HYWEL DDA HEALTH BOARD

RESPONSE TO

HYWEL DDA CHC

"ISSUES, OPINIONS & CONCERNS REGARDING HYWEL DDA HEALTH BOARD'S "YOUR HEALTH YOUR FUTURE CONSULTATION ON HEALTHCARE SERVICES

DATED 25 FEBRUARY 2013

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RESPONSE TO COMMUNITY HEALTH COUNCIL REFERRAL

1. INTRODUCTION

Section 1; paragraph 3 of the Welsh Government's *Guidance for Engagement and Consultation on changes to Health Services* (March 2011) (the Guidance) states that change is needed to have safe and sustainable services that meet modern standards at a time when resources are severely constrained. It also states that NHS bodies and Community Health Councils (CHCs) must work together to achieve these changes.

Section 5: paragraph 43 and Section 7:paragraph 54 of the Guidance and Paragraph 6 of the Welsh Government's additional Guidance on the *Process for handing potential referrals from Community Health Councils received in response to Local Health Board proposals for service reconfiguration* (8 February 2013) (the Referrals Guidance) state that where a CHC considers any proposals would not be in the interest of the health service, it may refer its objections to the Welsh Ministers.

Section 7: paragraph 55 of the Guidance and Paragraph 4 of the Referrals Guidance is clear that where that is the case, the CHC should, ***in the first instance***, submit a constructive and detailed response to the Health Board. The Health Board should then have the opportunity to formally and fully consider the objections raised. Only if the matter remains unresolved should the proposals be referred to the Minister for Health and Social Services (the Health Minister).

Paragraph 55 also states that the Health Board should extend the CHC all reasonable assistance in formulating a response. I hope you will agree that the Health Board has met with the CHC Executive and Members on at least 4 separate occasions recently; 7 January 2013, and on 12, 15 and 21 February 2013, where the Health Board listened to the CHC's concerns and provided responses to any issues raised – even those outside the consultation process. The feedback from your members at the February meetings was very positive and I trust you will agree that the Health Board has met the requirement of the Guidance.

The Health Board understood that the CHC letter received by the Health Board at 3.14pm on Friday 22 February 2013 (the First Letter) was the CHC's constructive and detailed response and would therefore formulate any subsequent referral to the Health Minister.

On the afternoon of Monday 25 February 2013, a Health Board officer made telephone contact with a senior CHC officer to confirm that the Health Board was aware that time was of the essence, and that a formal response would be provided to the CHC that afternoon. At 5.40pm on Monday 25 February 2013, in accordance with the Guidance, the specific issues picked up in the First Letter were responded to by the Health Board. In the interim, the CHC had written to the Health Minister in some differing terms from the CHC's First Letter.

As a result, the referral to the Health Minister (the Second Letter) would appear to have been submitted outside of the prescribed process. This response will focus on the "core grounds for referral" contained within the Second Letter.

These are:

- The consultation process itself did not meet the basic "Gunning Principles" on consultation
- The post consultation methodology and analysis of the various responses and submissions was flawed
- There were core issues excluded from the consultation exercise that should have been included, and particularly the intended provision of community care which should be the cornerstone of any change
- The consultation proposals have insufficient details in respect of financial and business planning models
- Due cognisance has not been given to the opinion of clinicians, or that of other external stakeholders who are expected to support the plans for change from acute to community settings, especially the GPs and local authorities
- Lack of detail in the provision of community care and "virtual wards" with the planned closure of Mynydd Mawr Community Hospital
- A number of healthcare configurations are deemed unacceptable and not in the best interests of patients and the public:
    - Women and children's, neonatal, SCBUs, obstetrics and paediatric services
    - A&E service at Prince Philip Hospital
    - MIU provision in Pembrokeshire
- The rurality and poor transport infrastructure of the Hywel Dda region has not been fully recognised in the plans that are to be implemented
- A lack of assessed health need and published equality impact assessment

Each of these areas will be addressed in the subsequent sections.

Many of the detailed concerns raised within the Second Letter and during post-consultation meetings between the Health Board and the CHC have been responded to in the papers provided to the CHC on 15 and 21 February 2013. These responses do not appear to have been reflected in the Second Letter and as they refer to specific service changes have been included in the relevant sections of this document.

Section 3: paragraph 18 of the Guidance and Paragraph 4 of the Welsh Government's additional Guidance on the *Process for handing potential referrals from Community Health Councils received in response to Local Health Board proposals for service reconfiguration* (8 February 2013) (the Referrals Guidance) sets out the requirements for the CHC to follow when it is dealing with service changes.

Having considered the content of the CHC's First and Second Letters, the Health Board contends that the CHC has failed to meet some important requirements of paragraph 18 of the Guidance and Paragraph 4 of the Referrals Guidance, insofar as it has **not:**

- Ensured that objections to change proposals are based on sound arguments in terms of how safe and sustainable services can be provided from within available resources;
- Proposed alternative solutions for providing/maintaining safe and substantive services within available resources; and
- Recognised that maintaining status quo is not an acceptable response if safe and sustainable services cannot be maintained within available resources – *as is the case for Prince Philip A&E, Mynydd Mawr Hospital, SCBU And neo-natal services and for both the Tenby and South Pembrokeshire MIUs.*

It was also the Health Board's understanding from the third joint meeting held on 21 February 2013 that agreement had been reached in relation to the closures of South Pembrokeshire MIU and Mynydd Mawr Hospital, and that the CHC was satisfied with the position in relation to equality impact. Their inclusion in the referral is therefore particularly disappointing.

2. BREADTH AND SCOPE OF THE CONSULTATION

2.1 Background

Before addressing specific issues raised in the Second Letter, it is important to put the process into context to demonstrate the breadth of activity and CHC engagement in that process.

2.2 Process

Regulation 27(1)(b) of the *Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010* (the CHC Regulations) states that it is the duty of the Health Board to involve the CHC in the development and consideration of proposals for service change.

In addition, the conduct of both an engagement and formal consultation process is governed by the Guidance, which sets out the responsibilities of both the Health Board and the CHC throughout the process.

There were three key phases to the Health Board's process:

- Clinical Engagement;
- Listening and Engagement with stakeholders and the wider population (Stage 1); and
- Formal Consultation (Stage 2).

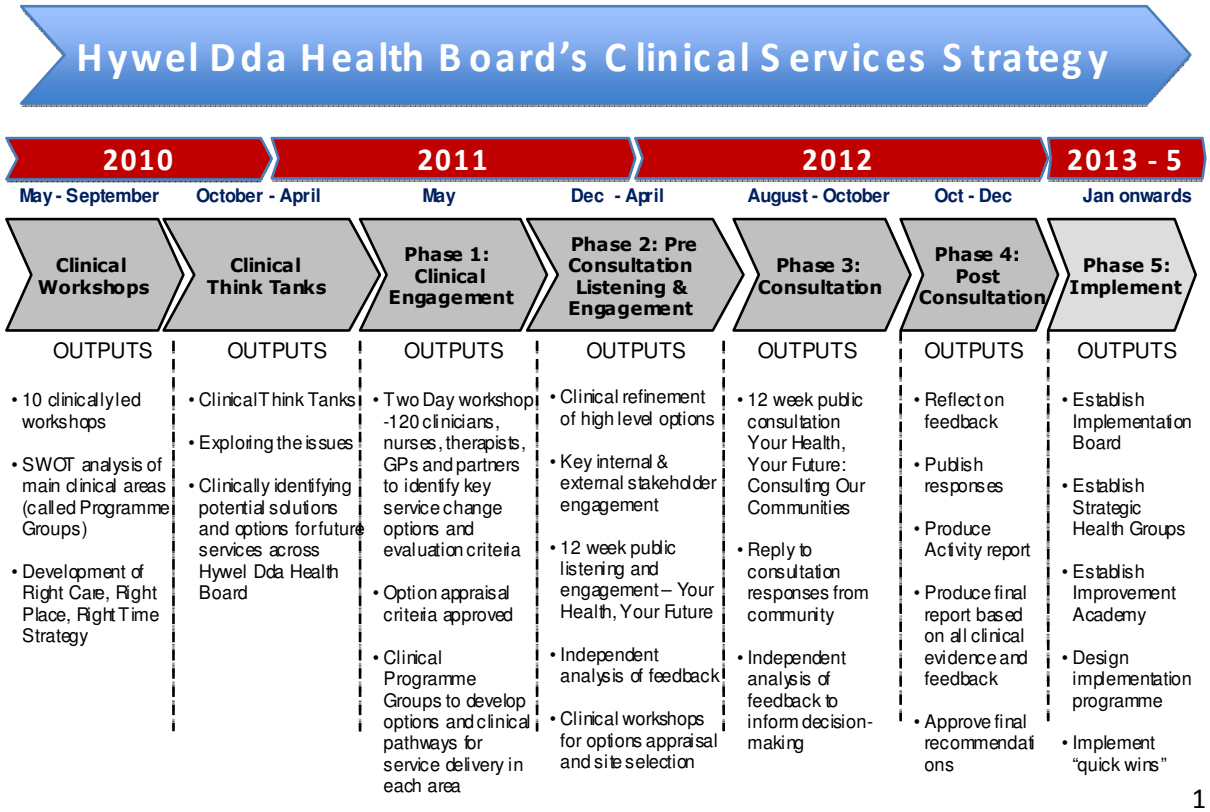
The Health Board contends that the CHC was engaged at each stage of the process – from the development and weighting of assessment criteria and the options appraisal process in September 2011; in mid-term reviews of both the listening and engagement exercise; to the formal consultation process.

Notwithstanding the detailed engagement with the CHC throughout the whole consultative period, there are a number of issues raised in terms of the process that surfaced in detail for the first time in your Second Letter. Despite a number of requests in the post-consultation discussions for more specific detail about what part of the process you considered flawed (including at the Public Board meetings on 15 and 31 January 2013), this detail was not provided to the Health Board, which again is disappointing.

The CHC is aware that throughout the process the Health Board has worked closely with the Consultation Institute to ensure that the consultation was accredited against best practice standards.

2.3 Timeline

The following is the over-arching timeline in relation to pre-consultation and the formal consultation process:



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This timeline shows the breadth of activity and clearly shows the significant clinical engagement undertaken before formal consultation (see also Section 3.5)

There is evidence throughout the process that Health Board options have been developed and adjusted as a result of the feedback received and this is covered in more detail in subsequent sections.

Set out below is a list of all meetings between the Health Board, CHC and others during the course of the consultation and post consultation period, which highlights the opportunity to debate and potentially resolve any outstanding concerns during that time.

