THE HYWEL DDA

COMMUNITY HEALTH COUNCIL

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

25th February 2013

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EXECUTIVE SUMMARY

This report sets out the issues, opinions and concerns which Hywel Dda Community Health Council (CHC) has collated from within its membership during the listening and engagement, consultation and post-consultation stages of Hywel Dda Local Health Board's "Your Health, Your Future" process.

A range of meetings with representatives of the Local Health Board (LHB) and discussions within the membership of the CHC have been held. Moreover, the CHC has spoken with key stakeholders including hospital clinicians and GPs. A number of issues and concerns remain outstanding.

The CHC recognises the complexity, breadth and depth of work required to engage meaningfully and consult with Hywel Dda's population. Concerns remain over aspects of this process.

The "Gunning" principles tend to be cited as providing a framework for public consultations to adhere to. The CHC feels that these principles have been applied inconsistently and this view is detailed in the main body of the report.

One of the overriding worries regarded the lack of detail within the consultation process which clearly showed how the proposals would transform vision into reality. Such detail is required to provide a foundation upon which CHC members can be assured of sustainability and safety.

Furthermore, members have concerns around the process of consultation with specific issues relating to the scope of consultation, its methodology, the design of the public questionnaire and the subsequent analysis of the data.

In relation to the specific service change proposals made by Hywel Dda LHB, and following a number of meetings with its representatives, a number of concerns remain. These centre on the impact of the proposals and the extent to which existing patient needs would be met, particularly in relation to Minor Injury Unit closures, Prince Philip Hospital emergency care provision and neonatal services.

In addition, certain underlying issues are raised which impact upon all of the proposed service changes and the general planned transition of certain hospital functions into community or primary care settings.

The CHC is concerned with the continued unavailability of detailed financial, workforce and business plans, the capacity of relevant community/social care and the extent to which local health needs and equality impact have been assessed.

In light of these concerns Hywel Dda CHC remains unable endorse the proposals given the (as yet unresolved) potential risks which are described in more detail within the report.

GUNNING AND PROCESS

The 'Gunning' principles have been much cited as offering 'certain fundamental propositions' that must be adhered to in a Consultation process. There are four.

Gunning (i): concerns the nature and content of consultation, whether and, if so, how open the decision maker was to alternatives and whether the outcome of consultation was a foregone conclusion. It thus raises issues of fairness, transparency and honesty on the part of decision makers vis-a-vis consultees

Gunning (ii): concerns the 'sufficiency' of reasons for change offered by the decision maker, including the accuracy, completeness, level and extent of information offered by the decision maker to the consultees. It also includes the criteria for consideration of proposals as well as the decisiveness and importance of their weighting at the end of the process. This principle raises the issue of clarity, accessibility and scope of messages: the necessary elements to enable an 'informed and intelligent response. It also raises the issue of use of feedback and how this is weighed in decision making.

Gunning (iii): concerns 'adequacy' of time for consideration and response – not merely the length of time, but the timing and extent to which other associated factors (statutory holidays, weather conditions, transport problems) impinged upon, and thus restricted, the quality and duration of the time-period. It also involves a consideration of the range, variety, method and scale of consultee response/feedback and the adequacy of the time-frame to collect, collate and present data and an evidential base back to consultees.

Gunning (iv): concerns the 'conscientious 'consideration of the 'fruits of consultation'. It is closely linked to Gunning (i) and (iii) and involves the demonstration of proof that the decision maker has appraised the consultation with at least a semi-open mind, has treated the whole process with seriousness, due deliberation and shown respect towards/ understanding of consultee reaction, involvement, opinions, propositions and alternatives. This means that it has to convincingly show the consultee that engagement has been meaningful, constructive, and transparent.

We, the Hywel Dda Community Health Council, believe that in applying the above principles, the Hywel Dda Health Board is shown to have been defective, unfair, and less than transparent, both procedurally and substantively. We base this assertion on evidence

and examples selected from 2011-2013, starting with its Listening and Engagement Phase up to and including its Post-Consultation Phase as defined by this Health Board. Integral to the issue of fairness are, of course, concerns about the exercise of the Board's equality obligations.

1. At the Listening and Engagement Phase, the Hywel Dda Health Board recognised and publicised that 'no change is not an option'. We, the Hywel Dda CHC agreed and positively welcomed change from the status quo. Indeed the CHC drew attention, in its Response document, to the inadequacy of health services in the area, citing, inter alia, inappropriate weighting of acute services, commensurate neglect of screening, dearth of public health initiatives, patchiness of community care, anticipatory health issues and chronic disease management. The CHC also recognised variations and inequalities regarding services, treatment and access, unbalanced distribution of resources in the context of compliance with regulatory and accreditation bodies, historical problems arising from poor management. Failure to achieve quality, compliance, efficiency, safety and sustainability were also noted. Importantly, the CHC drew attention to the Board's inability, year on year, to work within its allocated budget.

2. The issue of resources, budgets and financial management has been downplayed throughout the Consultation period despite the fact, obvious to all, that the Health Board simply could not and definitely cannot in future, manage to operate within its resource envelope and ensure quality, safety, accessibility and sustainability. Notwithstanding, at the launch of 'Together for Health' the Minister stressed that service change would focus on health processes (rather than change for financial reasons). This pledge focussed on protecting positive health, improving standards of care, 'creating a new attitude and momentum, including a new relationship with the public', involvement in public health initiatives, continuous improvement of services and patient experience, addressing inequalities and inconsistencies, multi-disciplinarity and cross-agency activity and creating partnerships between Government, the NHS and its partner organisations, and the public/users of services. Underpinning these processes would be adherence to the Bevan principles and 'a much more transparent approach to performance reporting, and a more open relationship with the people of Wales.'

