involved in managing their condition.

Where the future is already happening:

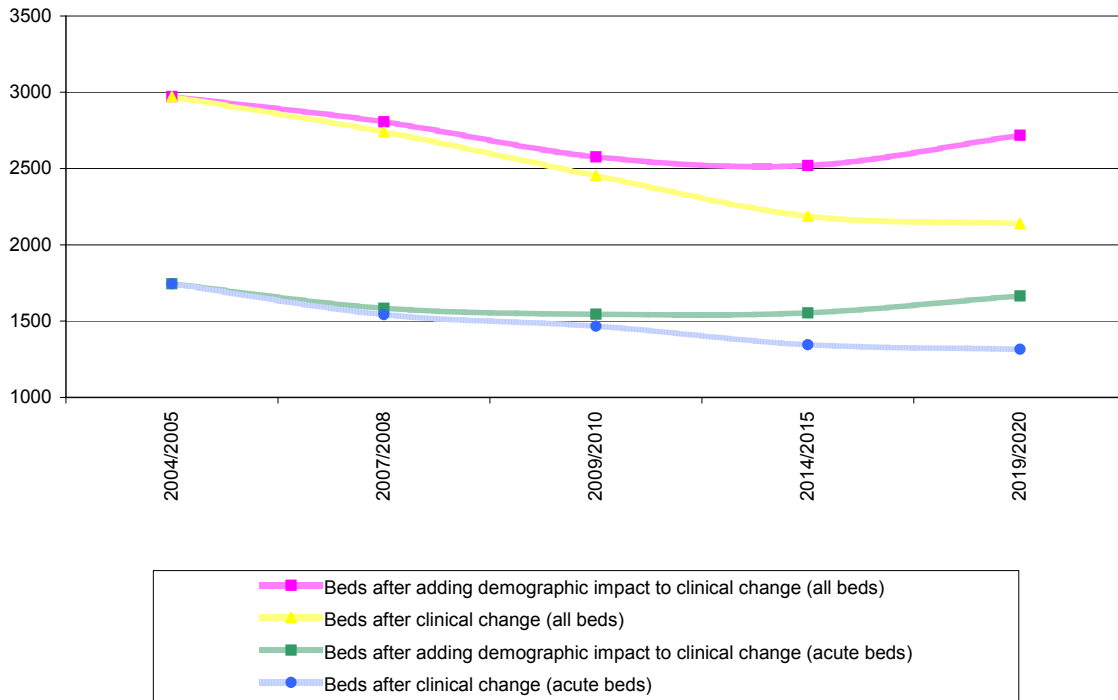
Involving the experts – the patients

The Expert Patient Programme run by Gwynedd Local Health Board, is a self management course for people with long term health problems. It helps people learn skills so they can manage their condition, including managing pain, developing coping skills and planning for the future. Courses are run in community settings and are led by volunteers who themselves have experience of living with a chronic condition.

Feedback from participants has been that they feel less isolated and more confident about their illness. Compliance with medication has also improved and participants have said that they are less reliant on their GPs for minor problems as they are managing their own conditions more effectively.

- 2.4.9 The service will work to put in place a network of 7 days a week, 24 hours, community based service to provide urgent care for patients. Where appropriate this will be done in co-operation with social services.
- 2.5 Work undertaken by a healthcare management consultancy firm, Teamwork, as part of the review of current services against UK best practice shows that there is considerable scope to move current hospital based services into a community, non-bed based setting. This will reduce the amount of care for which people have to travel to hospital sites, thus making some services more accessible.
- 2.5.1 The review has looked at both the impact of demography on the workload in the 15 years to 2019/2020 and the potential gains from introducing clinical efficiency and best practice over the 10 years to 2014/2015.
- 2.5.2 Taking demography and clinical change together for admitted care, whilst there is a predicted net increase in activity of just under 4% to 2014/2015, there is a net reduction in the occupied bed days of just under 15% to 2014/2015.
- 2.5.3 This is illustrated in the graph below in respect of:
- All hospital beds, both acute and community based
 - Beds on the acute sites

**Indictative Bed Requirments
2004 to 2020**



The development of alternative services in the community coupled with better use of hospitals means that the bed requirement for the service, taking into account both acute hospital and community beds, will have reduced from its 2004/5 level of about 2,900 to closer to 2,500 in 2014/15. Beyond this the growing demand for services will push the bed requirement up again. Evidence from the past two decades shows this requirement may well be offset by further advances in medical technology over the next 10 years.

2.5.4 A key element underpinning the re-focusing of services is the provision of a North Wales wide IT network which can easily and quickly transfer data and information between NHS (and perhaps in the longer term Local Authority) locations. IT is also key to underpinning the development of diagnostics which can be delivered locally, avoiding the need to travel to hospital.

2.6 The vision set out above presents both an exciting prospect for the future and a huge challenge in implementing it. It is a necessary backdrop to the rest of the proposal which focuses on the options and plans for the major hospital services in the future.

Summary

This section

- Relates this plan to the national strategy and local Health, Social Care and Wellbeing strategies
- Sets out a vision of how services can and should become more home and community focused and less dependent on beds, especially for people with long term health problems
- Quantifies the extent to which the bed base can be reduced to release resources for reinvestment.
- Identifies the need for a pan North Wales network of services to be developed to sustain many acute services.

3 Current arrangements

3.1 Introduction

3.1.1 At some point in time we are all likely to need access to the NHS to receive health care aimed at diagnosing and treating an illness or injury. We may also need medium/longer term support for ongoing needs and conditions, including palliative care.

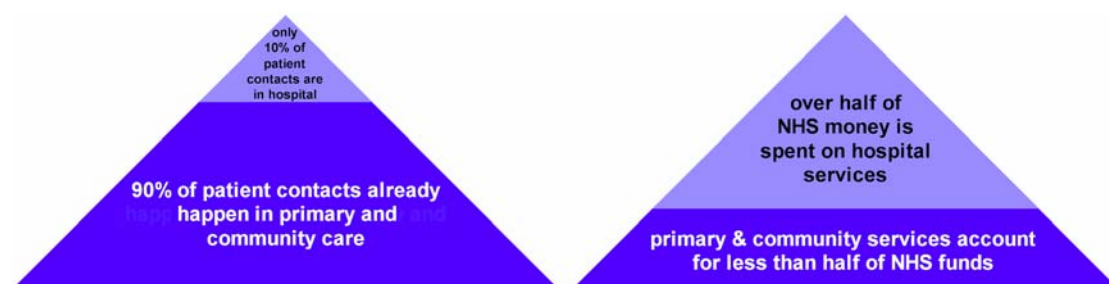
3.1.2 We might access our health services either in a planned way or as an emergency. Planned access can be to a member of the primary health care team (including a GP) or as a hospital outpatient, day case or in-patient. As an emergency you might attend a minor injury unit, GP out of hours service, hospital accident and emergency department or when necessary as an admission to an acute hospital ward.

3.1.3 Should you have highly specialist needs you may need to be referred to specialist hospitals such as Broadgreen for cardiac surgery or your child may be admitted to Alder Hey for paediatric surgery.

3.1.4 In response to these needs NHS services for North Wales residents are organised in the following levels of care:

- Primary Care
- Community Health Care
- Acute Care
- Highly Specialist Tertiary Care.

3.1.5 At present some 90% of the patient contacts take place outside hospital but are supported by less than 50% of the NHS funds received.



3.1.6 Together these services aim to provide an integrated range of services to respond to patients' needs and those of their carers and family. But the NHS cannot do this alone and therefore works with partners such as Local Authorities and the voluntary sector to meet these needs.

3.1.7 The review, which this document describes, looks at the future of acute and tertiary level services but it is helpful to understand how these are currently provided for you alongside the others levels of care.

3.2 Primary Care.

- 3.2.1 While hospitals are often the most visible part of the health care system, approximately 90 per cent of all episodes of illness (ranging between mental health and chronic conditions to relatively minor conditions) are seen and managed in primary care.
- 3.2.2 Primary care encompasses traditional services such as family practitioner services (GPs and their teams), dentists, opticians and dispensing pharmacists . These services are planned and arranged by your Local Health Board. Extended primary care teams will include social services professionals and health Trust staff such as district and school nurses, health visitors and community midwives.
- 3.2.3 Primary care services are very much local services and are provided either in your own home, the GP or dental practice, clinics or community hospitals and increasingly co-located with other independent health care providers, pharmacists and social services.
- 3.2.4 Primary care also has a significant role to play in relation to the level of acute hospital in-patient activity and demand as it acts as the gateway to other services and is often the starting and finishing point of the patient journey through the health care system.

3.3 Community Health Care

- 3.3.1 For many people health care is not simply a question of a referral to a specialist and a timely cure, nor is it something that can be easily managed by primary care. A large range of conditions such as heart disease, stroke, asthma, diabetes, the degenerative muscular diseases, physical and sensory disabilities and mental illness are long term requiring long-term care. The health care services required to meet these needs are generally provided in the community working together with Local Authority services and local voluntary groups.
- 3.3.2 Your care may be provided in a GP surgery, health centre, local hospital, or in your own home (including a nursing or residential home).
- 3.3.3 Community healthcare, therefore, sits between traditional primary and acute health care to meet the needs for patients who require multi-professional and inter-agency continuing care for their more complex conditions. These services help to keep people living at home, prevent admission to acute hospitals, facilitate safe and timely discharge from hospitals, reduce the potential for re-admission and promote personal independence.
- 3.3.4 Community healthcare encompasses the extended primary care team and other health care professionals such as physiotherapists, occupational therapists, specialist nurses and rapid response teams as well as hospital based staff who bring their skills into the community.

3.4 Acute Care

- 3.4.1 While recognising that acute care is both necessary and appropriate it acts in a supporting role to primary and community health care providing specialist and appropriate treatment for those who need it.
- 3.4.2 Patients may access acute health care either in a planned way (elective) or as an emergency (non-elective).
- 3.4.3 GPs provide the main route into planned care in the acute hospital system. These referrals will usually be for patients who, due to their condition or illness, require the specialist skills provided in acute hospitals. The vast majority of patients are seen in the outpatients setting and after assessment may either be transferred back to primary or community healthcare or be followed up as a planned in-patient or day case.
- 3.4.4 Emergency care has many different routes into the acute hospital and can be initiated by the GP, (either via Accident and Emergency (A&E) or by direct admission to a bed) via a 999 call or by self referral. The majority of emergency admissions onto a ward will come via the hospital accident and emergency department, but can also occur through a medical assessment or other fast track units such as coronary care.
- 3.4.5 The number of emergency admissions has been increasing over recent years and when coupled with increasing referral rates, if unchecked, places a considerable and unsustainable burden on the acute hospitals in North Wales. Therefore, the ability of North Wales acute services to maintain improvements in access times to planned care is limited by the pressures being placed on the system and the range of locations at which services are provided
- 3.4.6 North Wales residents currently access acute healthcare at five District General Hospitals, Ysbyty Gwynedd Bangor, Ysbyty Glan Clwyd Bodelwyddan, Wrexham Maelor Hospital, Bronglais Hospital, Aberystwyth and Countess of Chester Hospital. The three North Wales District General Hospitals are supported by three satellite hospitals providing some acute services, namely Llandudno General Hospital, Abergele Hospital and H.M. Stanley Hospital St. Asaph. The network of community hospitals in North Wales also supports the District General Hospitals by providing rehabilitation and care.
- 3.4.7 Many North Wales patients also attend Robert Jones and Agnes Hunt Hospital in Gobowen for orthopaedic services.