When	What
14 Aug 2012	**Consultation task and finish group meeting** (set up to monitor the consultation process) CHC attended meeting
11 Sep 2012	**Consultation task and finish group meeting** (set up to monitor the consultation process) CHC attended meeting
20 Sep 2012	**CHC Planning Meeting** Attended by the Health Board's Director of Finance and Economic Reform
2 Oct 2012	**Mid Consultation Review** Meeting to discuss delivery of consultation plan and to receive interim feedback report from ORS Additional activities put in place as a result of CHC observations
22 Oct 2012	ORS Interim Report shared with CHC
23 Oct 2012	**CHC Planning Meeting** Discussions on the plans for partnership working in the post-consultation phase
25 Oct 2012	All submissions received to date by the Health Board shared with the CHC Interim ORS report shared with CHC
7 – 8 Nov 2012	All additional submissions received by the Health Board during the last week of the consultation shared with the CHC
13 Nov 2012	**Board OD Session** Presentation by Consultation Institute on post-consultation requirements and the relative weightings to specific feedback CHC Executive/membership in attendance or participating. Post-consultation action plan shared/discussed
20 Nov 2012	**CHC Planning Meeting** Presentation by Director of Public Health on the emerging themes from the significant consultation submissions and discussions on their impact on the options Presentation by Consultation Institute on post-consultation requirements (for CHC membership only)
22 Nov 2012	Stakeholder briefing shared to describe the level of responses received and the next milestones in the decision-making process
29 Nov 2012	Meeting with CHC Executive to discuss submissions received and their potential impact on service change options Approach to EIA described following advice from NHS CEHR
7 Dec 2012	**Board OD Session** Presentation by ORS on the consultation feedback and discussion on the impact on the options CHC Executives and members in attendance.
10 Dec 2012	All submissions received directly by ORS shared with CHC
12 Dec 2012	Meeting with CHC Executive for ongoing discussions on the submissions received and their impact on service change options
18 Dec 2012	ORS presentation to wider CHC executive and members. Meeting with planning team to discuss outstanding issues and concerns and to discuss the equality issues that had emerged from the process

When	What
19 Dec 2012	**Public Board Meeting** Verbal update and discussion on post-consultation process with CHC Chair in attendance. This was followed by informal discussions between Health Board CEO, Chair, Vice Chair and Director of Planning and Chief Officer and Chair of CHC with the purpose of discussing the way ahead
21 Dec 2012	Meeting with CHC Executive for ongoing discussions on the submissions received and their impact on service change options
7 Jan 2013	Full day meeting with CHC Executive/Members for ongoing discussions on the submissions received and their impact on service change options. Many of the CHC Executive and Members were in attendance, together with the Health Board Chair, Vice Chair, Assistant Director of Planning, Associate Medical Director and the Associate Director of Public and Patient Involvement.
15 Jan 2013	**Extraordinary Public Board Meeting** The Board considered the Board Paper setting out the rationale for the recommendations. This information included details of alternative options and summarised the main objections received. The CHC Chair and Vice Chair sat around the Board table, and the Chief Officer was an observer.
31 Jan 2013	**Public Board Meeting** The CHC Chair sat around the Board table, and the Chief Officer was an observer.
6 Feb 2013	Facilitated arbitration meeting between the Chair and Director of the Board of CHCs in Wales, the LHB's Chair, Vice Chair and Chief Executive and the Hywel Dda CHC Chair, Vice Chair and Chief Officer.
12 Feb 2013	First of a series of three joint meetings held in Cardigan between some of the CHC Executives and Members and the Health Board's Vice Chair, Director of Planning, the Head of Planning and a Senior Planning Manager.
15 Feb 2013	Second of a series of three joint meetings held in Cardigan between some of the CHC Executives and Members and the Health Board's Vice Chair, Director of Planning, and the Head of Planning.
21 Feb 2013	Third of a series of three joint meetings held in Cardigan between some of the CHC Executives and Members and the Health Board's Vice Chair, Director of Planning, and the Head of Planning.

3. CORE GROUNDS FOR REFERRAL

3.1 The consultation process itself did not meet the basic "Gunning Principles" on consultation

It is not clear from the CHC's First and Second Letters which part of the CHC Regulations and the Guidance the CHC's objections are referring to.

Regulation 27(7) of the CHC Regulations, Section 7: paragraph 51 of the Guidance and Paragraph 6 of the Referrals Guidance provides, amongst other things, that where the CHC is not satisfied that the consultation has been adequate in relation to content, it may report its objection in writing to Welsh Ministers. Welsh Ministers may require LHBs to carry out such further consultation as it considers appropriate. We would have expected the CHC to raise this with the LHB as early as possible during the consultation period. This would have allowed for any further consultation to proceed without delay.

Regulation 27(9) of the CHC Regulations Section 7: paragraph 54 of the Guidance and Paragraph 6 of the Referrals Guidance state that where the CHC considers that the Health Board's proposal would not be in the interests of the health service in its district (i.e. Hywel Dda Health Board area) it may report in writing to Welsh Ministers – and in this case the Welsh Ministers would make the final decision on the outcome of the consultation.

The First Letter does not make any specific reference to the consultation process, whereas the Second Letter makes reference to both the consultation process (Regulation 27(7)) and that the proposals would not be in the interests of the health service In Hywel Dda Health Board area (Regulation 27(9)).

The Health Board would assert that it has complied with and followed the requirements of the CHC Regulations (as far as it relates to this consultation) and also to the Guidance. The consultation has been undertaken in line with the Guidance and has taken account of the Gunning Principles. At each key stage, the Board has considered an assurance report testing the process against the requirements within the Guidance and these principles.

In responding to the over-arching assertion that the consultation was flawed, both in terms of content and process, it should be noted that the Health Board has worked closely with the Consultation Institute throughout this period and has been subject to its Compliance Assessment. The Institute has indicated its intention to award its Certificate of Best Practice following a final end of process review. In addition, the Health Board has assessed the consultation against the Guidance, current case law and best practice through two key reports:

- **Board Meeting 6 August 2012**[1]
  This report covered the conduct of the listening and engagement phase and assessed the Health Board's readiness to start consultation, both in terms of content of the consultation (in line with the Guidance) and the programme of consultation.

- **Board Meeting 15 January 2013**[2]
  This report provided assurance to the Board on the conduct of the consultation and compliance with the Guidance.

The Health Board maintains that it has acted with fairness, transparency and integrity throughout the process and is concerned to note the CHC's assertions in the Second Letter that this was not the case. We consider that we have applied the Equitable Maxim of ensuring that he who comes to equity comes with clean hands.

The CHC has put forward a number of paragraphs to support its view that in applying the Gunning Principles the Health Board has shown itself to be defective, unfair and less than transparent, procedurally and substantively. Unfortunately, the CHC has not described its rationale clearly and it is therefore difficult to fully understand which of the Gunning Principles have failed to be met and for what specific reason.

However, in relation to the Principles, the Board reports referenced above also provided evidenced assurance that these had been addressed on the following grounds:

- ***Principle 1 – Consultation at the formative stage***
  The whole process has been iterative starting with work with our clinical staff, followed by listening and engagement with the wider population and then consultation (see Section 2.1.2).

  Pages 6 – 8 of the Second Letter appear to focus on perceived shortcomings in relation to the listening and engagement phase and use this as a challenge against compliance with the Gunning Principles. This phase of the consultative proposal was only aimed at establishing a dialogue with the population and to use the feedback received to inform the development of the formal consultation documentation.

- ***Principle 2 – The case for change and the information shared to allow for consideration and response***
  Again, as it has been an iterative process, we can demonstrate that at each stage we have made every effort to describe the case for change and provided significant levels of information that have met the Guidance in a variety of formats.

[1] Your Health; Your Future – Consulting Our Communities – Consultation and Communications (6 August 2012)
[2] Your Health; Your Future – Consulting Our Communities – Consultation Assurance Report (15 January 2013)

For example, we published versions of the Consultation Document for Children and Young People, as well as versions in Braille, large font and Easy Read. Consultation documents were supported by a suite of more detailed technical documents, underpinning the rationale for each proposal. This satisfies the requirement to provide appropriate information for a range of readers with differing levels of understanding and expertise.

The Health Board also provided a range of opportunities for staff, the public and key stakeholders to meet with Directors and Senior Health Board staff to discuss the proposals and gain any further detail that was required to inform their views.

Within the submission, there is a clear conflation of consultation on specific issues (significant service change) and how changes once approved might be implemented.

Whilst a legal consultation does not require a detailed description of how each change might be implemented, the documentation did include details of the Health Board's proposed Implementation Board and gateway process.

- ***Principle 3 – Adequate time for consideration and response***
  The public listening and engagement process commenced on 18 December 2011 and ran until 30 April 2012.

  This was followed up with a 12-week formal consultation (6 August – 29 October 2012). The Guidance suggests that a much shorter timescale of six weeks might be appropriate in view of the earlier listening process. However, the Board made the decision for an extended period of formal consultation to ensure that the public and stakeholders had sufficient opportunity to consider all aspects of the proposed changes.

  There is no specific length of time a consultation should run; however, we consider that the period should be proportionate to the scope of the changes being proposed and that this requirement has been exceeded.

- ***Principle 4 – The feedback must be conscientiously taken into account***
  The Board assurance paper (15 January 2013)[2] describes the diligent process the Health Board adopted to consider all feedback received.

  At each stage we can show that we have paid due regard to the views expressed (positive or negative) and adapted our thinking, where it is appropriate or possible to do so.

  The Board paper (15 January 2013)[3] making final recommendations clearly articulates how the approved service changes have changed from the original options put forward as a result of feedback received. We have also identified these within the specific service areas later in this response.

[3] Your Health; Your Future – Consulting Our Communities – Consultation Final Recommendations (15 January 2013)

The Gunning Principles sets out commonly accepted fundamental propositions that the Board may need to evidence in terms of a legal challenge (and which form part of the Consultation Institute Compliance Assessment). The real test for the Health Board in terms of a referral is whether the Guidance and the provisions of the CHC Regulations have been met.

The Board has determined that the process was robust and met the required standards (including Gunning) and this was supported by both the Consultation Institute and Opinion Research Services (ORS), who provided our independent analysis of both the listening and engagement process and the consultation responses.

In terms of wider issues, other principles the Health Board has considered are:

- ***Scope of the Consultation***
  The Health Board is required by the Guidance to consult on "substantial service change" (Section 5: paragraph 31) and not operational matters that relate to improving services in a general sense.

  We are entitled to consult on the options determined as sustainable and deliverable, rather than on all potential options open to us. A lawful consultation does not require consultation on all the options considered at the option appraisal stage (which had CHC engagement and involvement in determining criteria and setting weightings). However, the Health Board did share details of all the options appraisal considerations within the Technical Documents that supported the consultation. In addition, the Health Board was very clear on the criteria for assessing options; these were explicitly referred to in both the listening and engagement document [4] and the Consultation Document[5].