The services currently delivered from the seven hospital sites are:-

	Services	Wrexham Maelor	Glan Clwyd	Ysbyty Gwynedd	Countess of Chester	HM Stanley	Abergele	Llandudno	
Emergency & High Dependency Care	Major A&E	✓	✓	✓	✓	-	-	-	
	Minor Injuries		-	-	-		-	✓	
	ITU beds	✓	✓	✓	✓	-	-		
	HDU beds	✓	✓	✓	✓	-	✓	Coronary care beds (3)	
	Emergency Surgery	✓	✓	✓	✓		-	-	
	Emergency Medical Admissions	✓	✓	✓	✓	-	-	✓	
Surgical	Major Planned Surgery	✓	✓	✓	✓			Breast only	
	Routine Planned Inpatient Surgery	✓	✓	✓	✓	Ophthalmology only	Orthopaedics only		
	Routine Planned Day Case Surgery	✓	✓	✓	✓	Ophthalmology only	Orthopaedics only	✓	
	Outpatients	✓	✓	✓	✓	✓	✓	✓	
	Planned acute medical admissions	✓	✓	✓	✓	-	-	-	
Medical	Planned acute medical day case	✓	✓	✓	✓	-	-	Endoscopy service	
	Cardiac Catheter Laboratory	-	✓	-	✓	-	-	-	
	Renal Dialysis	✓	✓	✓	✓	-	-	-	
	Chemotherapy	✓	✓	✓	✓	-	-	-	
	Radiotherapy	-	✓	-	-	-	-	-	
	Outpatients	✓	✓	✓	✓	✓	✓	✓	
	Women & Children	Paediatric surgery	✓	✓	✓	✓	-	-	-
		Paediatric Inpatients	✓	✓	✓	✓	-	-	-
		Obstetrics	✓	✓	✓	✓	-	-	-
		Neo Natal Unit	✓	✓	-	✓	-	-	-
SCBU		✓	✓	✓	✓	-	-	-	
Outpatients		✓	✓	✓	✓	-	-	-	
Mental Health		Acute Inpatients	✓	✓	✓	-	-	-	-
	Outpatients	✓	✓	✓	-	-	-	-	

Note

Sites not included in this table which provide some acute service to North Wales residents are Robert Jones and Agnes Hunt and Bronglais.

	Services	Wrexham Maelor	Glan Clwyd	Ysbyty Gwynedd	Countess of Chester	HM Stanley	Abergele	Llandudno
Diagnostics	Pathology	✓	✓	✓	✓	-	-	Local laboratory
	Major Radiology	✓	✓	✓	✓	-	-	-
	Routine Radiology	✓	✓	✓	✓	✓	✓	✓
	Pharmacy	✓	✓	✓	✓	-	-	-
	Medical Physics	✓	✓	✓	✓	-	-	-
	ECG	✓	✓	✓	✓	-	-	-
Other Clinical Services	Audiology	✓	✓	✓	✓	-	-	✓
	Dietetics	✓	✓	✓	✓	-	-	✓
	Occupational Therapy	✓	✓	✓	✓	-	-	✓
	Physiotherapy	✓	✓	✓	✓	-	-	✓
	Speech Therapy	✓	✓	✓	✓	-	-	-

The volume of activity and spend for these services can be found in appendix F.

3.5 Highly Specialist (Tertiary) Care

- 3.5.1 These are highly specialist services that can only be provided effectively and safely in regional centres which serve large populations. Unlike primary, community and acute services, which are planned and commissioned by Local Health Boards, Health Commission Wales (HCW) arranges these services on your behalf.
- 3.5.2 North Wales Trusts provide a limited number of these services, namely Forensic Mental Health services at Ty Llewellyn Llanfairfechan and the North Wales Cancer Treatment Centre at Glan Clwyd Hospital with satellite clinics held at the other two District General Hospitals. Some patients attend English specialist cancer services such as Clatterbridge or Christies by reason of their particular cancer service requirements. The North Wales Hospitals also provide renal services together with the Royal Liverpool and Broadgreen University Hospitals.
- 3.5.3 Conwy and Denbighshire NHS Trust provide a North Wales highly specialist child and adolescent mental health service at Cedar Court, Colwyn Bay.
- 3.5.4 All cardiothoracic services, excluding heart and lung transplantation (national service), are provided in Merseyside and Manchester. Specialist cardiac services are currently being developed in Glan Clwyd Hospital and Countess of Chester Hospital with the introduction of local angiography.
- 3.5.5 The Walton Centre in Liverpool provides neurology and neuro-surgery services, but also provides outreach services into North Wales.

3.5.6 The Specialist Children's Hospital serving North Wales is Alder Hey Hospital, Liverpool. This hospital works closely with local Trusts to ensure that children can stay at home as much as possible when receiving their tertiary care.

3.5.7 Health Commission Wales arranges a comprehensive range of other highly specialist services for North Wales residents which include:

Ambulance services, burns services, complex allergy diseases, genetics, immunology, infectious diseases, morbid obesity services, plastic surgery, spinal services, child and adolescent mental health, specialist adult learning disability and mental health services (including medium and high level secure) and congenital disorders.

3.6 Other Issues

3.6.1 As part of 'Making the Connections', the Welsh Assembly Government's initiative to review expenditure in the 'backoffice' functions which support all public sector services, a pilot project has commenced in North Wales to identify how transaction processing in areas such as finance, personnel and procurement could be differently organised to offer a better service and to realise cost efficiencies. A project plan is due for completion in March 2006.

3.6.2 A review of local public sector delivery in Wales, The Beecham Review, commenced in late 2005 and will report to Welsh Assembly Government in the summer of 2006. It is expected to identify proposals which will lead to improved arrangements for public service delivery.

Summary

This section sets out the current pattern of NHS service provision across North Wales in:

- Primary care
- Community care
- Acute care
- Tertiary or highly specialist care

4 **The Case for Change**

4.1 This plan is about **improving** the services people in North Wales are offered.

“The simple fact is that the NHS needs to keep pace with a changing world. Rising safety and quality standards, rising expectations, changing patterns of illness, and new opportunities presented by technology and advances in treatment; all these make changing the way we provide services essential.”
Mike Ponton, Director of the Welsh NHS Confederation.

4.2 The need for change has been stimulated by the existence of two sets of factors. Firstly, those that are driven by evolutionary changes in the context in which we live and secondly those that arise when an issue becomes a constraint which, if not addressed, will become a problem.

4.3 **Evolutionary change**

4.3.1 **Population projections** for North Wales indicate that there will be an overall growth of 3.6% in the general population to 2023. However it is vital to note that there will be a change in the balance of the age of that population with a decline of the under 64 age group of 10% and a growth of 35% in the 65-74 group and 50% in the over 75s. It is estimated that this will increase the demands on health services by about 13% by 2019/2020.

4.3.2 **The burden of disease** changes over time. We currently find ourselves on the cusp of a shift from the prime need being one of addressing the acute impact of illnesses such as heart or respiratory disease to one where the focus has to shift to the management of chronic disease or diseases in an increasing older population.

4.3.3 **Technological change** constantly pushes us to reconsider how we provide and support care, whether we are describing clinical changes resulting from the introduction of new drugs, more portable or quicker equipment, or improved access for all to the internet. Such changes allow the substitution of drug therapy for a surgical intervention or the remote monitoring of clinical indications. Where access to a bed is required it will now be for a considerably shorter period and one which can be predicted and planned for.

4.3.4 In remote areas the use of telemedicine to connect to a central point from which expert advice can be given is already in use in North Wales to support dermatology services and to connect minor injury units with A&E departments. In other parts of the world examples abound where the telephone or the internet is used to connect patients with clinicians for consultation.

4.4 **Challenges Facing the Providers of Care**

4.4.1 **The introduction of national standards** or guidelines increasingly dictate what is required in the NHS. The impact of these on the way in which patients can be cared for, the necessary education and training which their introduction necessitates and the additional costs they bring are forcing providers to continually review how they deliver care.

4.4.2 The **medical workforce** is changing rapidly. There are five major challenges, nationally and locally, which we have to be able to respond to:

- Shortages of medical staff in certain specialist areas e.g. radiology, pathology, psychiatry and child and adolescent mental health, have led to difficulties in ensuring safe provision of care in certain areas and the employment of highly expensive locum doctors to cover vacancies. These shortages are likely to continue and will be accentuated by the need to improve access times and the likelihood that there will be a reduction in the availability of locum medical staff.
- The introduction of the European Working Time Directive (EWTD) has significantly limited the hours each individual doctor can work leading to major alterations in the working patterns of junior doctors (those in training), consultants and other medical staff. A maximum working week of 48 hours will apply to all doctors from 2009.
- Developments in the training of junior doctors have led to changes in their availability to work in a clinical capacity. Significantly, the Modernising Medical Careers project has reformed postgraduate medical education by establishing foundation training, which provides junior doctors with greater exposure to different specialties, and structured training and assessment. The impact of these changes coupled with the EWTD could lead to a consultant led service in some areas, whilst in others non-medical staff will be required to develop new roles and functions to compensate.
- New and amended employment contracts for both General Practitioners and hospital consultants have altered working patterns. GPs no longer have to offer 24-hour care and the consultant contract allows consultants to limit their working week to 10 sessions. The vast majority of consultants currently work in excess of this. The availability of medical time may consequently reduce. Whilst both contracts ensure that key improvements must be introduced they have placed an increased financial burden upon the service.
- The move toward increasing specialisation of the consultant post has meant a significant change in the nature of certain roles. This is likely to put pressure on the general surgical service in the future as the new generation of surgeons have more specialised roles and limited experience in training. There is also an increasing tendency for physicians to become specialised in their own right which will put pressure on acute general medicine.

4.4.3 Whilst across North Wales we have been able to recruit newly qualified nurses and support staff with reasonable success there are areas where **recruitment and retention** are problematic, affecting what and how we can deliver in certain services. This is a particular problem within certain nursing areas such as theatre staff. There are also problems recruiting pharmacists and the Allied Health Professionals – physiotherapy and occupational therapy being examples. The increasing requirement for specialist posts within nursing and other clinical professions creates further pressures in recruiting to general posts.

- 4.4.4 Developments across the health and social care sector will have an impact on secondary care. The shift in care and resources to primary and community care will be accompanied by a similar movement of NHS staff which will put pressure on the availability of certain staff and skills.
- 4.4.5 The demographic changes affecting the population of North Wales will be reflected in the workforce. Whilst the elderly population is increasing the workforce within North Wales will remain at a broadly constant level. This will pose a number of recruitment, retention and training challenges in ensuring that the NHS workforce is able to adequately deliver services.
- 4.4.6 These workforce challenges mean that planning on a pan North Wales basis and opening up the traditional boundaries between secondary, community and primary care staff will be essential. Staff will need to work across traditional and professional boundaries.
- 4.4.7 Urgent improvements to the existing **buildings**, many of them designed built or adapted to meet the challenges of the 1980s are sorely needed. These include
- Upgrading fire precautions and removing asbestos in Ysbyty Glan Clwyd
 - Copper corrosion at both Ysbyty Gwynedd and the Wrexham Maelor Hospital
 - Backlog maintenance and the functional suitability of HM Stanley and Abergele
- 4.4.8 Identifying the **funding** necessary to meet basic requirements. The present model of service is not sustainable within the current resources so new ways of using the funding to meet the changing demands on the service need to be found.
- 4.5 The impact of these changes and challenges mean that each provider of care is required to constantly review what they can safely do at any time, resulting in changes in the pattern of care.