  Our Consultation Document laid out all the substantial service changes we intended to progress, whilst calling out the options we had determined as deliverable.

  The Consultation Document (supported by a significant number of detailed technical appendices) provided a context for service change in line with national policy (*Setting the Direction*; *Rural Health Plan*; *Together for Health*) with a focus on those specific "significant" service change elements that required consultation.

  The Health Board takes exception to the CHC's allegation set out in Page 10: paragraph 11 of the Second Letter that "...*the HB appeared to be involved in a series of elaborate manoeuvres which had the effect of 'narrowing' the agenda for debate and demonstrably speeding up decision-making...'"* and would ask for evidence to substantiate such a sweeping and inaccurate claim.

[4] Your Health; Your Future – Discussion Document 2011/2012
[5] Your Health; Your Future – Consulting Our Communities – Consultation Document

It is interesting to note that there is a call for *"detail of processes and methodology"* in the referral. Other correspondence from the CHC criticises the Health Board for approval of the Implementation Board Terms of Reference along with a description of the Population Health Group structures (i.e. detail of the process and methodology for delivery).

- ***Fait accompli in terms of the decisions to be made***
  As described earlier, the Health Board can clearly demonstrate throughout the process where our thinking has been adapted from the initial options within the listening and engagement period through to the final approvals. This detail is included later in our response (See Section 3.7).

  The development of the clinical service strategy has been both a lengthy and highly inclusive process. The CHC has been involved from an early stage and is fully aware of the development stages. Through each stage, the Health Board can evidence the influence of the participants in the process on the development of ideas and the shaping of the Health Board resolutions agreed on the 15 January 2013.

  Within each service area, we provide evidence of where the service options and solutions have changed over time, reflecting in large measure the direct influence of the conversations held with staff, the public and stakeholders and the feedback received from all. This process led to the decisions taken at the Public Board meeting of the 15 January 2013.

  The listening and engagement phase was – as described earlier – the start of a dialogue in relation to the provision of healthcare in the Hywel Dda area, the challenges and potential options in relation to specific services. There were a number of issues identified in the feedback the Health Board reflected on, and decided either not to take forward to the consultation phase, or to alter the focus. For ease of reference, we have provided these specific issues in tabular form below:

ACUTE MEDICINE
Listening & Engagement
• Acute medical in-patient services to be located in each County – not in every hospital • Medical service model to be transformed to meet modern guidelines (Royal College of Physicians Toolkit)
Consultation
• Acute/emergency medicine question was included in "Emergency Department" consultation question with acute medicine being provided in every acute hospital.

ACUTE SURGERY
Listening & Engagement

• Emergency assessment and stabilisation in each County plus
  ○ Designated surgical centre in Glangwili Hospital or
  ○ Designated surgical centre in Withybush Hospital

Consultation
It was agreed that Acute Surgical Services should be retained in each County and therefore was not the subject of a question in the public consultation

TRAUMA SERVICES
Listening & Engagement

• Emergency assessment and stabilisation services in each County plus
• Designated Trauma Service in
  • Withybush Hospital; or Glangwili Hospital; or
  • Withybush Hospital and Bronglais Hospital; or
  • Glangwili Hospital and Bronglais Hospital

Consultation
It was agreed that Trauma Services should remain in each County and therefore was not the subject of a question in the public consultation.

BREAST CANCER
Listening & Engagement
• Breast cancer surgery to be undertaken by an accredited surgeon in IOG compliant single site: • Prince Philip Hospital; or Withybush Hospital
Consultation
It was agreed following the Listening & Engagement phase that surgery would be determined by the multi-disciplinary team and did not therefore need to be the subject of public consultation.

COLORECTAL CANCER
Listening & Engagement
• Colorectal cancer surgery to be undertaken by an accredited surgeon in IOG compliant single sites: • Glangwili Hospital; or Withybush Hospital
Consultation
It was agreed following the Listening & Engagement phase that surgery would be determined by the multi-disciplinary team and did not therefore need to be the subject of public consultation.

PLANNED CARE
Listening & Engagement
• New inpatient elective orthopaedic service and centre for orthopaedic surgery   o Prince Philip Hospital; or Withybush Hospital
Consultation Question (Summary Form)
• Day and Short Stay Surgery in each County; • Orthopaedic centre of excellence for Pembrokeshire and Carmarthenshire in either   • Withybush Hospital; or Prince Philip Hospital.
Board Decision 15 January 2013
• Day case, and short stay, planned surgery including primary joint replacements to be retained in all three counties. • For the south of Hywel Dda Health Board, Revisions and Complex Orthopaedic procedures to be carried out at one site, namely the Orthopaedic Centre at Prince Philip Hospital, Llanelli. • Multi disciplinary teams and clinical networks to be established to determine the right locations for surgery, operating a common service waiting list.

We can therefore demonstrate that we have considered alternative solutions put forward and that we have reflected on the issues raised, and then adapted our thinking where it was right to do so. Where we do not believe an alternative proposal is deliverable or practical, then we have explained why and discounted it.

This was made clear in the final recommendations paper considered at the Board meeting on 15 January 2013.

- ***Process of consultation***
  Generally, this can be considered where something "clearly and radically" went wrong in terms of the scope and delivery of a consultation.

  Regulation 27(7) of the CHC Regulations and Section 7: paragraph 51 of the Guidance describes the criteria by which the CHC can raise an objection in relation to the process; these relate to inadequacy in:

  - content or time allowed;
  - consultation with CHC at the inception of any proposal; and
  - the frequency with which the CHC is consulted throughout the proposal and decision making process.

  The evidence presented to Board (15 January 2013) would strongly indicate that the process was robust and this is supported by the Consultation Institute validation.

Page 16; paragraph 6 of the Second Letter appears to be congratulating the Health Board on its process: *"...The formal Consultation period ran from August 6th to October 29th 2012 and included an extensive programme of engagement with staff, stake-holders and the public. This process was applauded by the CHC as it resonated with one of its recommendations following Listening and Engagement, viz. a wide range of feedback mechanisms should be used involving less heavy reliance on 'technical' (on-line computer-reliant) means..."*

The Health Board therefore fails to understand the criticism of the consultation process.

In summary, the Board is firmly of the view that the consultation was reasonable, proportionate, fair and inclusive and met the Guidance, as well as adopted best practice.

3.2 The post consultation methodology and analysis of the various responses and submissions was flawed

Over-arching analysis was undertaken by Opinion Research Services (ORS), an independent research organisation, to the highest industry standards, and we consider there is no substance to this aspect of the referral.

In addition to the analysis commissioned from ORS, the Health Board initiated its own comprehensive internal process for considering all submissions received that included the following:

- Key submissions received by the Health Board during the consultation process were shared on receipt with senior members of the planning team and relevant directors
- All submissions were also passed to ORS to inform the independent evaluation of feedback
- In line with the Guidance, all submissions were shared with colleagues at the CHC so that they had the opportunity to consider all views received
- A task and finish group, led by the Director of Planning, was established to over-see the post-consultation process. This included an Independent Member with experience of consultation processes
- Executive sponsors were identified; the Director of Public Health was nominated to oversee the process for ensuring that the issues raised in submissions were recognised and given due consideration
- The submissions received were divided into different groups e.g. professional bodies, statutory bodies, residents etc
- A set of criteria to evaluate each response was developed
- A team of senior managers was tasked with evaluating responses from different groups and identifying the main issues raised
- An Assistant Director co-ordinated the process of collating the findings of the evaluations

- The findings were collated in two ways:
    - By service proposal
    - By identified group
- Once collated, relevant information was shared with the authors of each section of the Board paper so that the main views and issues could be considered
- All information collated was shared with the Director of Planning, the Director of Public Health and the members of the established task and finish group
- A further piece of work was undertaken by the Assistant Director of Corporate Services and a senior member of the Public Health team - to draw out all of the cross-cutting high level themes. This was assured by the Director of Public Health
- The findings were shared with both the CHC and the Board and have been used to inform the development of the final decision making paper for the Board.

ORS has stated that consultation should not be simply a "numbers game" in which the loudest or majority of voices automatically prevail. Above all, consultation is to consider the arguments and reasons for people's views – for an authority to see if it has overlooked anything material or if its proposals carry unforeseen implications. All feedback was summarised in the ORS final report[6] which was shared as an interim report with Board members and the CHC on a number of occasions prior to final consideration at the Board meeting of 15 January 2013. It is understood that ORS will be responding separately to the CHC submission.
ORS has confirmed that while considering all 274 submissions carefully, particular attention was paid to those from key stakeholder organisations. Chapter 4 of the ORS report summarised, in detail, 30 of those from key stakeholder organisations. In its summaries, ORS highlighted the particular issues, arguments and positions of each submission.

The 30 organisations whose submissions were summarised in detail were:

- Royal College of Surgeons Professional Affairs Board in Wales
- Royal College of Paediatrics and Child Health and the Paediatric and Child Health National Speciality Advisory Group
- Royal College of Nursing in Wales
- Royal College of Midwives
- National Clinical Forum
- Wales Deanery
- Healthcare Professionals Forum
- National Specialist Advisory Group: Mental Health
- Powys Teaching Health Board
- Society and College of Radiographers
- Chartered Society of Physiotherapists
- Public Health Wales
- Welsh Ambulance Services NHS Trust
- Hywel Dda Maternity Services Liaison Committee
- Emergency Nurse Practitioner Team Leader

[6] Your Health; Your Future – Hywel Dda Health Board's Consultation on Healthcare Services – Balancing Opinions January 2013

- Hywel Dda Community Health Council
- Montgomeryshire Community Health Council
- Betsi Cadwaladr Community Health Council
- Prince Philip Physicians
- Llanelli Rural Council (including a commissioned report)
- CIHS / SOSPPAN
- Residents of Glanymor Ward, Llanelli (via open questionnaire)
- General Surgery Clinical Team Leader
- Save Withybush Action Team (SWAT)
- Pembrokeshire Health Concern
- Ward 9 staff at Withybush hospital (via open questionnaire)
- South East Pembrokeshire Community Health Network
- Pembrokeshire Health, Social Care and Wellbeing Forum (facilitated by Pembrokeshire Association of Voluntary Services)
- UNISON
- aBer Campaign Group.

In addition to those detailed summaries, in the remainder of Chapter 4 ORS grouped all the submissions by type of organisation and analysed by their main concerns and issues in a tabular format. The report index showed how the organisations were grouped:

The Health Board also had additional sessions to look at the feedback in more detail and to identify any additional concerns that Independent Members might have.