Summary

This section sets out the need for change:

1. Evolutionary factors

- Growing elderly population increasing demand for service
- Changes in the burden of disease
- Technological changes

2. Service challenges

- National standards and guidelines
- The changing medical workforce
- Staff recruitment and retention
- Required improvements to the estate
- Identifying the funding to meet these challenges

5 Options and Evaluation

5.1 This section sets out the process used for developing and evaluating the options to deliver acute and tertiary services to the residents of North Wales in the future.

5.2 Process

5.2.1 The Project Board established to oversee the review agreed five outline options for consideration alongside criteria for assessment. The options and criteria were agreed by the six Local Health Boards and the Trusts as the basis for review.

5.2.2 The options were then reviewed over a six month period by a number of clinical and technical groups drawn from the health, social care and voluntary sector organisations. They were supported by a small information support team drawn from the health organisations and further supported with activity, best practice data and financial and activity projections from the management consultancy firm, Teamwork.

5.2.3 Throughout the review, a stakeholder forum (the Reference Group) was kept apprised of the outputs from the working groups and invited to input views at key stages.

5.2.4 The views of all the groups and evidence were drawn together by the Project Board in an overall evaluation of the options which is presented below.

5.2.5 More details on the organisation and process of the review are given in Appendix C.

5.3 The Options and Criteria

5.3.1 Five options were put forward to be judged against a set of criteria:

Option	Description	Name
1	There are currently 6 sites which between them provide local, acute and some tertiary services. NEWT operates clinical networks with the Countess of Chester to provide some of these services.	Status quo
2	This would involve the consolidation of the current services onto the 3 main sites (Ysbyty Gwynedd, Glan Clwyd and the Wrexham Maelor), which will all provide some, but not all, acute services. In practice this would mean that services would need to be consolidated between the sites, but each site would specialise in at least one service.	Three acute sites
3	There are two components to this option being: <ul style="list-style-type: none"> • NWWT and C&D combine/network to provide all acute services at one site, supported by a local non-acute services at the other site. • NEWT and the Countess of Chester combine/network to provide acute services, supported by the other site. 	Two acute sites
4	This option consolidates acute services into a single site for North Wales supported by local non-acute service sites. The site could be located at <ul style="list-style-type: none"> • at Ysbyty Gwynedd • at Glan Clwyd • at Wrexham Maelor • on a “green field” site 	Single acute site

5	This option looks at a single super hospital being developed for North Wales covering local, acute and some tertiary services. There will be no other sites to support this, only primary care networks. This centre could be at: <ul style="list-style-type: none"> • at Ysbyty Gwynedd • at Glan Clwyd • at Wrexham Maelor • on a “green field” site 	Single super hospital
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5.4 Specialist Services: The Summary Evaluation

5.4.1 This evaluation relates only to acute services which, as set out in Appendix B, are major planned and emergency services, many of which require the support of critical care facilities.

5.4.2 Having weighed the advice received from the task groups the project board considered each of the options against the evaluation framework shown below and ranked each option against the criteria, with marginal differences indicated as equal ranking. All rankings are for relative purposes only and do not in any way reflect on the safety or quality of current services.

5.4.3 A ranking of 1 is considered best.

Criteria	Option				
	Status quo	Three acute sites	Two acute sites	Single acute site	Super hospital
A. Access/distance to Services	1	1	2	3	4
B Clinical (Standards and Safety)					
Medicine	5	1	2	3	4
Surgery	4	3	2	1	1
C. Staff Sustainability					
Medicine	5	1	2	3	4
Surgery	4	3	2	1	1
D. Financial Costs					
a) Capital	2	2	1	3	4
b) Revenue	4	1	1	2	3
E. Flexibility (Estate)	1	2	3	4	5
F. Spatial Plan	1	1	2	3	4

5.4.4 The outline ranking is explained as follows:

A) Access/distance to services

The best access to acute services, measured by travel time using private transport, is offered by the status quo and the three site option. For this reason they have been ranked one. An estimation of the travel times for the three site option is given in Appendix F7. As the number of sites diminishes the access time for the majority of the population increases, hence the other rankings. Where access to acute services is easiest to English providers, primarily the Countess of Chester and Robert Jones and Agnes Hunt for orthopaedics, these patient flows are

expected to continue for patients in the east. Similarly, for the patients in south Gwynedd who use Bronglais Hospital in Aberystwyth.

B) Clinical (standards and safety)

Medicine

For the medical specialities, top ranking has been given to the three site option. This will allow specialist medical beds to be most closely integrated with local acute beds and community services. As the number of sites diminishes the distance and, therefore integration, of the acute services with the local acute services diminishes, hence the other rankings. The status quo has been given the bottom ranking due to the clinical issues on the satellite sites for which more detail is provided in section 6.

Surgery

Surgical services are able to support all options except the status quo. In terms of ranking between the options, some of the sub specialties such as breast, ENT and urology may need to work on fewer sites in the future in order to maintain and improve standards. This trend has already started, with some of the cancer sub specialties. For this reason the single site has been given the best ranking followed by two sites and then three sites.

C) Staff sustainability

Medical

Medical specialities believe that a three site option is more sustainable due to the nature of medical specialities. There are advantages in being able to work flexibly with community staff on a local level to better integrate services, which it is considered will help attract staff in the future. Whilst there are recruitment issues within medicine it is perceived that less than three sites could adversely affect recruitment and retention. For this reason the three site option has been ranked one and the ranking diminishes as the number of sites reduces.

The clinical issues relating to the satellite sites referred to in section 6 mean that it will be difficult to attract staff to work on these sites and account for its worst ranking.

Surgery

At present surgical staff are being recruited to services across three acute sites. There are, however, pressures on this arising from the increasingly specialist training for surgeons, the amended consultant contract and the requirements of the European Working Time Directive which is due to be fully implemented by 2009. This means that there will be less consultant time available for services in the future. For this reason the single site option has been ranked one since it offers the most flexibility in terms of future recruitment and therefore maintenance of on call rotas and managing of the workload. As the number of sites increases the flexibility reduces and the ranking diminishes.

The trend to merge some on call rotas has already started and is currently operating in vascular surgery and urology between North East Wales NHS

Trust and the Countess of Chester.

The workforce challenges referred to in 4.4.2 will require a pan North Wales approach in order to manage them. This will be neither cheap nor easy under all the options.

D) Financial Costs

The financial assessment of the options has been undertaken specifically for relative cost purposes and the results of these are reflected in the rankings. Because of the methods of estimation used, further detailed work will be necessary to support the implementation plans.

Capital spend

The estimation of comparative capital costs produced a range varying from £220 million to £400 million. The capital modelling provided for making the estate fit to run a 21st century service as well as remedying the estates problems of the past.

The cheapest option is the two specialist sites, since this makes good use of existing quality buildings across North Wales and minimises the use of expensive new buildings. The three site option is slightly more expensive with the single site options being the most expensive.

In the longer term, if acute services were concentrated on fewer sites, there would be less duplication of major items of equipment. However with greater integrated working some of these benefits will be achieved within the 3 site option.

Revenue

The detailed configuration of how services would be provided within any of the options has not yet been developed sufficiently to support detailed costing of the potential running cost of each of the options.

Teamwork, the healthcare management consultancy company, has supported the initial review with a high level modelling of the options. This supports the conclusion that the status quo is not affordable within the existing level of funding. Radical modernisation of how services are provided is essential to generate financially viable solutions.

In considering the potential differences between the options, it would be expected all options would need to configure services to provide elective and emergency care at a standard unit cost, reflecting the possible development of payment by results with a standard tariff.

A known factor in comparing the revenue consequences of the options is the revenue consequence of capital spends. This would support a similar ranking to the capital above. The issues raised by the clinical group suggest that an increased investment would be required in the medical workforce to support three acute centres, but the cost of providing NHS transport (999 services and patient transport services) will increase as the number of sites are reduced across North Wales. It is therefore estimated that the revenue costs of the three and the two site options are broadly similar.

The increased capital spend and the transport costs required to support one site make it more expensive.

E) Flexibility

Flexibility has been considered in terms of the need to meet the demands of the future, in particular in the years from 2015/16 onwards. The more site area that is available the more flexibility there is to adjust the existing estate should this be required at some time in the future.

F) Spatial Plan

‘People, Places, Futures, the Wales Spatial Plan’ sets out the strategic integrated agenda for Wales for the next 20 years. The plan supports the development of economic hubs on the Menai Straits and in Deeside/Wrexham, whilst maintaining economic support to the coastal area of central North Wales. Given this, it is considered that options 1 and 2 provide the best support to the objectives of the spatial plan. The other options progressively lessen the support for the plan.

5.4.5 Conclusion

The balanced conclusion, taking into account all of the issues considered in the review, is that the use of three acute hospital sites in North Wales is the best option for services for the future.

Each site will offer an A&E service and acute medical and surgical services. It is not intended to offer exactly the same services on each site. For reasons of clinical quality, medical staff availability and specialist knowledge some services will be concentrated onto one or two sites. Consequently, the detailed service configuration on each site will be the subject of ongoing reviews, and the changes in patterns of medical staffing training and supply will be kept under review.

5.5 Affordability

5.5.1 If the recommended best practice proposals were implemented the changes in bed numbers and outpatient attendances on the acute sites could release about £23 million by 2014/2015, for the health economy to reinvest in alternative services. Of this, approximately £15.6 million may need to be spent to support the capital charges which will be incurred as part of the capital investment programme on the three main sites. Given the issues of rurality and developments already introduced since the base year of 2004/2005, it may be more realistic to plan on the achievement of only 80% of best practice. This would release about £19 million, to reinvest in alternative services against which the cost of capital charges will need to be offset.

5.5.2 Teamwork also supported the need to consider similar clinical improvements in the use of community hospitals which, if achieved, will release further resources to support alternative patterns of care.

- 5.5.3 The figures exclude the impact of demography. Planning assumptions in terms of potential growth in NHS funding to support demographic changes are not available beyond the next 3 years in order to consider the impact of this issue. The proposed model does ensure the configuration is flexible to address this issue.
- 5.5.4 The detailed costings and funds available for alternative investment will vary for each health economy and will need to be agreed locally.
- 5.5.5 The figures do not take account of the requirement for transitional funding to support pilot schemes and double running costs in the interim period before the new service pattern is bedded in. Transitional funding to support the proposals will need to be quantified and secured through the business plans as part of the implementation.
- 5.5.6 All options require significant capital investments. This partly reflects a range of backlog maintenance issues on all 3 sites but within each site we will look at the opportunity to use this to modernise the way the buildings contribute to service delivery.
- 5.5.7 This then ensures that service in North Wales can demonstrate that the capital investment will lead to significant value for money benefits. It is anticipated that within the overall financial regime savings from efficiencies are utilised to fund the additional capital charge costs and revenue consequences of capital investment.
- 5.5.8 However, the Welsh Assembly Government will consider strategic funding to support elements of the increased capital charges in certain situations to assist major strategic developments. This might be appropriate for part of the proposed solution in North Wales but will need to be determined through the business case process. If agreed, this would fund part of the increased level of capital charges identified within the model, which would free up more money to invest in alternative services.
- 5.5.9 In overall terms, given appropriate support, the proposals of the review are affordable for the health economy of North Wales.

Summary

This section sets out the

- Process of the review
- The five options considered for acute sites
- The evaluation of the options against the criteria

It concluded that for reasons of access, clinical quality and safety, estate and value for money

- North Wales will require three major hospital sites providing acute services in the medium to long term, although the services on each site will vary
- Acute services currently on the three satellite sites should move to the main sites.

6.0 Implications for Satellite Sites

- 6.1 The satellite sites all currently provide some acute services but are not supported by around the clock anaesthetic, surgical and intensive care facilities. This means that although they may have a role in delivering local services it is proposed that they do not have a medium or long-term role in the delivery of acute services.
- 6.2 The scope to reduce acute service bed capacity provides the opportunity to move acute services from the satellite sites onto the three major sites, where they will have access to a wide range of specialist back up, thus improving clinical quality and sustainability.
- 6.3 During the transition period, whilst the necessary estates work is done on the main sites, Llandudno could be used as an interim facility for local services to avoid the need to re-provide these.

Facilities at the Three Satellite Sites

	H M Stanley	Abergele	Llandudno
Inpatient Beds			
Stroke Rehabilitation	20		
Ophthalmology	2		
Orthopaedics		49	
Surgical			18*
Medical			33
Acute Care of the Elderly			37
Rehabilitation			45
Coronary Care Beds			3
Theatres			
Ordinary		2	2
Day Case Theatres	2		
Endoscopy Suite			1
Day Case Beds			
Surgical			18*
Orthopaedics		9	
Ophthalmology (Chairs)	20		
Endoscopy (Chairs)			6

Note

- * As from spring 2006 the current level of activity in these two wards will be delivered from 18 beds rather than 36 beds.

6.4 *HM Stanley Hospital*

- 6.4.1 The site currently provides ophthalmology day case surgery, a 20 bedded stroke rehabilitation unit and a range of outpatient and therapy services. The site as a whole has backlog maintenance requirements amounting to £2.5million to restore it to a 'fit for purpose' condition and functional suitability. This includes work on the electrical systems, heating, structural repairs and theatre replacement.
- 6.4.2 Ophthalmology services are currently part of the review of surgical sub specialities. The services currently provided at HM Stanley will be re-provided in Glan Clwyd, or alternative suitable accommodation elsewhere, in accordance with the outcome of this review.
- 6.4.3 Stroke rehabilitation services are currently the subject of a review. They will be re-provided in more suitable accommodation elsewhere in accordance with the outcome of this review.
- 6.4.4 The future nature and location of the other services on HM Stanley site will also need to be worked through by Denbighshire LHB in discussion with Clwyd (Denbighshire Committee) CHC.
- 6.4.5 If these proposals are accepted Denbighshire LHB will work with Clwyd (Denbighshire Committee) CHC on the detailed timing and implementation of the proposals.

6.5 *Abergele Hospital*

- 6.5.1 The site currently provides inpatient and daycase beds for elective orthopaedics. It has backlog maintenance requirements amounting to £4.4 million including replacing the electrical and heating distribution systems. The functional suitability of the existing clinical areas is extremely limited and still involves the operation of Nightingale-style wards. The use of the site is also limited by the weight restrictions on the single bridge access to the site.
- 6.5.2 Under the proposals the orthopaedic services will transfer to the Glan Clwyd site where they can be delivered in better accommodation, providing a centre of excellence in purpose built accommodation with the full round the clock back up facilities of a major hospital.
- 6.5.3 If these proposals are accepted the Conwy LHB will work with Conwy East CHC on the timing and details of the implementation of the plans.

6.6 *Llandudno Hospital*

- 6.6.1 Llandudno Hospital at present provides a small number of acute services for a wider catchment area as well as local services for its catchment population. Conwy LHB envisages that the hospital will have a future role in continuing to provide out-patient, local medical in-patient and diagnostic services for the local population. For acute services it is proposed that the following changes take place.
- 6.6.2 The site currently has three coronary care beds which do not meet the requirements of the National Service Framework for Coronary Heart Disease

which states that “all patients admitted to a district general hospital with a cardiac diagnosis should be seen by a cardiologist within 24 hours”. In addition, without 24 hour anaesthetic cover it will become increasingly difficult to maintain the clinical quality levels specified in ‘Quality Requirements for Adult Critical Care in Wales’. The beds should therefore move to the major hospital sites.

- 6.6.3 Without on site access to round the clock general surgical, intensive care and radiology support Llandudno is not able support an Accident and Emergency department. The review supports the re-designation of the A&E department as a minor injuries department. The site will not be able to accept unselected medical emergencies which will transfer to Ysbyty Gwynedd and Glan Clwyd.
- 6.6.4 A breast surgery service is currently offered at Llandudno for north west and central North Wales. The need to develop a more extensive reconstructive surgery service in North Wales along with the clinical advances such as sentinel node biopsies mean that in the medium term the continuing development of excellent breast surgery services will be better serviced by locating them on an acute hospital site where the full range of clinical support facilities are available. Given the recommendation to provide separately for planned services on the acute sites this offers the opportunity to develop a centre of excellence in purpose built facilities. The details as to where and when this will happen will be determined through the sub specialty work referred to in paragraph 7.4.7.
- 6.6.5 Breast Test Wales offer an outpatient and diagnostic service adjacent to the Llandudno site. They have indicated their willingness to work with whichever service configuration is suggested by this review.
- 6.6.6 These proposals open the possibility of using the site as a centre of excellence for enhanced rehabilitation services. The combination of several rehabilitation disciplines on the one site would support the development of community based chronic disease management. It would also facilitate the concentration of acute services on the major sites. Conwy LHB will lead the discussions on how this could be achieved.
- 6.6.7 If these proposals are accepted Conwy LHB will work with Conwy West CHC on the detailed timing and implementation of the changes.

Summary

This section recommends

- The transfer of ophthalmology services from HM Stanley to Ysbyty Glan Clwyd or suitable alternative accommodation
- The transfer of the stroke rehabilitation service from HM Stanley to more suitable accommodation
- The transfer of orthopaedic services from Abergele to Ysbyty Glan Clwyd
- The transfer of coronary care beds from Llandudno to the major sites
- That Llandudno no longer receives unselected medical emergencies
- That breast surgery services transfer to the main site(s)
- That the development of Llandudno as a centre of excellence for enhanced rehabilitation services is explored.

7. Proposal – The New Plan

- 7.1 A vision for the future of health services in North Wales is outlined in Section 2. This identifies a change in the balance between hospital based care accounting for 10% of patient contacts and over 50% of the resource and the NHS in the community where some 90% of the patient contacts take place, but where less than 50% of the resource is used.
- 7.2 This section clarifies what is proposed, how it will be achieved and what the consequences will be for all stakeholders. Whilst the focus of this proposal is primarily the changes needed within the acute hospitals setting, reference is also made to what will have to happen within community settings in order that ‘out of hospital’ care can become a real alternative where more appropriate. The proposal also considers the likely impact upon and consequences for providers in the social and other care sectors.

2006 – 2011: What is proposed?

7.3 Local Services

- 7.3.1 We will commence discussions with GPs, consultants and others to design how care can be delivered in the community. Care pathways describing the management of care for a range of long term medical conditions will be agreed and implemented across North Wales. These will be based on the assumption that care will be provided by partnerships between General Practitioners and consultants working as specialists in the most appropriate community setting with access to ‘in hospital care’ only where there are no other clinically appropriate alternatives. These pathways will be common across North Wales but their application may sometimes differ in accordance with the differing needs presented by urban or rural settings.
- 7.3.2 We will work towards making health care within the community available on a twenty-four hour basis, supported by information systems to support local decisions about diagnosis, treatment and care.
- 7.3.3 Emergency access to hospital care will continue to be through three North Wales accident and emergency departments based, as currently, on the three acute sites in North Wales, plus the Countess of Chester and Bronglais Hospital. Each health community will review current arrangements to ensure that once triaged any attendee can be directed to the most appropriate care within the health or social care sectors.
- 7.3.4 Appropriate alternatives to ‘in hospital care’ for those whose care needs are not acute will be identified and developed. It is estimated that this could affect up to 25% of hospital services. This will be accompanied by a workforce shift from hospital services.
- 7.3.5 Whole systems pilots to manage chronic diseases in the community will be run over the next two years and, if successful will be rolled out thereafter.

7.4 Acute Services

- 7.4.1 Acute services requiring a hospital base in North Wales will only be provided from the three main North Wales hospital sites, namely Ysbyty Gwynedd,

Ysbyty Glan Clwyd and Wrexham Maelor Hospital supported by the Countess of Chester, Bronglais Hospital and the Robert Jones and Agnes Hunt hospitals. This consolidation will be achieved by the transfer of the small number of acute services currently provided at the three satellite sites (at Llandudno, Abergele and HM Stanley) to one or more of the three major sites.

- 7.4.2 The buildings on the three major sites will receive investment to eliminate the maintenance problems and make them fit to provide a 21st century service. This will need to take account of the transport and parking issues which are always of concern to the public. This investment will commence as soon as possible after the completion of this consultation and should be completed over the next 8 to 10 years.
- 7.4.3 It is proposed that acute medical and coronary care services currently provided on the Llandudno hospital site will transfer to Ysbyty Gwynedd and/or Ysbyty Glan Clwyd. The in patient breast surgery services provided at Llandudno will also transfer to a major site. The opportunity to develop the site as a centre of excellence for enhanced rehabilitation services will be explored.
- 7.4.4 It is proposed that orthopaedic services at Abergele will transfer to Ysbyty Glan Clwyd.
- 7.4.5 It is proposed that the ophthalmology services based at HM Stanley site at St Asaph will transfer to Glan Clwyd or alternative suitable accommodation.
- 7.4.6 The stroke rehabilitation service at HM Stanley is currently being reviewed and will be moved to a more suitable accommodation as determined by the review.
- 7.4.7 In order to continue to provide services that are safe and of the highest quality, further work on more sub specialist services will be carried out. It is anticipated that some services will be consolidated onto one or two sites in North Wales as a result. This has already started, with oral maxillo facial surgery services being consolidated at Glan Clwyd. It is anticipated that this work will be completed over the next 18 months.
- 7.4.8 The plan builds on the strength of the existing network of the three major hospitals sites within North Wales and the existing links with the English hospitals on the border.

7.5 Tertiary Services

- 7.5.1 It is proposed that highly specialist, tertiary services will continue to be provided, as currently, with most of these services being in the major centres in Liverpool and Manchester. As noted earlier, technological and other developments can change our ability to safely deliver certain interventions and it may become viable for some of these services to be provided in North Wales. For this reason these services will be kept under continuous review.
- 7.5.2 The future of neo-natal intensive care services will be the subject of a separate piece of work which will be led by Health Commission Wales.

7.6 The Impact of these proposals

7.6.1 For the provision of healthcare

7.6.2 The release of beds, through the reduction of inappropriate admissions and the rigorous management of care pathways where admission to a bed is required will allow:

- Each local community an opportunity to consider fully options for the future use of the satellite sites.
- Beds released on the Llandudno site to be available to be used as interim facilities during the maintenance and improvement work on the Ysbyty Gwynedd and Ysbyty Glan Clwyd sites.
- Inappropriate hospital admissions to be reduced which is better for patients since it minimises the dislocation from their home and their families.
- The separation of planned facilities from the emergency service will help meet national waiting time targets.