On Page 14: paragraph 1 of the Second Letter, the CHC claims that *"...the Health Board has breached Gunning principle (iv) – i.e. that it has failed to conscientiously consider the fruits of consultation..."* In addition, on Page 17: paragraph 8 of the Second Letter the CHC accuses the Health Board of sharing submissions incrementally and irregularly

The rigorous process that was put in place to consider all submissions received has been described above and it is worth noting that the Board decision was not taken until 10 weeks after the end of the consultation. The Guidance allows for a decision to be taken within 4 - 6 weeks of the end of the consultation (albeit with CHC agreement) and this implies that Health Boards are not expected to take extended periods of time to consider feedback.

The Health Board was well aware of the key emerging issues throughout the consultation period and these did not change significantly, despite a significant amount of submissions received towards the latter stages of the process.

There is a wealth of evidence to demonstrate that all information was shared in a timely way with the CHC (see also Section 2.1.2). Information was in some respects shared incrementally was because it was received incrementally (some respondents submitted in the early/middle stages of the consultation and the majority responded in the final week). Given the practical considerations, the Health Board was able to organise, copy and scan a large number of submissions and share them with the CHC within a week of the end of the consultation.

In addition to this, the CHC received interim feedback from ORS during the consultation process and indeed the majority of Health Board directors, the Chairman, Independent Members and the CHC received the final feedback at the same time from ORS in a joint presentation on 7 December 2012, a full month in advance of the January Board meeting.

The CHC has asserted that the sharing of feedback was "chaotic". This is absolutely refuted and the table in Section 2.1.2 clearly shows what was shared and when in a structured and organised manner.

3.3 There were core issues excluded from the consultation exercise that should have been included, and particularly the intended provision of community care which should be the cornerstone of any change

Section 5; paragraph 31 of the Guidance requires the Health Board to consult on "substantial service change" and not operational matters that relate to improving services in a general sense.

Regulation 26 of the CHC Regulations is clear that the CHC must have regard to the need to consider any service change within the context of such current priorities, resources and governance structures as are notified to it by Welsh Ministers.

The provision of care closer to home has already been the subject of consultation at an all Wales level, in the development of the *Rural Health Plan;* the Health Board is now charged with implementing that policy.

The dialogue with our communities on our five year strategy commenced in September 2010 (*Right Care, Right Place, Right Time …. Every Time*), with a focus on care closer to home. Our activities included presentations and discussions with a wide range of stakeholder groups and staff.

The pre-consultation dialogue, which commenced on 18 December 2012, provided further context in relation to the *Rural Health Plan*/*Setting the Direction* in terms of what community services might look like in the future.

The discussion document *Your Health: Your Future* set out the vision for Hywel Dda Health Board, explaining the case for change and the challenges currently faced not only by Hywel Dda Health Board but also by NHS Wales.

Its purpose was to continue the process of public dialogue (not consultation) to raise awareness of the challenges, explain the case for change and to present potential solutions to some of the issues identified. A dialogue such as this does not require detailed information and analysis, but is a basis for discussions.

A number of questions were asked to survey public opinion only and the feedback in high level terms was:

- 87% supported a focus on quality and safety
- 82% felt value for money was important
- 82% felt we needed to address the demographic challenge
- 73% supported more care closer to home
- 45% agreed with specialising some services in fewer centres (41% disagreed)
- Those respondents who live in rural areas and have to travel were significantly more supportive of the vision
- Transport was an issue for many

BUT

- There were significant objections to perception of "downgrading" – Prince Philip and Withybush Hospitals
- There were demands for Bronglais Hospital to be a special case (rurality)

The main Consultation Document followed that up with an extended description of how community services would be configured in the future and this was accompanied by a Technical Annexes on Community Services and our Primary Care Strategy[7] [8].

The Health Board has presented to the CHC in a number of forums in relation to the configuration of community services – including on the Virtual Ward at a CHC Planning Committee - and the "Five Year Strategy" has been a recurring theme on the agenda of this group.

[7] Your Health; Your Future – Consulting Our Communities – Technical Document 7a – Community Services (August 2012)

[8] Your Health Your Future - Consulting our Communities - Technical Document 8 - Primary Care Strategy

It is therefore strongly felt that there was sufficient content throughout the process to provide a clear vision for wider health service planning on issues that did not require formal consultation as "significant service change". It is strongly believed by the Health Board this information provided sufficient information for the public and stakeholders to make an informed decision based on the details provided.

In the post-consultation meetings, this was discussed at length and we had reached agreement on the way forward in relation to the CHC's involvement with it being a key feature of future Planning Committee agendas moving forward.

The Health Board's view is that:

- no service change was wholly predicated on the provision of additional community services.
- the Consultation Document described an over-arching view of what community services would be available in the future (and it should also be noted that some of these services (e.g. Community Resource Teams) are already in place).
- the Consultation Document, with supporting technical information, contained sufficient information to permit the public to draw their own conclusions and to make informed choices.
- there were no other specific service changes described within community services that required formal consultation as "significant service change".

3.4 The consultation proposals have insufficient details in respect of financial and business planning models

These issues were discussed in significant detail during the course of the three joint meetings held with the CHC on 12, 15 and 21 February 2013.

High level financial analysis was included within the Technical Appendices[9] and there was a specific chapter relating to finance within the main consultation document.

A response to this issue was included within the Health Board's detailed response to the First Letter dated 24 February 2012, as follows:

"As discussed at earlier meetings, the Health Board does not receive 3 – 5 year allocations and is currently planning to annual allocations issued by the Welsh Government. This may change in the future.

In accordance with our statutory duty, the Health Board has to lay a balanced financial plan for consideration by the Board before 31 March every year. This plan is informed by the current annual Allocation Letter and the current year's financial position.

[9] Your Health; Your Future – Consulting Our Communities. Technical Document – Background and Introduction (August 2012) (Section 8)

For Financial Year 2013/2014, the Allocation Letter was received on 7 February 2013, and as has been the case for the past 3 years. Key meetings with external partners like the Deanery, WHSSC, etc as well as internal Managerial Leads (in Primary Care, Mental Health & LD, Counties, Continuing Care, Medicines Management) have been held in the past 2 weeks, and will continue for another 2-3 weeks. Consequently, in line with other Health Boards we are now firming up our annual income and expenditure assumptions in this timeline.

Our opening challenge has to deal with 2012/13 performance and new 2013/14 cost pressures of about 3.7% (£21m) as per the National Finance Agreement.

There is a danger of conflating the Clinical Services Strategy plans (as per the Consultation) outlined at £14.8m (about 2.5%) with our wider service plans, which with Welsh Government and other income from the Deanery come in at just over £700m, and which are a normal annual operating requirement.

You will recall that the Director of Finance attended the CHC Planning Committee on 20 September 2012 and outlined the financial challenges faced by the Health Board and has made a commitment to regular attendance at this group to maintain an ongoing dialogue and ensure a detailed understanding of the financial challenges.

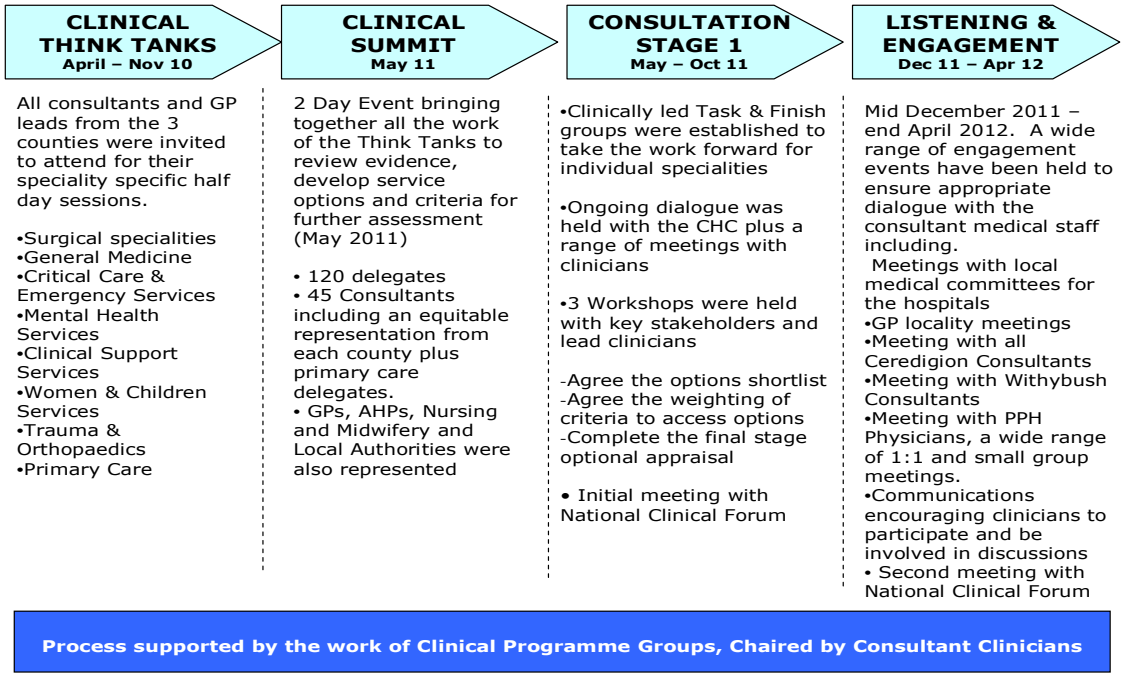
The consultation recommendations were agreed by the Board on 15 January 2013 and the Health Board is now considering – as part of the annual planning process which service changes can be 'operationalised' this coming year and which will be subject to detailed financial planning through the implementation/gateway process."

3.5 Due cognisance has not been given to the opinion of clinicians, or that of other external stakeholders who are expected to support the plans for change from acute to community settings, especially the GPs and local authorities

It is the Health Board's view that there is no substance to this aspect of the referral. Due account was taken of all feedback received and this is covered in more detail at Section 3.2.

It is worth pointing out the breadth of clinical engagement both in the preparation phases for the consultation and during the listening and engagement phase.

The following diagram highlights this work all of which can be evidenced:



In terms of local authorities, there were presentations and discussions in full Council meetings during the course of the 12-week consultation, coupled to presentations at Local Service Boards and Health, Social Care and Well-being Committees in each county. Similarly, there were evening presentations and question and answer sessions with Town and Community Councils in each county.

The Board – and the CHC – had several presentations from ORS in relation to the feedback where the detail of the information received was discussed in detail and Section 3.2 describes the key clinical submissions given detailed consideration.

The final recommendation report to the Board reflected on all the information received specific to each proposed change.

The Health Board is concerned that the CHC does not provide specific detail of its own engagement with local professional groups and has not provided evidence for consideration by the Board in making its final decisions, nor has it provided evidence of these discussions.

Another area where the Health Board has concerns is the apparent lack of CHC engagement with the key professional bodies, such as the Royal Colleges, the Deanery or the All Wales Neonatal Network.

The views put forward by the CHC appear to reflect the views of the pressure groups associated with specific service areas and not broader geographic considerations at a Hywel Dda level in line with its statutory duty.

It is our view that the arguments put forward therefore do not have balance and do not reflect a strategic Hywel Dda vision of healthcare provision as required by the Guidance.

3.6 Lack of detail in the provision of community care and "virtual wards" with the planned closure of Mynydd Mawr Community Hospital

The following are responses to questions raised by the CHC during the course of the three joint meetings held on 12, 15 and 21 February 2013.

<table>
<tr><th>Question</th><th>Response</th></tr>
<tr><td>Can we expand on the economic case for the £1.8m savings on the closure of Mynydd Mawr Hospital identified in the Consultation Document – in particular the income and expenditure, staff costs for re-training, redundancy, additional travelling costs for staff in the community, and any income from sale of the building?</td><td>Savings from Mynydd Mawr are based on the site closure and savings in estates costs including energy, maintenance and rates, as well as facilities including catering and hotel services. Any receipt from the disposal of the site is not included in the savings. Under current guidance proceeds up to £0.500m from sales of assets approved by the Minister can be retained by Health boards for re-investment. Proceeds above this can be retained subject to Ministerial approval and approved Business Cases.

Gross Savings
<table><tr><td></td><td>£000</td></tr><tr><td>H&D Services</td><td>136</td></tr><tr><td>Portering</td><td>101</td></tr><tr><td>Catering</td><td>75</td></tr><tr><td>Wards, Medical & OT</td><td>1292</td></tr><tr><td>Energy</td><td>80</td></tr><tr><td>Rates</td><td>11</td></tr><tr><td>B&E Services</td><td>7</td></tr><tr><td>Capital Charges</td><td>71</td></tr><tr><td>Other</td><td>10</td></tr><tr><td>Total</td><td>1783</td></tr></table>This list details the gross savings quoted in the Technical Doc 1, Introduction and Background.
The majority of these cost headings will see full or near full savings achieved. However, the new unit in PPH has now been designed and work is underway on the nursing skill mix. This will enable savings to be made against the Mynydd Mawr staffing levels, however, these cannot yet be detailed. Of course, as previously stated, the Health Board has a no redundancy policy and all staff will be redeployed appropriately.

This issue will be further considered by the CSS Implementation Board.

The Director of Finance has also offered to work more closely with the CHC to contextualise financial planning and suggests this as an agenda item for the Planning Committee.</td></tr>
</table>

Question	Response
Have we considered the financial cost of building the new ward (Frailty) in Prince Philip Hospital (PPH)?	This is built into planning assumptions for the 2012/13 and 2013/14 Discretionary Capital Programme.
What is the timescale for the new ward in PPH?	Board Paper P25, Sec 5.10 Updated based on building programme likely to be Sept 2013
Do we have a Business Plan for the proposed new Community Resource Centre (CRC) in Cross Hands?	Board Paper P25, Sec 5.9
What is the timescale for the new CRC in Cross Hands?	Board Paper P25, Sec 5.10
What is the impact on Social Care staff of the shift of services from in-hospital to the community (e.g. the Virtual Ward)?	As we move forward with the development Community Resource Teams there will be greater integration between health and social care staff. There will be opportunities for single line management, shared care co-ordination and avoidance of duplication. Service models will support people with known Long term conditions to be managed effectively in the community and reduce avoidable hospital admissions. Care Closer to Home is an enabling mechanism for health and social care delivery, the example given of Virtual Ward has been evaluated elsewhere and there is a body of evidence that by working in this way people can remain well through better management of their condition, lessening of episodes of relapse and the promotion a greater collaboration between primary care, community services, condition specific specialist nurses and therapists and social care. Once properly embedded these models will also reduce the reliance on long term residential and nursing care in care home as we see people remain supported at home.
Have we undertaken a risk assessment on the impact of closing beds in Mynydd Mawr Hospital?	Board Report P24, Sec 5.6 Plus, P21, Sec5.3 This issue will be further considered by the CSS Implementation Board
Can we clarify the way in which respite care is provided at present in Mynydd Mawr Hospital and how it will be provided in the future when Mynydd Mawr is closed?	Board Report P21, Sec 5.3 plus he service remains available for those who qualify in Amman Valley Hospital. This issue will be further considered by the CSS Implementation Board
Can we clarify how we will be moving staff from an in-hospital setting to working within communities?	Tech Doc – Background and Introductions P85, Sec 6, Workforce. This will be based on the implementation of the Health Board Organisational Change Policy.

Question	Response
When will Virtual Wards be created?	This is an incremental increase in service provision. Additional investment has already been made and further is planned.
Can we see a draft costing for a virtual ward	Provided separately.
Will ART teams in the Ceredigion area be increased and if so when	The aim is to increase the skill base of the core community nursing teams so that ART is the service response rather than a stand alone team.
Enhanced community teams with all the necessary components are going to be costly to educate and put in place. There is no budget plan can we see the budget plan?	Budgets from acute settings for training and education will transfer from secondary care.
Can we clarify the future status of Tregaron Hospital?	The Cylch Caron Strategic Outline Case has been approved as has funding for the Local Authority to lead on the development of an Outline Business Case. This is a multi-agency project which will result in a new facility and the closure of Tregaron Hospital.
Can we describe the principles behind the economic argument for moving services from in-hospital to the community?	Board Report - Financial Context P7&8 Sec 1.5. Policy Drivers: Setting The Direction Rural Health Plan Together For Health
Have there been discussions with senior officers in the three County Councillors about moving some services from in-hospital into the community?	These discussions take place in the Local Service Boards, Health, Social Care and Wellbeing Boards, plus the Joint Health & Social Care Leadership Boards in Ceredigion and Carmarthenshire and the Care Closer To Home Board in Pembrokeshire.
What is the level of GP support for the Welsh Government's strategy: *Together for Health* and the Health Board's vision for shifting some in-hospital services into the community?	The LMC acknowledged the inclusivity of the process and recognised that the status quo is not an option.
What is the Health Board's approach to Chronic Conditions Management – in particular where GPs are being asked to undertake additional work? How can we ensure that the GPs will deliver our vision within current resources?	Board Report P10, Sec 2.3 plus Tech Doc Community Services P20 The intention is to provide more locality support to free GP time to manage patient risk as effectively as possible.
Can we explain what is included in the Welsh Government's recent statement about the 1.5% increased funding for GPs?	Nationally negotiated inflationary increase to the Global Sum.
Continuing Healthcare – what evidence can the HB provide to show that it has considered the cost of CHC with the current demographic challenges?	The Health Board has a detailed plan for the delivery of CHC. This can be discussed as an agenda item for a future Planning Committee.

The following is an analysis of the initial options put forward during the listening and engagement phase, the options put forward for consultation and the final options approved by the Health Board on 15 January 2013.

Listening & Engagement
Not the subject of a specific question. However, the issues raised included: • Care closer to home • The duplication of facilities • The inefficient use of community hospital beds • Need for new investment in community based facilities
Consultation
Proposal to close Mynydd Mawr Hospital and re-provide the service in other ways.
Board Decision 15 January 2013
• Approve the delivery of a new service at Prince Philip Hospital that will provide multi-speciality care to the frailest of our inpatients bringing together Psychiatry for the Elderly and Geriatric Medicine. • Approve the subsequent closure of Mynydd Mawr Hospital. • Note that staff will transfer to the new services. • Instruct the implementation group to ensure that equality impact issues are fully explored with plans to address any issues through the gateway process. • The Board is asked to acknowledge the charitable funds that have been provided to Mynydd Mawr Hospital and gifts that have been donated in memory of patients (Plaques etc). The Board will ask the implementation group to ensure that all the donated items and the charitable funds are fully used in the new facility in Prince Philip Hospital or in the Community Resource Centre at Cross Hands.

No alternative model has been proposed by the CHC and the status quo is therefore being proposed.

In the First Letter, following a series of post consultation meetings, no mention was made of Mynydd Mawr Hospital. The Health Board understood this to be confirmation of the verbal assurance received that the CHC was supportive of the closure of the hospital.

The CHC appear to have paid no regard to the clear clinical rationale for the closure, the risks in the current service and the improved in-patient service provision now being developed in Prince Philip Hospital, to co-locate the services of Psychiatry for the Elderly and Geriatric Medicine.

There appears to be no recognition of the investment which has already taken place in community service provision and the additional investment planned both within Carmarthenshire and in the other counties.

The Health Board is to establish a Clinical Service Strategy Implementation Board which will provide assurance that alternative services are in place in advance of changes being made.

The CHC will have associate membership of this group and will have the opportunity to consider the specifics of community service provision. The process will also involve a detailed gateway mechanism to evidence the readiness for implementation of the revised service.

The final recommendations paper to Board on 15 January 2012 provides more detail on the service model.

3.7 A number of healthcare configurations are deemed unacceptable and not in the best interests of patients and the public:

Each service specific sub-section incorporates the response to questions posed by the CHC during the post-consultation discussions.

It is the Health Board's view that the vast majority of these answers are not reflected in the submission and are therefore included within the relevant service section of this response.

3.7.1 Women and children's, neonatal, SCBUs, obstetrics and paediatric services

The following are responses to questions raised by the CHC during the course of the three joint meetings held on 12, 15 and 21 February 2013.