7.6.3 We will work towards common standards of care across North Wales.

7.6.4 The plan provides stability backed up with safe, efficient and effective evolution, whilst building in the flexibility needed to respond to the growth in demand for services and future developments in medical technology.

7.7 For the Social Care Sector

7.7.1 Throughout this review a level of anxiety has been expressed as to the impact upon the social care sector and their ability to cope with the consequences of the proposed model.

7.7.2 Identifying and then funding more appropriate, less clinically focussed care for those who are currently or traditionally NHS patients (particularly in community hospitals) is difficult but this should not be allowed to stop health and social care initiating an urgent review of how this can be achieved. This needs to be done in partnership with the independent and voluntary sectors.

7.8 How are these changes to be achieved?

7.8.1 The proposals need to be supported during this consultation

7.8.2 The proposals must be recognised as only the first step in a longer term commitment to provide services to meet the constantly changing needs of service users and ensuring that we have the right staff with the right skills and equipment in the right place to meet those needs.

7.8.3 For those parts of the plan that cover all North Wales and for which plans have not been settled, it is proposed that the planning is continued over the next 18 months with the clinical and non-clinical task and finish groups expanded and enhanced to detail the implementation of each objective. Representation from the social care sector and the voluntary sector, along with patient involvement on the appropriate groups is essential.

7.8.4 The review of these services will not undermine the strategic plan to consolidate acute services on three the major sites, supported by the Countess

of Chester, Robert Jones and Agnes Hunt and Bronglais Hospital, which is the core of this consultation, and which forms the foundation for future strategic financial capital investment decisions.

- 7.8.5 The relevant LHBs and Health Trusts in conjunction with the CHCs will consider the future role of the three satellite sites without acute services. It is anticipated that these reviews will be completed within two years.

7.9 2011 to 2015

- 7.9.1 It is anticipated that the capital investment commenced in the first five years will be completed by 2014/2015.
- 7.9.2 The predicted increase in the older population will become more pronounced after 2011. The focus of attention must be in planning for the demands this will place upon the system, ensuring that North Wales has sufficient capacity in both the acute hospital base and the community and sufficient staff with the appropriate skills and competencies.
- 7.9.3 The completion of the planned modernisation strategies across North Wales by 2011 will ensure that the system as a whole becomes more flexible and therefore more capable of dealing with a continuing increase in demand, ambitious targets to improve access, changes in service provision and additional changes to working practices.
- 7.9.4 It is, however, anticipated that with the demographic changes predicted demand will still exceed the services which can be delivered if further change does not take place. We will, therefore, have to consider yet further alternatives based on continually developing best practice.

Summary

This section sets out the proposals and their phasing:

From 2006 to 2011

- There will be a significant development of the capacity to manage chronic disease in a community setting, thus releasing hospital beds.
- The consolidation of acute services on the major hospital sites, including their move from the satellite sites.
- The investment in the hospital estate on the three main sites will commence. This is a major capital investment plan to make them fit for a 21st century health service
- The work on the optimum configuration of sub specialities will be concluded
- Planning will involve social care, voluntary sector partners and patient groups.

From 2011 to 2015

- Completion of the implementation of the new service model by 2014/15.
- A further review to plan for the needs of 2016 and beyond.

8 **Implementation**

- 8.1 This document sets out a bold vision for a better and more community based health service for North Wales. It is a vision and, if accepted, much detailed work will need to take place on the plans to realise it. The service will need to fully engage its staff, GPs, local authorities, CHCs and the public in this process. Detailed plans as to how this is to be achieved and how the chronic disease management pilots will work will be completed over the summer, based on the assumption that the vision is accepted.
- 8.2 The proposal is for strategic and interconnected plans for acute services, and tertiary services for the residents of North Wales. The acute services to be provided from the three North Wales sites will be more connected (through clinical networks) than in the past, and the implementation arrangements will be integrated.
- 8.3 A detailed timetable for implementation of the acute services hospital plan will be completed over the summer period based on an assumption that the plan is accepted. This work will commence in order to avoid losing time before implementation and to meet the need to prepare a Strategic Outline Programme for Capital Investment as soon as possible. Of course, if the plan is not agreed then the implementation work would be redundant. However, by way of general guidance major investment could be commenced within two years of approval and substantially completed within 8 to 10 years, dependent on demand for capital from elsewhere in Wales, and the total available.
- 8.4 Major financial capital can only be secured from the Welsh Assembly Government when there is an agreed acute and tertiary services plan for North Wales. The plan would need to be agreed by all the North Wales Local Health Boards and Trusts.

Transitional Arrangements

- 8.5 The implementation plan will require a series of temporary changes while major building works take place on the three sites. The building works will involve modifying and upgrading existing buildings and some new building. Consequently it is likely that some of the satellite sites could be temporarily used for interim purposes as improvements to the three major sites are made. The logistics of such moves has not yet been worked though in detail, and will form part of the implementation plan. As a consequence, it may be several years before acute services are moved from all the satellite sites.

Summary

This section sets out the implementation arrangements

- Detailed plans for the realisation of the vision to be drawn up
- A detailed capital investment programme to be drawn up.
- Detailed plans for transitional arrangements to be established

9 Consultation

You have the right to expect the highest standards of health services possible. We, the North Wales Local Health Boards and NHS Trusts, believe that the changes proposed in this document will help meet this expectation by helping your NHS in North Wales to deliver better, more responsive and effective services.

We are undertaking this consultation with you because your views are critical if we are to make the right improvements to patient care in North Wales and agree a framework on which future service and investment decisions can be made.

We are seeking your opinion :

- On our vision for health services for North Wales residents
- On the specific changes to acute and highly specialist services described in this document.

This consultation document has also been produced to allow a wide range of individuals and organisations to discuss and contribute their views on the vision and proposals to re-shape acute and tertiary services for the residents of North Wales. Comments and views are encouraged from everyone with an interest in the proposals, including but not limited to:

- Residents of North Wales
- NHS and social care organisations including the Welsh Ambulance Services NHS Trust
- Patient and public involvement forums and other groups representing patients and the public
- Voluntary organisations and other groups
- Local Authorities, community and town councils
- Assembly Members and Members of Parliament
- Staff side trade unions, and
- The Community Health Councils in North Wales.

We welcome your views on all aspects of the proposals. You can make them known in a number of ways. During the consultation we will be arranging a series of stands and exhibitions in local public buildings explaining the proposals and answering questions. We will also be arranging to meet with various stakeholder groups to discuss proposals. A full programme detailing these arrangements is available with this consultation document. Written comments on the proposal can be made:

By post to:

Andrew Butters
Project Director
Room G3
Croesnewydd Hall
Croesnewydd Road
Wrexham
LL13 7YP

By email to: ANDREW.BUTTERS@new-tr.wales.nhs.uk

This consultation will last until 26th June 2006 by which time all responses should be returned.

How will a decision be reached?

At the conclusion of the consultation process we will seek the views of the Community Health Councils locally on your comments and contributions. Thereafter, we will collate and consider all views and comments received during the consultation period. We will take these into consideration before a final decision is taken, particularly those of the Community Health Councils given their special responsibility to represent patient interests.

In the event that we have agreement with the CHCs on the proposals we will then proceed with their implementation and confirm this at our public board meetings. Alternatively, should the process fail to reach agreement we may refer the consultation proposals and its outcome to the Minister for Health and Social Care for a decision.

In the event that the proposals in section 7 are supported through this consultation we recognise that further discussions will need to be held with:

- Conwy Community Health Councils regarding the future use of Llandudno Hospital and the Abergele site
- Clwyd (Denbighshire Committee) Community Health Council regarding the future use of H.M. Stanley site..

Where can I get extra copies of this document?

If you need extra copies of the consultation document, they are available to download via the internet at the following address:

www.wales.nhs.uk/norwalesecare

To obtain hard copies of this document, please contact:

Andrew Butters
Project Director
Room G3
Croesnewydd Hall
Croesnewydd Road
Wrexham
LL13 7YP
Tel: 01978 727871

MAKE SURE YOU TAKE THIS OPPORTUNITY TO HAVE YOUR SAY.

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.
Acute Care	Care requiring major planned or emergency treatment, often requiring the support of critical care facilities.
Admitted Care	The care a patient receives in hospital.
Clinical	Involving the care, treatment or study of patients. Clinical care is usually provided in hospitals and clinics.
Care Pathways	See pathways of care
Community Care	Health or social care and treatment outside of hospital. It can take place in clinics, or in people's homes.
Community Hospital	A local hospital in a community setting separate to an acute hospital site.
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.
Pathways of care	A plan for an individual's care based on their assessed need.
Paediatric	Child health services.
Primary care	The first stage of treatment or prevention 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
Secondary care	The second stage of treatment when you are ill and usually provided by a hospital (outpatient and inpatient services).
Triage	A process by which a patient is assessed upon arrival to determine the urgency of the problem and arrange appropriate treatment
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.

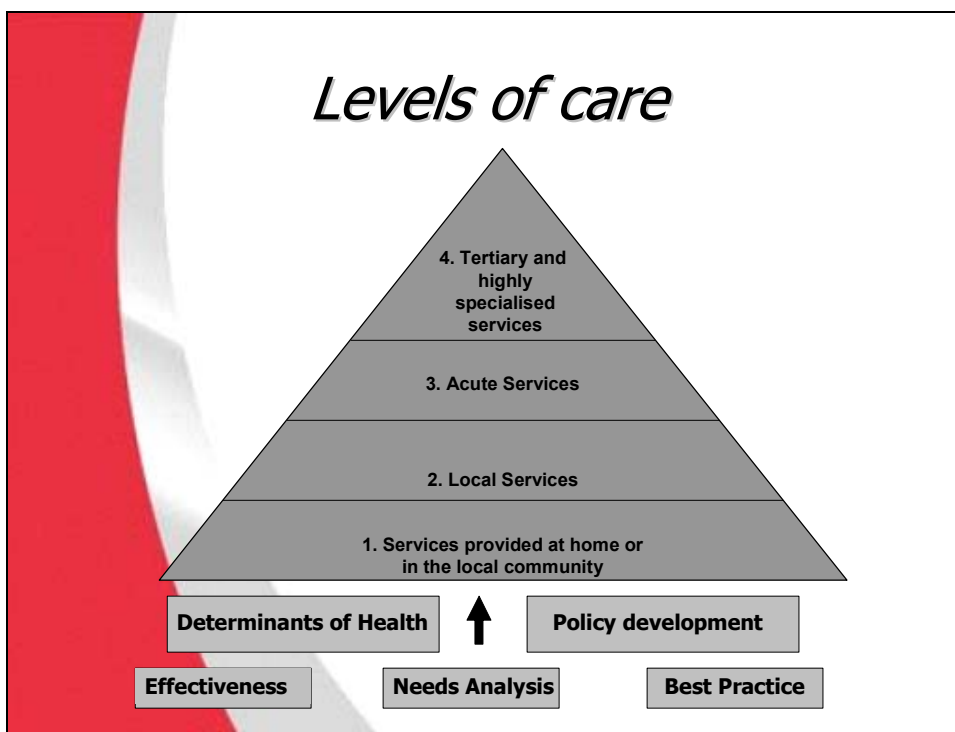
Glossary of Acronyms

A&E	Accident and Emergency
AHPs	Allied Health Professionals
BSC	Business Services Centre
CAMHS	Child and Adolescent Mental Health Services
CHCs	Community Health Councils
CT	Computer Tomography
DGH	District General Hospital
DH	Department of Health
EHR	Electronic Health Record
ENT	Ear, Nose and Throat
EPR	Electronic Patient Record
EWTD	European Working Time Directive
HCW	Health Commission Wales
IM+T	Information Management and Technology
FCEs	Finish Consultant Episodes
LHBs	Local Health Boards
MDT	Multi Disciplinary Team
MRI	Magnetic Resonance Imaging
NHS	National Health Service
NPHS	National Public Health Service
OOH	Out of Hours
PET	Positron Emission Tomography
WAG	Welsh Assembly Government
WTE	Whole Time Equivalents

Designed for Life

Designed for Life is the national strategy for health services through to 2015 and was published by the Welsh Assembly Government in May 2005. It sets out an approach to designing health care service within which the current proposals for North Wales fit. A full copy of the document can be accessed via the website at www.wales.nhs.uk/norwalesecare.