Question	Response
Can the CHC have sight of the capital cost analysis for the two options identified in the Consultation Document: a Level 2 Neonatal Unit in Glangwili Hospital (GGH) or Withybush Hospital (WGH)?	Details forwarded separately Original Position – Tech Doc Page 9th Section 8.2.4 Investment £ 2.1m The finance section of the Technical Document, Introduction and Background, assumes that additional investment will be required to sustain acute services on three sites and develop a Level 2 Neonatal Unit. The Board's decision is to aspire to a Level 2 neonatal, however this will be a clinically- led process and it is possible a Level 2 neonatal unit will not be achievable due to the scarcity of paediatric trainee posts. The cost assumptions would, in these circumstances, be revised downwards.
Why didn't the Health Board's Paper (15 January 2013) include the Potential Negative Impacts of increased perinatal mortality and inability to breast feed?	Board Report P95, App 9 and P54, Sec 9.3 This issue will be further considered by the CSS Implementation Board
Can the Health Board provide detail on how they will provide stabilisation and resuscitation services at WGH? *The Consultation Document refers to this being resolved by a clinically led group.*	Board Report P59, Sec 9.6 and P60, Sec 9.9 This issue will be further considered by the CSS Implementation Board
Is the Level 3 SCBU currently provided from Singleton Hospital moving to Morriston Hospital?	Not to the best of current knowledge

Question	Response
If the Level 3 SCBU moves to Morriston Hospital, is a Level 2 Neonatal Unit in GGH viable?	It remains viable as it would help retain the maximum level of activity within Hywel Dda
Can we confirm the Deanery's current position on Paediatric training posts in Hywel Dda?	Board Report P49, Sec 9.2 This issue will be further considered by the CSS Implementation Board.
How was travel times for mothers/babies being moved from WGH to GGH calculated (as referred to in the Consultation)?	Technical Documents travel times i.e. Tech Doc Background and Introduction P82, Sec 5.7.2 Public Health Wales Observatory Figs
Were these travel times agreed with WAST?	These were car travel times.
Does the Health Board consider a transfer time of 60/70 minutes (excluding loading and off-loading) for a mother in premature labour acceptable? *This based on a patient being taken from St David's to GGH by ambulance in good weather conditions.*	We recognise the risks, which is why, despite the manpower pressures and professional opinion external to the Health Board, the decision is to retain Obstetric and acute Paediatric provision in each County. Please see previous comments on the need for robust stabilisation and transfer protocols.
Does the Health Board consider a transfer time of 70/80 minutes (excluding loading and off-loading) for a mother in premature labour acceptable? *This based on a patient being taken from St David's to GGH by ambulance in poor weather conditions.*	We recognise the risks, which is why, despite the manpower pressures and professional opinion external to the Health Board, the decision is to retain Obstetric and acute Paediatric provision in each County. Please see previous comments on the need for robust stabilisation and transfer protocols.
Can the Health Board confirm the process for dealing with emergencies if all the cots are full in GGH?	Strict protocols are already in place for this occurrence across South Wales.
What can the new Clinically Led Groups achieve that is different to the groups that have discussed this in the last two years?	Groups to now have discussed the service options> work can now be focussed on the details of operational delivery.
Can we contact colleagues in ABM ULHB to discuss (informally) any proposals to move the Level 3 Unit from Singleton to Morriston Hospital?	Colleagues in ABMU have confirmed they do plan to move Neonatal and Obstetric services to Morriston Hospital. It has not been determined if this is a question for public consultation and therefore no timeframe has been set.
Can we contact WAST to agree travel times from GGH to WGH?	Blue light, 40 mins Normal, 1 Hr
Can we confirm the Deanery's current position on Paediatric training posts in Hywel Dda?	Board Report P49, Sec 9.2 This issue will be further considered by the CSS Implementation Board.

The following is an analysis of the initial options put forward during the listening and engagement phase, the options put forward for consultation and the final options approved by the Health Board on 15 January 2013.

Listening & Engagement

(Summary of proposal)

- With all 3 counties retaining either
  Midwifery-led unit or
  Midwifery-led and Consultant Obstetrician-led care

- Complex Obstetric Unit, Paediatric HDU and level II Neonatal Unit
  Glangwili Hospital or
  Withybush Hospital

Consultation

Summary of proposal

- Midwifery-led and Consultant Obstetrician-led care in each County plus
- Complex Obstetric Unit, Paediatric HDU and level II Neonatal Unit in
  Glangwili Hospital, or
  Withybush Hospital

Supplementary Consultation Question:

If it proved only possible to provide in-patient paediatric services in Bronglais and one hospital in the south, which hospital?

- Glangwili Hospital, or Withybush Hospital

Health Board 15 January 2013

List of recommendations from Board report:

- Acknowledge the high quality care that is presently provided by staff in all sites.
- Approve for a clinically led implementation programme, including staff from all sites.
- Ensure we maintain training status in Paediatrics and Obstetric services.
- Further develop community Paediatric nursing.
- Ensure that there are well developed transitional care services at each obstetric unit.
- Continue to aspire to achieve a level II neonatal service in Glangwili Hospital, whilst acknowledging this is unlikely with the present availability of trainee doctors.
- Develop clear and robust stabilisation and resuscitation services at
- Withybush, Bronglais and Glangwili Hospitals.
- Develop a service specification for high dependence neonatal care in Hywel Dda with clear pathways to level II and level III units.

- Develop an obstetric unit at Glangwili Hospital also managing the highest risk births, recognising the requirement of safe and sustainable services.
- Retain consultant obstetric services at Withybush and Bronglais Hospitals.
- Continue with inpatient paediatric services at Glangwili, Withybush and Bronglais Hospitals.
- Develop a Paediatric high dependency unit co-located with the neonatal unit at Glangwili Hospital.
- Ask the implementation group to ensure that equality impact issues are fully explored with plans to address any issues.

The Board will be aware of the significant challenge across the UK in recruiting paediatric doctors. We will explore all practical means to recruit to the posts to maintain rotas across three sites. Our lead senior paediatric doctors and nurses will be asked to support our efforts in this work and assure the implementation board that we are able to operate a safe and sustainable service.

However, if recruitment problems militate against safe and sustainable acute Paediatric services in both Glangwili and Withybush Hospitals, the Board is asked to approve to locate a single service in Glangwili Hospital for the south of Hywel Dda.

In effect, the CHC proposal is the 'status quo' option which is not felt by the Health Board to be a safe and sustainable service and a position not supported by the Deanery.

The final approved option took account of the feedback received to address the issues raised in terms of future sustainability.

The CHC has stated its belief that the Health Board's ambition to develop a Level II Neonatal Unit at Glangwili Hospital is inappropriate and indeed unattainable. The Health Board's position is that it remains appropriate but that it may indeed be unattainable based on medical staffing pressures and particularly the reduction planned in training posts by April 2014.

The Health Board, at the Board meeting on 15 January 2013, decided it should still aspire to this and in doing so, as part of the implementation process, explicitly describe the high dependency service that the Health Board will deliver for neonates, in partnership with neighbouring Health Boards and taking into consideration the wider discussions about Level III neonatal services that are being held as part of the South Wales Programme.

The Health Board maintains that, as described in the Consultation Document, neonatal services struggle to meet standards and we cannot guarantee their robustness into the future. We believe that this is not acceptable and that our services should meet the standards. This assertion is supported by professional bodies including the National Clinical Forum and the Neonatal Network. This is a multi-service issue and a service proposal which also needs consideration of Obstetric and High Dependency Paediatric Services. Even if we cannot deliver Level II Neonatal care in the future, SCBU services should also be delivered in a single unit, with robust and safe stabilisation and transfer services elsewhere, in a unit which can meet modern and future standards.

The Health Board maintains this should be on the same site as the paediatric high dependency beds and the centre for the 'complex' obstetric service for the Health Board. In delivering the services in this way we will be able to achieve the critical mass requirements specified by the Deanery so that trainee doctors can achieve the competencies required to enable them to become consultants in their speciality. This could not be achieved if the site chosen was Withybush Hospital, irrespective of the location of Swansea services.

The CHC is incorrect in its assertion regarding the "*unacceptable and detrimental impact on patient services at Withybush Hospital",* should the current Health Board proposal be implemented. Our proposal means;

- Paediatric referrals would not need to go to Carmarthen;
- This would not lead to the downgrading of Withybush Hospital and the A&E would be retained.
- Paediatrics would be maintained at Withybush Hospital;
- The ability to stabilise at risk babies prior to transfer is an essential facet of the Health Board recommendations.

The CHC appear to have paid no regard to the breadth of the Health Board proposal. The Health Board does, however, recognise the risk that remains to its service model, particularly the ability to maintain acute Paediatric Services on three sites, and therefore asked a supplementary question in the consultation regarding the most appropriate location, should recruitment pressures mean that only one acute service can be maintained for the south of Hywel Dda. This is not the Health Board's preferred solution, but recognises the challenges that exist in attempting to sustain multi-site services.

Simply bolstering the existing SCBU units will not address the following issues:

- Paediatric High Dependency Service;
- Maintenance of Obstetric training posts;
- Maintenance of Paediatric training posts;
- Future service sustainability;
- Ensuring care is delivered appropriate to modern standards.

3.7.2 A&E service at Prince Philip Hospital

The following are responses to questions raised by the CHC during the course of the three joint meetings held on 12, 15 and 21 February 2013.

Question	Response
What is the proposed service model for Emergency Services in PPH?	Board Report P47, Sec 8.8 & 8.9. 5 Work Groups each with GP representation: • Minor Illnesses • Mental Health & Intoxification • Minor Injury • Frailty • Acute Medicine The Board decision means there will be no immediate service change at PPH. The clinical model to be implemented, including the staffing requirements, is subject to the determination of the clinically led workstreams now underway. As a consequence, no savings will be realised until this work and the implementation has been completed. This issue will be further considered by the CSS Implementation Board
How will we be up-skilling our nurses to become Enhanced Nurse Practitioners to allow them to deliver Minor Injury Services in PPH?	Board Report P40,41 Sec 8.2 Accredited training programmes are run jointly with the University. These are both theory and practical competency based. These will be tailored to extend the scope of practice. This issue will be further considered by the CSS Implementation Board

Question	Response
Will the Out of Hours GPs in PPH have to increase their level of service in the new model?	Please refer to previous answers on the development of the service model.
Can we comment on the capacity and resilience of A&E Services in Morriston Hospital?	Board Report P39 Sec 8.2 and P43, Sec 8.3 This issue will be further considered by the CSS Implementation Board
Has the Health Board undertaken a risk assessment of the current A&E Service provided in PPH?	Board Report P46, Sec 8.6
Has the Health Board considered the impact of the new unscheduled care service in PPH on the residents of Llanelli (being the most populated area)?	Board Report P39, Sec 8.2 and P78 App 6 This issue will be further considered by the CSS Implementation Board
What is the timetable for the change to unscheduled care services in PPH?	Board Report P47, Sec 8.10
Can we clarify the role of GPs in Prince Philip Hospital's A&E Department - now and in the future?	Tech Doc – Emergency and Urgent Care P16, Sec 4. Board Report P47, Sec 8.8 & 8.9. 5 Work Groups each with GP representation: • Minor Illnesses • Mental Health & Intoxification • Minor Injury • Frailty • Acute Medicine This issue will be further considered by the CSS Implementation Board
Can we clarify the position on non-emergency transport between Glangwili Hospital (GGH) and PPH for Llanelli patients who are discharged from A&E in GGH?	Board Report P62 Sec 10.2
Would it be possible for emergency surgical patients to be triaged in PPH to avoid them making the trip to GGH?	ENP's can triage within their scope of practice. Surgical cases will be signposted to alternative provision as now. This issue will be further considered by the CSS Implementation Board
Can we provide an update on the role of the Welsh Ambulance Services NHS Trust (WAST) in the Workstreams in PPH?	WAST officers are involved in the 5 workstreams underway.
What the financial arrangements for monitoring activity and resources to provide A&E Services in Morriston Hospital – in particular the impact on WAST and ABM UHB?	Regular contract discussions take place relating to on-going patient activity.

Question	Response
To review the audit / evidence that has been undertaken in relation to PPH A&E which suggests that 80% who attend only have minor injuries	Tech Doc 5 Emergency and Urgent Care, P18.
Can you say categorically that the residents of Llanelli and district will be able to continue to access AMBU for secondary care services, and as an example women and children's and maternity services?	As answer given to Q33, P9 of answers at meeting 12th Feb 2013. In addition, there are no plans to increase the range of 'prior approval' specialities to include Paediatrics or Maternity services.
Can you give a clear definition of what are termed to be 'Minor Injuries' in Hywel Dda?	The HDHB Treatment Room LES includes minor injuries and post-operative wound care. For the purposes of claiming under this LES, minor injuries are defined as including: • Lacerations capable of closure by simple stripping and suturing • Lacerations capable of closure by simple gluing • Reduction of minor dislocation • Removal of foreign bodies from eye • Removal of foreign body from skin • Assessment of injury with no intervention, for example: o Following advice to attend specifically given by a general practitioner o Following recent injury of a severity not amenable to simple domestic first aid. o Following recent injury where it is suspected stitches may be required o Following blows to the head where there has been no loss of consciousness. o Minor trauma to hands, limbs or feet not requiring intervention • Partial thickness thermal burns or scalds that don't required specialist intervention • Creature bites – including human and dog bites.
Can the CHC have an update on the progress of the five Workstreams in Prince Philip Hospital (PPH)?	This can be arranged for a future CHC Planning Committee meeting.
The case put forward by the physicians at the hospital in favour of the treatment of medical emergencies remaining at PPH Hospital has been covered briefly by the final post-consultation document put to the board (15 January 2013) Could the LHB give us further clarification of the Board rebuttal?	The Health Board has considered the response of the Physicians along with that of all respondents to the Consultation. As a consequence the physicians have been engaged to lead the work to consider the most appropriate service model for emergency and urgent care services for Llanelli.

Question	Response
Can we provide the CHC with details of the training syllabus for ENPs?	The syllabus can be shared. To provide it with meaning and context, we suggest the Health Board lead presents to a future Planning Committee Mtg.

The following is an analysis of the initial options put forward during the listening and engagement phase, the options put forward for consultation and the final options approved by the Health Board on 15 January 2013.

Listening & Engagement - Questions
• Major emergency department at Glangwili • 3 urgent care centres at Bronglais, Prince Philip and Withybush Hospitals, or • Major emergency department at Withybush • 3 urgent care centres at Bronglais, Glangwili and Prince Philip Hospitals, or • Major emergency departments at Bronglais, Glangwili and Withybush Hospitals • 1 urgent care centre in Prince Philip Hospital
Consultation - Questions
• Emergency services centralised at Glangwili. More limited emergency services at Withybush and Bronglais Hospitals. Nurse-led local accident centre at Prince Philip Hospital and no medical admissions unit, or • No change to existing emergency services at Glangwili, Withybush and Bronglais Hospitals. Prince Philip to have an emergency medical admissions unit and a nurse-led local accident centre.
Board Decision 15 January 2013
Continue work towards the implementation of Option B: • 24/7 emergency departments co-located with purpose-built clinical decision and assessment facilities at Bronglais, Glangwili and Withybush Hospitals; and • To adopt the terminology that will be standardised across Wales. The final decision is yet to be made but to note it is likely that the services that are not full emergency departments will be called Urgent Care Centres. At Prince Philip Hospital, a clinically-led group has started to explore the unscheduled care services needed in primary care and at the hospital, and in particular a reshaping of “front door” services. The Board is asked to approve for this clinically-led group to continue and to: • Deliver an integrated service delivered through a new model of secondary and community care. This will involve doctor supported, primarily nurse delivered services but will sit within an integrated services model for GPs, pharmacists, paramedical and community services teams; • Deliver a 24/7 emergency medical assessment and admission service; and • Use this work to inform service delivery models at other sites within the Health Board.

This clearly demonstrates how the Health Board’s position has changed during the course of the whole process.

The CHC concern seems only to be that in a new service model there should be a qualified doctor to manage the non-medical emergency patients. This represents the status quo.

The Carmarthenshire Surgical Services Review (subject to consultation in 2005) clearly articulated the clinical case for emergency surgical services to be located on a single site in the county and this was included as a Technical Annex[10] to the consultation document (which also included a section describing why the earlier consultation would not be revisited).

The Health Board has evidenced that with no in-patient services in the specialties of Paediatrics, Gynaecology, General Surgery, Trauma, ENT and other surgical specialities, the hospital can only safely manage medical emergencies and minor injuries and illness.

For this reason, the preferred clinical model is to fast track medical emergencies directly to an Emergency Medical Assessment Unit, and have an Enhanced Nurse Practitioner (ENP) delivered service for the 'minor injuries' work.
Therefore, it is imperative the service model is clear and clearly 'signposted' for the public.

The Health Board has now established clinically-led workstreams, involving the hospital physicians, nurses, local GPs and WAST among others, to design the detailed service model.

This will be subject to the assurance process managed through the Implementation Board described earlier.

3.7.3 MIU provision in Pembrokeshire

The following are responses to questions raised by the CHC during the course of the three joint meetings held on 12, 15 and 21 February 2013.

Question	Response
What is the nature of the future service provision for the 50% of patients who are local residents who currently access the Tenby MIU?	Board Report P32, Sec 6.9 This issue will be further considered by the CSS Implementation Board
Can we provide the cost of the proposed 8-week additional MIU service for visitors to Tenby during the summer months?	Subject to a commissioning process. This issue will be further considered by the CSS Implementation Board
Who will be providing this 8-week MIU service for visitors in Tenby?	Board Report P32, Sec 6.7. This issue will be further considered by the CSS Implementation Board
Is there an analysis of the time period of the additional Minor Injury Service in Tenby – is the 8-week period sufficient?	Board Report P 75, App 4

[10] Your Health Your Future - Consulting our Communities - Technical Document 13 - Review of Surgical Services in Carmarthenshire (2005)

Question	Response
Does the 8-week period in the summer include the Bank Holiday period?	It does.
Could the proposed new 8-week Minor Injury Service during the summer be extended to the Easter holiday period – an additional 2 weeks	There does not appear to be evidence to support this with activity broadly consistent from April to July.
How much will the new service in Tenby cost?	This is subject to negotiation. This issue will be further considered by the CSS Implementation Board
Will the new MIU service in Tenby (including the 8-week summer period) cost more than the present MIU service provided from Tenby Hospital?	The combined new service will be less expensive than the current service. This issue will be further considered by the CSS Implementation Board
What criteria will be used to evaluate the 8-week pilot project in Tenby in the summer?	The SLA is under development and will form part of that detail.
Can we clarify the future use of Tenby Hospital?	Board Report P29,Sec 6.3 This issue will be further considered by the CSS Implementation Board.
Can we clarify the cost of changing the delivery of Minor Injury Services from the current setting in Tenby and South Pembrokeshire Hospitals to GP practices?	<u>South Pembs</u> The current cost of staffing the service is circa £156k p.a. The new service is intended to be provided by the Argyle practice as an extension to the Local Enhanced Service. This will be payable on a cost per patient treatment basis. The current MIU facility in South Pembs hospital may yet be part of the solution for the provision of the new service. The Health Board will see a saving against current costs, although the extent of that saving is dependent upon the take up of the new service. Costs of new service are subject to negotiation. <u>Tenby</u> The current cost of staffing this service is circa £199,000 per annum. The new service is planned to be: a) An increased provision of the local enhanced service (LES) by local GP practices b) The provision of an 8 week summer service The cost of this is dependant upon a commissioning and tendering process. Based on the above, the Health Board would

Question	Response
	expect the cost of the service to be significantly less than is currently in place. However, until negotiations are completed regarding both the LES and summer service, the cost savings will not be known.
What is the impact of tourism on the provision of Minor Injury Services in Tenby?	Board Report P29, Sec 6.3 and App 4, P75 Fig 1
What is the impact on GPs as a result of the decision for Minor Injury Services to be provided by GP surgeries?	Board Report App 5, P76
What is the impact of the closure of the Minor Injury Units (MIUs) at Tenby and South Pembrokeshire on hospital services?	Board Report P26, Sec 6.2
What will be the impact on staff when Tenby and South Pembrokeshire MIUs are closed?	Board Report P28, Sec 6.3
What has been the GPs input to the decision about closing Tenby MIU?	Discussions took place with the GP's during the period of the Consultation. The decision was a Health Board decision based on due regard being paid to the range of issues and opinions.
What is the impact on GPs by the decision to close Tenby MIU?	Board Report P32, Sec 6.9 This issue will be further considered by the CSS Implementation Board.
Will the new MIU services in Tenby and South Pembrokeshire be delivered by GPs?	They are likely to be managed by GP's based on an extension of the LES delivery. The new Tenby summer service is subject to a commissioning process. This issue will be further considered by the CSS Implementation Board.
Can we provide an update on our discussions with GPs in Argyle Street Surgery?	Discussions are progressing well. An SLA is being drafted for discussion which will form the basis for future service provision. This issue will be further considered by the CSS Implementation Board
What is the role of Pharmacists in providing Minor Injury Services?	Tech Doc Primary Care Strategy P17
How will the public access Minor Injury Services in Withybush Hospital?	As now
Will there be any changes to Minor Injury Services provided in Cardigan Hospital?	A minor injuries service is being planned for the new Cardigan Hospital
Will there be any changes to Minor Injury Services provided from Llandovery Hospital?	No
Will there be a weekend service in Tenby?	Board Report P32, Sec 6.7 & 6.9
Can we confirm the proposed hours of operation of the GP MIU services?	This will be GP core hours.

The following is an analysis of the initial options put forward during the listening and engagement phase, the options put forward for consultation and the final options approved by the Health Board on 15 January 2013.

Listening & Engagement
No specific service question. The issue of the economic sustainability and the need to make the best use of limited resources emerged with the temporary closure of the service, to enable staff to supplement the Withybush Hospital emergency Department, which was suffering a staffing shortfall.
Consultation Questions
• To what extent do you agree or disagree with the proposal to transfer the minor injuries service at South Pembrokeshire Hospital to local GP surgeries and redeploying the nurse practitioners. • To what extent do you agree or disagree with the proposal to transfer the minor injuries service at Tenby Hospital to local GP surgeries and redeploying the nurse practitioners.
Health Board 15 January 2013
• The closure of the Minor Injuries Units at Tenby and South Pembrokeshire and seek to redeploy nursing staff to support Withybush Emergency Services; • To explore alternative use of the existing premises, in discussion with local GP practices and the local authority; • To further develop the Community Pharmacy "Choose Well Campaign" and signposting directly to A&E where needed; • To commission a one year pilot for 2013 (subject to review) for the period mid July to September (8 weeks) to provide a service, including weekend and bank holiday minor injuries service in Tenby area. Providers could include a local GP Practice, pharmacy or voluntary sector provider. <u>For South Pembrokeshire</u> • Core hours service: negotiations take place with the local GP Practice to pick up registered and temporary patients. These Practice negotiations to also include the patients requiring core contract services (both registered and tourist population); • Out of hours service: further work continue on developing the Community Pharmacy "Choose Well Campaign" and signposting directly to A&E where needed. <u>For Tenby</u> • Core hours service: negotiations take place with the two local GP Practices concerned with the view that one or both of the Practices undertake the core hours, registered and temporary residents service; • These negotiations will also include the core hours, registered and temporary residents under either their core contract or temporary resident allocation. However, it is acknowledged that as the tourist population is significant, the temporary resident allocation may need adjusting; • Out of hours service: further work continue on developing the Community Pharmacy "Choose Well Campaign" and signposting directly to A&E where needed.