The framework and definitions used in this document have been based upon the four levels of care identified in Designed for Life. These are presented below for easy reference



These levels of care will not be rigidly compartmentalised. The aim will be to reduce barriers between services and increase integration at all points.

Level 1: Primary Care Networks

The role of Primary care Networks will be to provide:

- Primary care
- Health education and promotion
- Sub hospital specialist care (e.g. nurse consultant, GP/Dentists with a specialist interest)

- Diagnostics (e.g. point of care testing)
- Demand management
- Minor injuries
- GP/dental ‘out of hours’
- Secondary care outreach
- Seamless care with social care and local government
- Rehabilitation services
- Health maintenance support
- Ante-natal care
- Post-natal care
- Drop-in breast feeding services
- Children and family services
- Early intervention service
- Assertive outreach teams
- Crisis intervention

Level 2:Local Services

The role of Local Services will be to provide:

- Emergency care (e.g.)
 - Minor injuries
 - Rapid access clinics
 - Local emergency assessment
 - Emergency admissions
 - Base for emergency response community teams
 - Routine emergency medicine e.g. chest infections, cardiac failure
- Elective care (e.g.)
 - Outpatient clinic suites including designated children’s facilities for consultations, minor procedures and dental services
 - Endoscopy suites for diagnosis and treatment
 - Day care and short stay unit for routine surgery
 - Diagnostic unit including radiology (from plain film and ultrasound up to CAT scanner/MRI, pathology and ECG and echocardiography).
- Integrated care (e.g.)
 - Rehabilitation beds
 - Sub acute beds
 - Palliative care
 - Stroke unit
 - Therapies centre
 - Resource centre (for patient and carer support; voluntary sector, multi agency/multi professional teams)

- Family healthcare (e.g.)
 - Midwifery-led units
 - Paediatric clinics/joint GP and paediatric clinics
 - Local diagnostic services
 - Emotional health and wellbeing services

- Mental health (e.g.)
 - Integrated partial hospital – extended day hospital
 - Outpatient clinics
 - Inpatient services
 - Day hospital
 - Liaison services

Level 3: Acute Services

The role of acute services will be as follows:

1. Major elective and major emergency services that cannot be decentralised to Local Services will need to be consolidated. This will ensure we can provide robust and sustainable services for the future because of the challenges of the increasing influence of sub-specialisation, higher clinical standards, clinical training, new legislation and other pressures on the workforce.

2. The services that will be further considered carefully in this context include:
 - Accident and Emergency
 - Trauma
 - Emergency and Specialist Medicine
 - Neonatology
 - Emergency Surgery
 - Paediatrics
 - Critical care
 - Cancer Services
 - Obstetrics
 - Complex Surgery
 - High tech diagnostics

3. It is anticipated that these services – or components of them – will need to be consolidated within a single “acute care centre”. In addition consideration will be given to the further development of tertiary outreach services at this centre.

4. The concept of the Acute Care Centre is to create a highly specialised facility to support the treatment of complex morbidity and acute emergency care. This will act as a back up facility for local services in providing advice, assessment, diagnosis and treatment where it cannot be delivered safely at local level and in transferring patients back when they no longer require specialist attention.

5. Major emergency and specialist services requiring critical care together with specialist services for women and children would be consolidated in a single centre, strategically located, to serve the entire catchment population. The organisation of the Centre will be built around acuity of illness rather than specialist wards.
6. The Acute Care Centre will be networked closely with Local Services to provide back-up to them in terms of specialist advice, assessment and treatment, and critical care.

Level 4: Tertiary and highly specialised care

1. The role of tertiary centres will be to provide highly specialised services, often with a large research and teaching component.
2. Concentration into specialist departments improves services by accessing high specification technology and expertise. Such centres within and close to Wales will play an important part of continuing to attract high calibre professionals in future.
3. Services in this context will include for example:
 - Cancer
 - Plastic surgery and burns
 - Neurosurgery
 - Cardiac surgery
 - Renal transplants
 - Specialised children's services

Where numbers of patients are very small, we will continue to access United Kingdom Centres of Excellence.

Organisation and Process of the Review

1. A Project Board was established to oversee the organisation of the process for the review, and to draw together a recommended plan for North Wales.

The Board had an independent Chair and representatives of the Health Trusts, LHBs, Community Health Councils and Local Authorities in North Wales. The Health and Social Care Department, Regional Director also attended the Board, but did not take part in the recommendation decisions. The Board Membership was:

Trefor Jones, Chair
 Gail Roberts, Chief Officer, Clwyd Community Health Council
 Dr David Gozzard, Medical Director, Conwy & Denbighshire NHS Trust
 Grace Lewis Parry, Chief Executive Gwynedd LHB
 Hilary Pepler, Chief Executive, North East Wales NHS Trust
 Dr Janette Fells, Medical Director, Flintshire LHB
 Kate Elis Williams, Director of Finance, North West Wales NHS Trust
 Phil McGreevy, Chief Executive, Flintshire County Council
 Andrew Butters – Project Director

2. The review process commenced in May and was formally launched in July 2005. The launch involved a presentation of the reasons for change and set out the process and timetable. Representatives from most public organisations and other sectors attended the launch, discussed the case for change, and agreed the process.
3. The Board established 13 task and finish groups to review clinical, financial, estates, transport, HR, IM&T, and needs assessment issues.
4. A stakeholder Reference Group, chaired by Mr Lloyd FitzHugh was established, and included, Trust and LHB Chairs, Trust and LHB staff and union representatives, Professional Groups representatives, Community Health Councils, (members and officers), Local Authorities (members and officers), County Voluntary Services Councils, Public and Patient Involvement Groups, Higher Education representatives, other NHS providers, commissioners and agencies serving North Wales, and representation from the independent sector.

The Reference Group on an interactive basis received the views of the task and finish groups and provided commentary on the views and proposals as they emerged.

5. The involvement of such large numbers of individuals which has been sustained over the 9 month period to the point of formal consultation on this document is a credit to the individuals and their organisations. Alongside the intense review and involvement activity, there was an information and communication programme, including meetings with AMs, MPs, Local Authority Committees/Cabinets, CHC Chairs and Chief Officers, and information made available to the public and interested parties through for example, the Project Web site, and publication of the booklet “You and Your Health Service – A Review of Major Hospitals in North Wales”.

6. Local Health Boards and Trust Boards have been updated by their Chief Executives, and agreed the principles underpinning the review.
7. The Project Board developed five outline options for the task and finish groups to review against agreed criteria. The Local Health Boards and Trusts received these at their meetings, and were content with the framework.
8. The proposed plan set out in this document was recommended to the North Wales LHB and Trust Chief Executives by the Project Board, having considered the work of the Task and Finish Groups and the views of the Reference Group.
9. The Chief Executives concurred with the proposed plan and recommend it to their organisations as an integrated plan for North Wales.

References

Welsh Assembly Government Publications

- Designed For Life: Creating World Class Health and Social Care For Wales in the 21st Century - *WAG 2005*
- A Profile of Long Term and Chronic Conditions in Wales – *WAG 2005*
- Health Status Wales 2004/2005 – *WAG 2005*
- Making the Connections: Connecting the Workforce – *WAG 2005*
- Modernising Diagnosis Imaging Services in Wales – *WAG 2005*
- National Service Framework For Older People in Wales (Draft) – *WAG 2005*
- Pathology Modernisation – *WAG 2005*
- Adult Mental Health Services: Raising the Standard – *WAG 2005*
- People, Places, Futures (Wales Spacial Plan) – *WAG 2005*
- Review of Health and Social Care in Wales (the Wanless Review) – *WAG 2004*

Department of Health Publications

- Our Health, Our Care, Our Say – *DH 2006*
- The National Service Framework For Long Term Conditions – *DH 2005*
- The National Orthopaedic Project – *DH 2005*
- National Quality Requirements in the Delivery Of Out Of Hours Services – *DH 2005*
- The Implementation and Impact of Hospital at Night Pilot Projects and Evaluation Reports – *DH 2005*
- Building Telecare In England – *DH 2005*
- A Guide to Promote a Shared Understanding of the Benefits of Managed Local Networks – *DH 2005*
- Taking Healthcare to the Patients: Transforming NHS Ambulance Services - *DH 2005*

- The Acutely or Critically Sick or Injured Child in The District General Hospital: A Team Response – *DH 2005*
- Treatment Centres: Delivering Faster Quality of Care and Choice for NHS Patients – *DH 2005*
- A Compendium of Solutions to Implementing the Working Time Directive For Doctors In Training From August 2004 – *DH 2004*
- The NHS Cancer Plan and the New NHS Providing a Patient Centred Service – *DH 2004*
- Modernising Pathology Services – *DH 2004*
- Modernising Medical Careers – *DH 2004*
- Configuring Hospitals Project – *DH 2003*
- Radiography Skills Mix – A Report on The Four-Tier Service Delivery Model 2003 – *DH 2003*
- Day Surgery: Operational Guidance Waiting Booking and Choice – *DH 2002*
- Comprehensive Critical Care: A Review of Adult Critical Care Services - *DH 2000*
- Shaping The Future NHS: Long Term Planning for Hospitals and Related Services – *DH 2000*

Other Relevant Publications

- North Wales Planning Forum Secondary Care Review – High Level Options Appraisal – *Teamwork Management Services 2006*
- Neonatology Review – Health Commission Wales (Specialist Services) 2005
- Care of the Newborn Baby in Wales – The Way Forward – Health Commission Wales 2005
- Quality Requirements for Adult Critical Care in Wales (Draft) - All Wales Critical Care Development Group 2005
- Drivers to Change – *National Public Health Service For Wales 2005* (Unpublished Report)
- Cancer Services In Wales – Publication of National Cancer Standards and the Implication for Commissioner and Providers through The Cancer Networks WHC (2005) 051

- Developing a Modern Surgical Workforce – *Royal College Of Surgeons In England 2005*
- A Picture of Health: How The NHS in Wales Could Look in 2015 – *Welsh NHS Confederation 2005*
- Transforming Chronic Care – The University of Birmingham 2005
- Quicker Treatment Closer to Home – *Audit Commission 2004*
- Transforming Health and Social Care in Wales – *Audit Commission 2004*
- Ideal Design of Emergency Access - *Modernisation Agency 2003*
- Critical Care Outreach 2003 - *Modernisation Agency 2003*
- The Emergency Department: Medicine and Surgery Interface Problems and Solutions – *Royal College of Surgeons of England 2004*
- Paediatric Surgery: Standards of Care – *British Association of Paediatric Surgeons 2002*
- Better Care for the Severely Injured – *Royal College Of Surgeons In England 2000*

NORTH WALES SECONDARY CARE REVIEW

WORK OF THE CLINICAL GROUPS

Introduction

This appendix presents a brief summary of the outcomes of the work of the clinical task and finish groups. Six clinical task & finish groups (T&F), comprising long-term medical conditions (LTC), emergency access, surgery, paediatrics & obstetrics, diagnostics and mental health have shaped the clinical model. A Clinical Futures Groups, comprising the Medical Directors of each Trust, has supported the clinical groups throughout the process.

Long term Medical Conditions

The LTC group supported 3 acute centres to deliver medical care. The group has identified that patients currently stay in hospital longer than clinically necessary. To make best use of expensive hospital beds, the LTC group put forward a range of alternative services, including investment in discharge support teams, expanded capacity in general practice, multidisciplinary teams to support patients after discharge, and rapid review specialist clinics for early detection of medical problems and to support recovery.

For certain medical conditions, and to make best use of medical resources, there was a proposal that some hospital services should be delivered on a pan North Wales basis. Examples given were rheumatology, cardiac angiography, and acquired brain injury.

The group has proposed that medical interventions could take place away from the acute care centres, hence greater investment in an expanded provision of primary and community care. This would also include greater investment in information technology (IT) to support remote diagnostic treatment. This would be delivered by increasing the number of community-based teams, supporting people in their own homes. The LTC group has noted the future projected care needs for older people particularly in relation to dementia.

Paediatrics, Obstetrics and Gynaecology

The T&F group supported 3 centres for acute care for paediatrics, obstetrics and gynaecology.

A major driver for the group has been the fact that about 90% of paediatric admissions are emergency. The group has proposed that routine surgery for children remains in each of the 3 acute centres but for highly specialised surgery to take place in Alder Hey Children's Hospital. A single highly specialised service was proposed for neonatal intensive care. The group would like to highlight the importance of CAMHS which is currently under review.

There was support for the principle that a large proportion of births could take place in midwifery led units. However, some obstetric procedures could be consolidated across North Wales eg foetal medicine. Further consolidation of gynaecological procedures was recommended eg cancer gynaecology. Moreover, the group supported the expansion of community based gynaecology care that would have the capacity to carry out diagnostic testing and treatment services; for example, colposcopy, post menopausal bleeding, early pregnancy assessment and hysteroscopy.

Emergency Access

The emergency access group supported 3 acute centres capable of providing category 1 services under the Civil Contingency Act. On site services required to support this include general surgery, medicine, trauma and orthopaedics, anaesthetics and critical care, diagnostics, paediatrics, obstetrics and gynaecology. In order to address a rising demand on emergency services, an expanded range of minor injury services has been proposed. Building capacity in A&E departments has also been supported, for example, GPs working in A&E, emergency care practitioners triaging patients, 24/7 social care provision, emergency review clinics and closely integrated observation wards to facilitate quicker discharge. Support was given to the investment in IT and telemedicine to support a wide spread of emergency access points.

Surgery

The surgical group has had to take account of EWTD, surgical specialisation and changes to medical training in considering their support for an emergency trauma and general surgical response for each of the 3 acute centres. This will cost more but is deemed to be achievable within clinical governance requirements.

Work has already started in considering sub-specialty surgical care, for example, urology, ENT, orthopaedics and ophthalmology and how they can best be configured to support emergency and planned care requirements in the future.

The group supported splitting emergency and elective surgical work.

Diagnostics

The diagnostics group has supported the three acute service centres. Each centre will need 24-hour pathology laboratories providing clinical chemistry, haematology, blood transfusion services, histopathology and mortuary facilities and microbiology; and an imaging centre providing nuclear medicine and 24-hour access to plain radiography, fluoroscopy, ultrasonography, CT, MRI and endoscopy.

The diagnostics group also supported increasing routine diagnostic access in primary and community care to improve patient access. An example would be community based phlebotomy. This needs to be a carefully managed process in partnership with primary care. There was scope for some diagnostic capacity to be delivered on a more planned

basis which, given further investment, would enable the rationalisation of some diagnostic facilities for North Wales.

Improved transport and IM&T links will be vital in achieving this. It was also noted that the scale of increase in activity required to meet WAG targets and this vision of the future would require substantial investment in addition to new ways of working. Full participation in the national modernisation agendas for imaging and pathology will be essential.

2004-2005 Surgical & Medical Activity for North Wales by site

Specialities	Types of Care	Ysbyty Wrexham Maelor	Ysbyty Glan Clwyd	Ysbyty Gwynedd	HM Stanley Hopsital	Abergele Hospital	Llandudno Hopital	Total
		FCE	FCE	FCE	FCE	FCE	FCE	FCE
A&E	New Attendances	59180	49766	37513	468	0	19037	165964
	Review Attendances	4169	2161	2288	0	0	1307	9925
Surgery	Non elective inpatients	8753	8958	9214	160	298	7	27390
	Elective inpatients	5371	6447	4784	19	905	612	18138
	Day Case	6148	3103	7154	6013	2123	2747	27288
Medicine	Non elective inpatients	15019	21632	14502	162	0	3466	54781
	Elective inpatients	802	1562	1010	22	0	163	3559
	Day Case	3707	15335	7122	0	0	706	26870
Paediatrics	Non elective inpatients	3644	6182	4847	0	0	16	14689
	Elective inpatients	123	81	46	3	0	0	253
	Day Case	11	193	72	0	0	0	276
Obstetrics	All cases	4257	4530	2934	0	0	0	11721
	New Outpatients	34561	36377	31793	12854	2188	9476	127249
	Review Outpatients	101357	84610	86826	24637	5328	21957	324715

Notes

1. FCE = Finished Consultant Episode

2. Source: Patient Administration Systems based in each of the North Wales Trusts

North Wales Local Health Boards

Planned Revenue Expenditure for 2005-2006

	Wrexham LHB	Flintshire LHB	Denbighshire LHB	Conwy LHB	Gwynedd LHB	Anglesey LHB	Totals	%
Income	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Total Income	159,009	155,647	135,385	145,549	164,871	82,576	843,037	
Expenditure								
Primary Health Care Services								
Primary Healthcare Services(excluding prescribing)	21,866	24,255	20,357	19,915	27,143	14,792	128,328	
Primary Healthcare Prescribing	24,197	24,577	17,368	19,416	17,009	11,192	113,759	
Sub total - Primary Health care	46,063	48,832	37,725	39,331	44,152	25,984	242,087	28.7%
Secondary & Community Health Care Services								
Conwy & Denbighshire Trust	5,120	22,415	80,993	58,144	3,750	1,945	172,367	
North East Wales	87,735	51,129	4,013	2,350	4,817	916	150,960	
North West Wales	126	542	115	29,584	96,640	46,533	173,540	
Other Welsh Trusts	58	78	48	58	3,290	36	3,568	
Non Welsh Trusts	8,202	19,069	2,056	2,068	2,644	1,698	35,737	
Sub Total - Secondary & Community Health Care Services	101,241	93,233	87,225	92,204	111,141	51,128	536,172	63.6%
Other health care services								
Welsh Ambulance Services	72	115	153	148	25		513	
Voluntary organisations	320	180	982	255	152	122	2,011	
Continuing Care	5,889	5,392	3,897	5,826	3,227	2,171	26,402	
Other Health Care Expenditure (e.g. Wanless, cross border flows, waiting lists)	2,411	4,924	2,838	5,085	3,257	1,179	19,694	
Sub total - Other health care costs	8,692	10,611	7,870	11,314	6,661	3,472	48,620	5.8%
LHB costs								
Local Health Board running costs	1,421	1,423	1,204	1,202	1,326	1,172	7,748	
National Public Health Service	732	702	627	676	728	371	3,836	
Business Service Centre	860	846	734	822	863	449	4,574	
Sub Total - LHB costs	3,013	2,971	2,565	2,700	2,917	1,992	16,158	1.9%
Total Expenditure	159,009	155,647	135,385	145,549	164,871	82,576	843,037	100.0%

Note

This represents 2005/06 annual expenditure plan as at October 2005.

**North Wales NHS Trusts
Workforce Profiles at the 31st March 2005**

Appendix F3

(figures based on actual staff in post on this date)

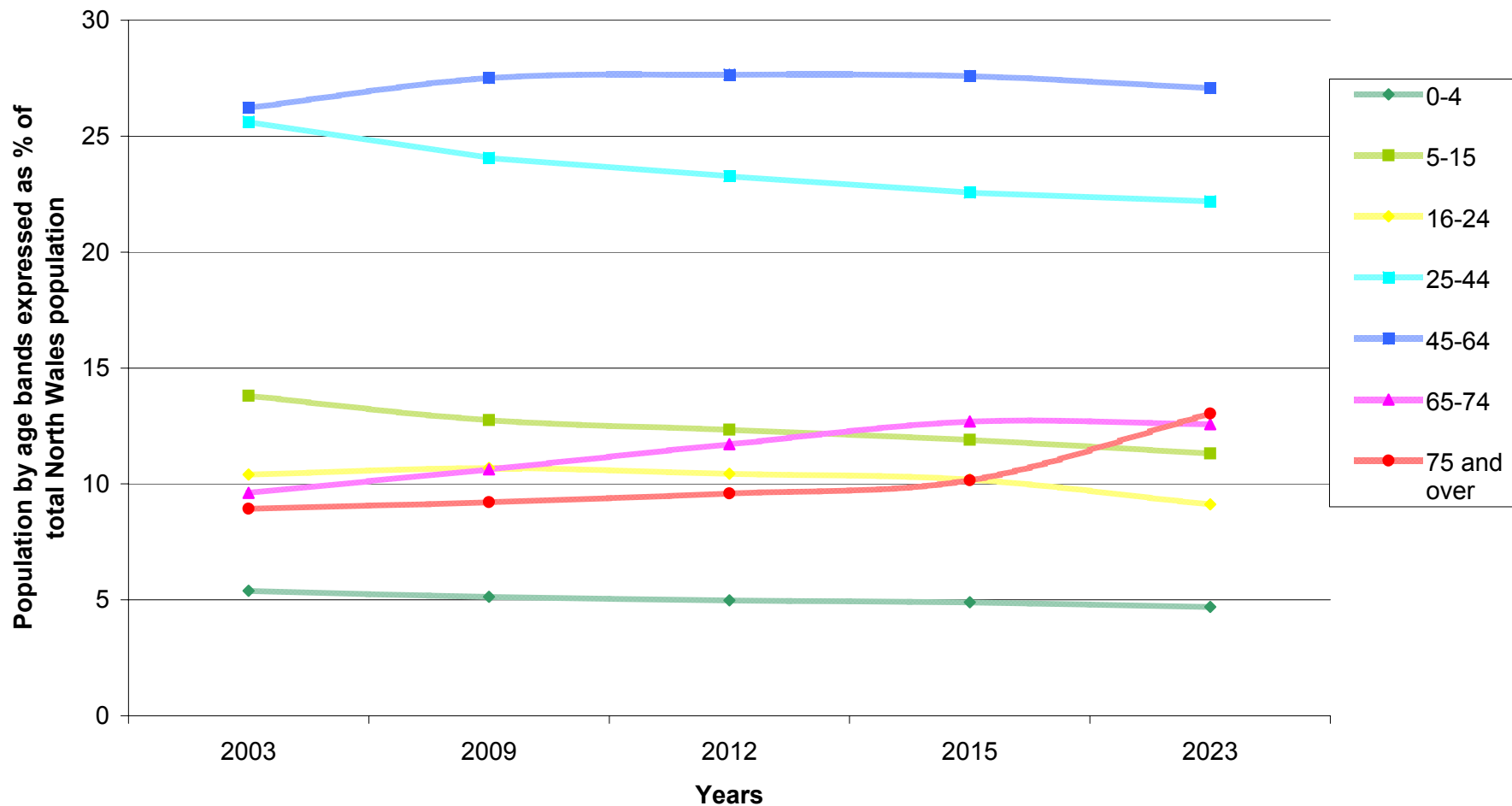
Staff Group	North West Wales Trust	Conwy & Denbighshire Trust	North East Wales Trust	Total
	whole time equivalent in post	whole time equivalent in post	whole time equivalent in post	whole time equivalent in post
Chairman & non executive directors	7	7	7	21
Executive board & senior managers	66	102	85	254
Medical	311	327	309	947
Dentists (consultant restorative dentistry & consultant orthodontists included in medical staffing above)	0	27	0	27
Dental hygienists & nurses	0	64	0	64
Nursing	2,372	2,166	2,233	6,771
Scientific, therapeutic & technical	618	717	564	1,899
Admin & clerical	690	720	686	2,096
Facilities	378	492	366	1,236
Maintenance	68	59	20	147
Other Trust employees	0	0	6	6
Social workers	5	0	0	5
Total	4,515	4,682	4,276	13,473