The CHC concerns appear to favour a 'status quo' model of service. In addition, the verbal assurances provided at the third joint meeting on 21 February 2013 were that the CHC was broadly content with the South Pembrokeshire MIU closure.

The Health Board has clearly adapted its thinking in relation to the service in Tenby – including in the final recommendation the provision of an additional service in the town during the peak tourist season. This adaption was as a result of the specific issues raised during the consultation process.

There appears to be no real consideration of the main drivers for change which have been made clear in documentation and through numerous discussions.

At a time when the Health Board consistently struggles to fill nursing vacancies at Withybush Hospital Emergency Department, which services the whole population of Pembrokeshire, the skilled Emergency Nurse Practitioners in Tenby and South Pembrokeshire Hospitals are under utilised and the service uneconomic.

3.8 The rurality and poor transport infrastructure of the Hywel Dda region has not been fully recognised in the plans that are to be implemented

The following are responses to questions raised by the CHC during the course of the three joint meetings held on 12, 15 and 21 February 2013.

Question	Response
Is there sufficient WAST capacity to address future demands?	Board Report P62, Sec10.2
What is the impact of centralising services on certain social groups?	This will be address as part of on-going EQIA analysis. This issue will be further considered by the CSS Implementation Board
How much is the HB relying on private ambulance services?	Board Report P63 Sec10.3

The Health Board's plans are wholly predicated on the rurality of Hywel Dda. A strategy of care closer to home will actually mean less travel, but there is clear evidence of the consideration of transport issues in both planning future service delivery and the consultation.

Transport has been a recurrent theme in all our public documents and discussions and this can be clearly evidenced and the final recommendation paper considered by the Board on 15 January 2013 included a transport section and overview.

The Consultation Document contained a chapter specifically related to transport, with two accompanying Technical Annexes; one on non-emergency transport[11] and a further document on a local project to improve access to transport services[12].

[11] Your Health Your Future - Consulting our Communities - Technical Document 11 - Non-Emergency Transport

[12] Your Health, Your Future - Consulting our Communities - Technical Document 11b - Improving Customer Access to Rural Health Services

Finally, transport will form part of the gateway approval process for implementing service change and will be overseen by the Implementation Board the TORs[13] of which were approved by Board on 15 January 2013.

In relation to discussions about transport, the CHC sit on the Steering Group for the ICAHRS transport project and the Health Board's transport lead attends all CHC locality meetings both of which ensure ongoing CHC engagement in the development of transport solutions that meet local needs.

3.9 A lack of assessed health need and published equality impact assessment

The following are responses to questions raised by the CHC during the course of the three joint meetings held on 12, 15 and 21 February 2013.

Question	Response
When did the Health Board carry out the Equality Impact Assessments (EIA) on its proposals?	Board Report P5,6,7 Sec 1.4 See also the attached explanatory briefing.(included later in this section)
Can we clarify the policy for residents of Hywel Dda to access services out of the HB area – in particular for residents of East Carmarthenshire who may wish to access services in Morriston Hospital?	There are no plans to change current arrangements as a consequence of the Consultation. The Health Board operates a system of prior approval (referral management) for referrals to hospitals external to Hywel Dda in order to ensure that as many core services are delivered locally wherever clinically appropriate and to further develop and sustain current Hywel Dda services being provided. There are a range of service exceptions for Amman Valley Practice. There are no restrictions for accessing emergency care, other than ambulance protocols
Could you confirm that the statement below from Consultation Final Recommendations is that of the same technical document that was in the consultation stage Assessment for Impact part 2 (Sec 5.5, Mynydd Mawr)	The statement refers to the content of Technical Document 12 Assessment for Impact Version 2 which was published at the same time as the Consultation documentation The document contains information on the demographic and socio-economic make up of the Hywel Dda Health Board area and formed part of the Initial screening exercise for an Equality Impact Assessment. This is part of the initial processes and work is ongoing, on more detailed analysis and exploring ways of alleviating/ mitigating potential negative impacts and enhancing positives (as response shared in meeting of the 15th Feb 2013).

[13] 01/13 - Your Health Your Future Consulting Our Communities Governance Arrangements For The Implementation Of The Clinical Services Strategy

Question	Response
How long will the Health Board continue with its reconfiguration before it undertakes an EIA?	Please see attached explanatory briefing, supplementing information in the Board Report (and included later in this section).
Where is the EIA published?	As above
If an EIA has not been undertaken – why not?	As above

It was the Health Board's understanding, following the third joint meeting on 21 February 2013, that the equality assessment work undertaken to date was broadly acceptable to the CHC.

However, the following is the Health Board's position as shared with the CHC at the second joint meeting on 15 February 2013 and again in response to your First Letter on 25 February 2013.

"During the initial Listening and Engagement exercise, the Health Board undertook a screening exercise to broadly identify key staff, service users and members of the public who would potentially be affected by any changes to the way services within the HB could be delivered In the future. Results from the screening exercise were published alongside the Consultation document and related Technical Documents[14].

It is important to remember that all of the technical documents contain relevant information that forms part of the evidence base that informs equality impact assessment/analysis. Further analysis will be undertaken at each development stage taking into account any demographic changes to the population as outlined in the 2011 Census and to staff.

While the initial work was being undertaken it became evident that use of the NHS EqIA toolkit may not be the most appropriate way to approach EqIA when addressing major service change across a range of services.

At this stage, the Health Board took advice from the NHS Centre for Equality and Human Rights (NHS CEHR) and, rather than publishing any EqIA information as separate documentation, decided to adopt an approach of integrating EqIA analysis into it's planning and decision making processes using the following 5 questions as a template:

- *Is the purpose of the policy/change/decision clearly set out?*
- *Have those affected by the policy/decision been involved?*
- *Have potential positive and negative impacts been identified?*
- *Are there plans to alleviate any negative impact?*
- *Are there plans to monitor the actual impact of the proposal?*

In a recent meeting with the NHS Centre for Equality and Human Rights, the change in approach to EqIA was re-emphasised, with a move towards evidencing integration of equality considerations throughout the planning and development

[14] Assessing for Impact Stage 1 – Gathering the Evidence – Parts 1 and 2

process and documentation rather than the development of a single document that stands alone.

We have used the NHS CEHR as a source of advice and support so that we may meet our statutory requirements and adopt best current practice. They have recently agreed to work with us during the implementation stages to build on the work that has already been achieved

The formal consultation identified elements where potential adverse impacts may ensue and these were reported to the Board:

- *Concerns re infrastructure being in place to support changes – funding, and staff resources, support from staff and other stakeholders, transport, ambulance, technology*
- *Distances and time taken to travel as a result of services moving out of county, which may have a greater impact on family life, those households who do not have access to their own transport, elderly and disabled service users, those on low incomes and young carers*
- *Elderly, disabled and female service users*
- *Extra pressure on individuals and their families to take responsibility for their own care*
- *Concerns from staff with regard to sufficient resources to facilitate the provision of more services within people's homes or community.*

At our meeting with you on 29 November 2012, at Ystwyth, we discussed the emerging themes and issues in detail and also outlined the approach we planned to take to equality analysis, based on guidance from the Equality and Human Rights Commission. There was further discussion at the Board OD session on 7 December 2012 and a more detailed discussion of emerging equality issues was held with you at the meeting in Cardigan on 18 December 2012 and re-iterated at the meeting in Gwent on 7 January 2013. The approach and the potential equality impacts are described in detail throughout the Board paper that was presented on 15 January 2013.

We do not view EqIA as a "task and finish" exercise. We consider it to be something that is ongoing and which involves continuous engagement with staff, service users and other key stakeholders in order to identify ways of alleviating or mitigating any potential negative impacts and enhancing potential positive impacts of any service reconfiguration.

The actual impact of proposed plans on service users, particularly those with protected characteristics, will be monitored in a number of ways including:

- *Patient profile across services*
- *Patient experiences through patient surveys, monitoring of patient safety incidents, complaints and claims*
- *Health outcomes by protected characteristic – as a minimum by gender, ethnicity, disability and age*

- *Nature of employment choice offered to staff and whether sufficient consideration was given to how relocation has impacted on protected characteristics*
- *Through staff engagement and communication.*

The identification of any potential negative impacts does not prevent the Health Board from continuing with outlined plans for service reconfiguration during the ongoing EqIA. In terms of the local mechanisms for the pathway design and implementation of any changes, the requirement for a detailed equality analysis is embedded within the "gateway" approval mechanism. The process is designed to incorporate engagement with appropriate representative bodies to explore ways of reducing or ameliorating any impacts as future services are being designed and implemented."

Ultimately, the requirement is for the Board to make a decision from an informed position (i.e. aware of the potential impact). The Board final recommendations report covers this area service area by service area and in approving the recommendations each has a caveat that requires the impacts to be mitigated and assured through the implementation process.

The Health Board and CHC received presentations from the Consultation Institute in relation to this issue where the iterative process of equality analysis was discussed. This appears to have been discounted in the submission.

Similarly, each recommendation approved by the Board incorporated a requirement for any equality impacts to be mitigated in the pathway design/ gateway process. Again, this has not been acknowledged in the submission.

The Health Board has invited your EqIA Member lead to work closely with the Health Board Equality Officers in the development of the assessments for each service pathway.

Taking into account the advice of the NHS CEHR and the iterative process of analysis and addressing impacts during the course of pathway development (the gateway process) we feel this element of challenge is without grounds. There is evidence to show that we are considering equality issues in all our planning and service development.

In respect of Health Needs Assessment, strategic details are contained within the Technical Appendices[15]. As the CHC is aware, work is underway through Foundations for Change and the establishment of locality teams to develop needs assessments for smaller (locality) population bases which will inform future service design and delivery.

[15] Your Health; Your Future – Consulting Our Communities. Technical Document – Background and Introduction (August 2012) (Section 9)