Note:

1. The table includes staff employed in the community element of the Trusts as well as the Acute setting e.g. School Nurses
2. The individual Trust figures include staff who are hosted by the Trusts but who provide services across the North Wales Region for example the Cancer Treatment Centre & the Community Dental service at Conwy & Denbighshire Trust
3. Managers employed by the North Wales Cancer Network plus All Wales posts such as the Agenda for Change project director are hosted by the Conwy & Denbighshire Trust
4. Source: Figures produced by the individual North Wales Trusts Financial Management Systems

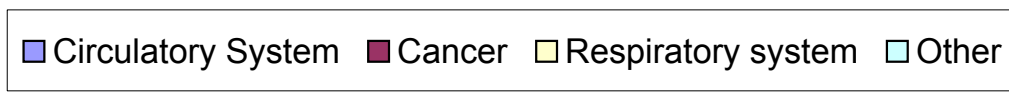
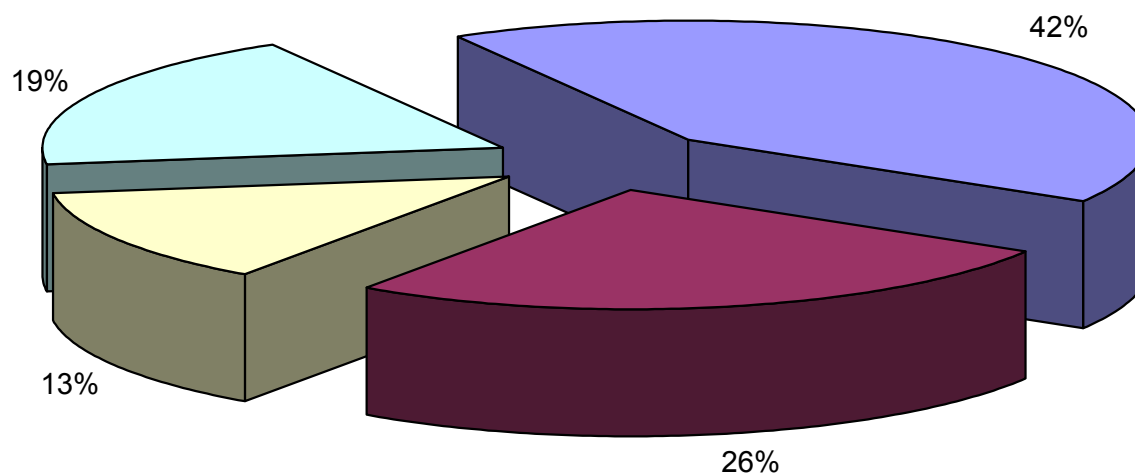
Population Age Profiles for North Wales 2003 - 2023

(Source: NPHS Summary of the Population of Wales, September 2005)



Major Causes of Mortality in North Wales 2001-2003

(Source: NPHS Summary of the Population of Wales, September 2005)



Morbidity in North Wales by Unitary Authority

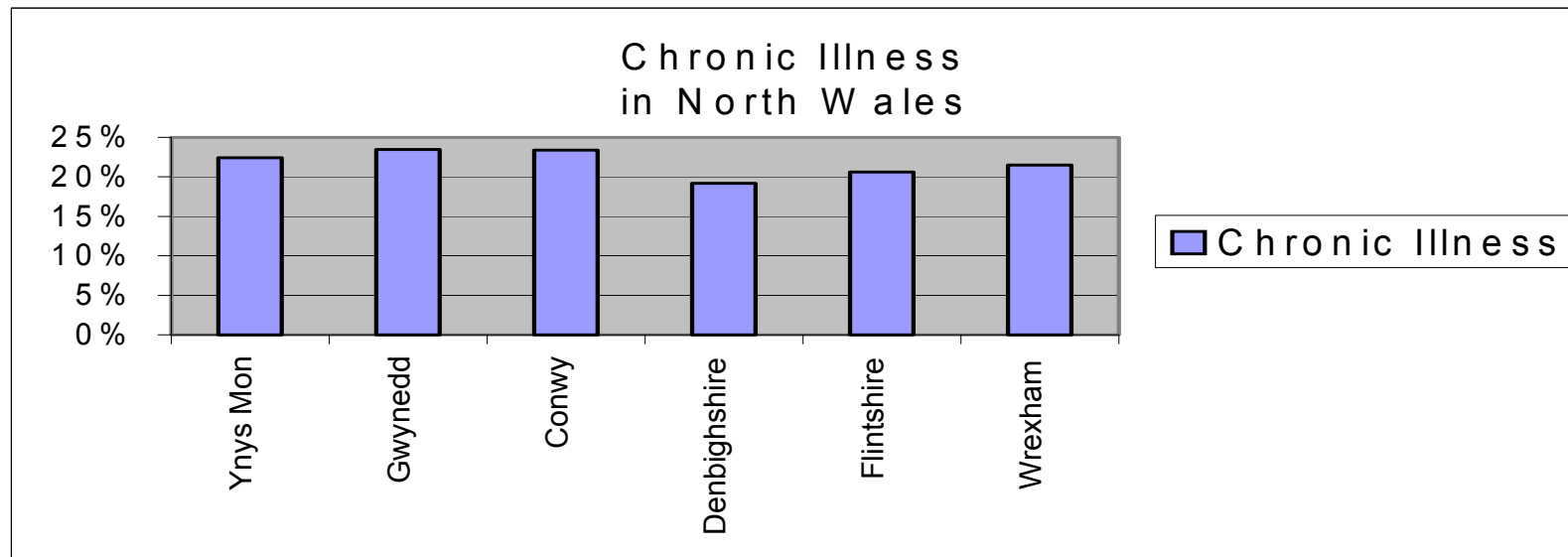
(Source: Office of National Statistics 2001 census)

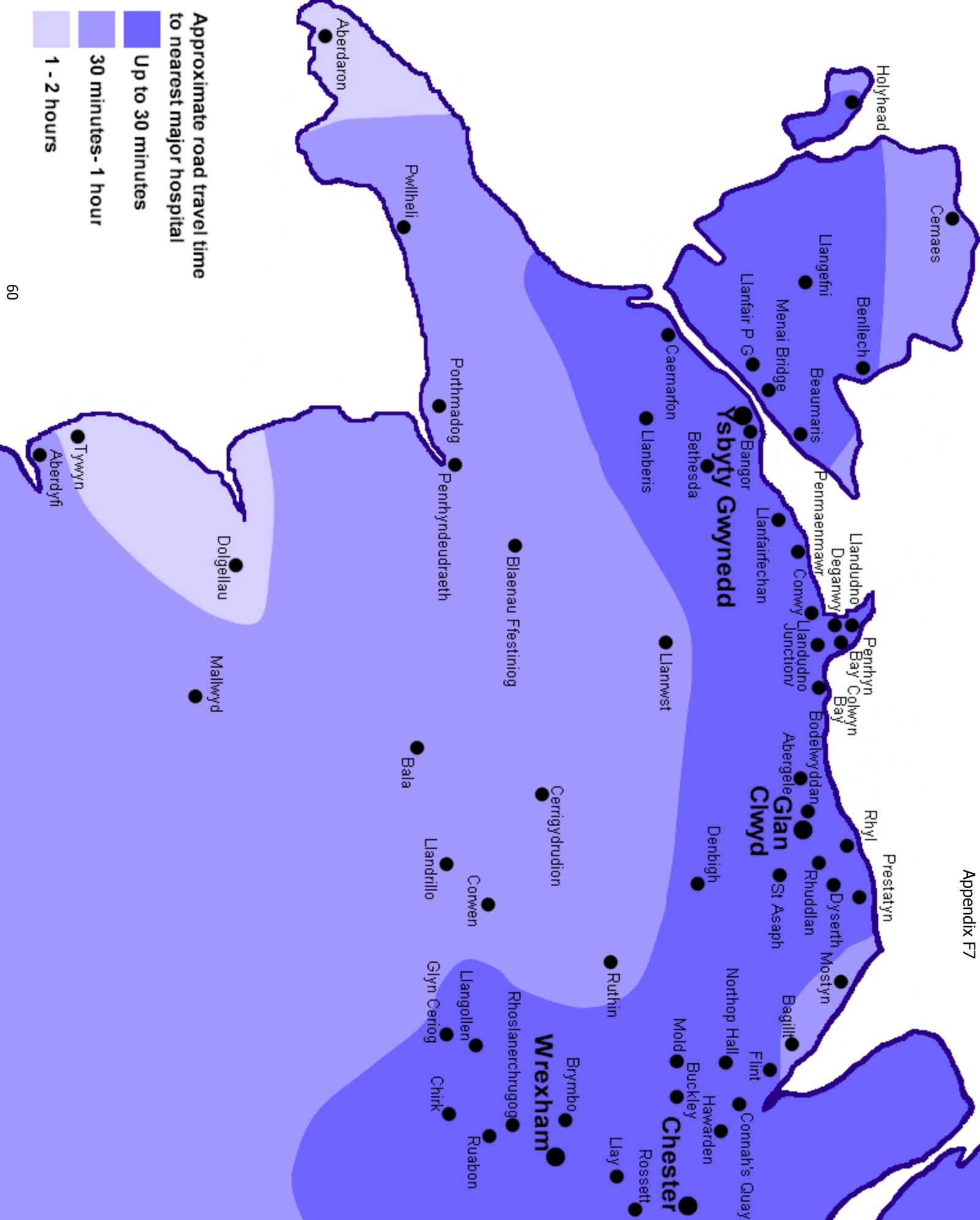
Evidence shows that older people with chronic respiratory disease accounted for the greatest use of hospital bed days particularly during the winter months

A recent review of chronic disease showed that for the population of Wales as a whole about one third of people over the age of 16 self report having at least one chronic condition. This rises to two thirds of the population over the age of 65 years.

Overall 23% of people report having some form of limiting long term illness in Wales, higher than England (18%) and other home nations (20%).

For North Wales the situation by County is shown below.





North Wales Health Region



Welsh Index of Multiple Deprivation 2005

Overall Index of Multiple Deprivation