3. This vision and its associated rhetoric could not be disagreed with. At this point, however, it was impossible to assess, without detail, whether this vision was feasible, affordable and sustainable. The 'sufficiency' of rationale for proposed change as a criterion was met at this stage: there was acceptance by the CHC, and promised by the HB , that the parameters of change would be: improvement of health outcomes, compliance, adequate staffing profiles, appropriate infrastructure, efficiency, safety, equity of access and provision, accessibility and sustainability. Affordability had to be assumed, almost as an act of faith.

4. Nevertheless, the CHC drew attention to the lack of detail in relation, for example, to the fact that the Health Board had not detailed the processes and methodology it would put in place to achieve its aspirations or to show how, in operational terms, the changes would impact across different services and different parts of Hywel Dda. There was, equally, no consideration of resourcing, training (including CPD), recruitment, transport, use of technology or how movement towards increased care in the community would be effected. The CHC also flagged the substantial resource issues around organisational and work-pattern change, the costs linked to building community infrastructural and resilience, public education, retraining, attitude change, inter-agency collaboration, enhanced public health and awareness, as well as detailed consideration of the social, economic, demographic and cultural impact on change in Hywel Dda's disparate communities. Also highlighted were themes associated with the varied geography of the Hywel Dda area, predominantly rural/remote, but with several more urban pockets of multiple deprivation or groupings with 'protected characteristics'. Here the CHC featured the dearth of information in the HB's documentation regarding transport, transportation, the road network, car use and car ownership, the emergency services and their funding, staffing and work schedules, the input of the Third Sector, the quality of housing stock and various dimensions of deprivation associated with rurality.

5. Only a very small proportion of these many complex and interrelated issues were carried forward by the Health Board into the consultation phase, despite their repeated assurances. The concerns raised followed the CHC's own comprehensive opinion-gathering from a wide range of individuals and groups on their experience of the NHS in Hywel Dda and their use of resources as patients, and as potential future patients. We also conducted in-depth research into

alternative service models and examples of good practice in rural settings. We drew attention to the absence of informed data - those offered by the Health Board were at far too general a level, and were out of date. Whilst this duty was executed by the CHC with due diligence, objectivity and professionalism and accurately reflected feedback from thousands of interested and engaged members of the public, stakeholders and a range of organisations, as well as our own research, the Health Board failed to offer the expected detail on the con tent of its changes and even less on the processes and methodology. The 'sufficiency' criterion thus was only, in the final analysis, superficially met because the decision making basis was flawed and its information largely invalid.

6. The public perception was that there was a considerable gap between the ministerial rhetoric, the ability of the HB to deliver within the widely-recognised constraints of the resource available and their willingness to conscientiously listen and engage. Thus, the belief grew that the HB was set on pursuing a cost-cutting agenda, that the Listening and Engagement exercise was needless, based on a flawed and inappropriate commercial model, and that the outcome was a foregone conclusion. The CHC Response document stated: 'The HB has told us why change is necessary. It has not told us what changes or how. The public is not resistant to change per se – it can be positive and improving and offer opportunities for needs-led innovation and patient-centred solutions. But there are fundamental omissions which are variously seen as deliberate obfuscation, coyness of intention, lack of joined up thinking or an indication that major decisions have already been taken; that the nature and direction of change are a fait accompli; that "engagement" is a charade'. In short, the first Gunning principle had not been fulfilled and has not been fulfilled subsequently (see below).

7. Engagement or consultation was not adequate (Guidance 51a) subsequently in relation to key issues raised at that point:

   - how inequalities and inconsistencies across the Hywel Dda area are to be addressed
   - how the Health Board proposes to effectively balance patient safety, optimal outcomes access and quality with drastically reduced resources in a sustainable manner
   - how the shift of emphasis from hospital-based care to care 'closer to home' is to be planned and delivered in the immediate,

medium and long term, to include adequate, safe and feasible interim arrangements

- how the effectiveness of an 'integrated care system' will be monitored and its success and quality judged
- how community infrastructure, knowledge, resilience and support is to be operationalised
- where is the comprehensive risk analysis for change (based on need, equity, safety, comprehensiveness, sustainability, data at an appropriate level of analysis ?
- how 'care in the community' is to be staffed, funded and delivered across sectors and across the 'formal-informal' care spectrum.

8. In progressing from Listening and Engagement to full Consultation this 'agenda of concern' was reduced in content, scope and process by the Health Board; some issues fell out of the arena of debate and were not selected by the HB as topics for the Consultation phase or the feedback emanating from it. Neglected issues that had featured in the earlier rhetoric were: protecting positive health, improving standards of care, creating 'a new attitude and momentum' involving a new relationship with the public, public health initiatives 'continuous improvement ' of services and patient experience, embracing new technological processes, multidisciplinarity and cross-agency activity, new partnership arrangements, mechanisms for effecting cultural and organisational change, modelling, feasibility, affordability, safety and sustainability. Whilst it is accepted that the prerogative for identifying (Full) Consultation items lies with the HB, there needs to be transparency with regard to choice and issues selected for further action, as well as with the provision of rationales that are acceptable, or at least understandable to the public at large.

9. In response, the HB has given various rationales for these omissions:

    - questions about 'how' do not need to be part of the Planning process; it is sufficient for them to appear later at the Implementation stage(this, of course, is questionable and does nothing for the criteria of 'adequacy of information' transparency etc .) The CHC has consistently argued that any item within Implementation needs to be planned and developed first and should therefore be made transparent to the public. Managing public expectations is vital to the development of

trust between decision makers and consultees in order to bring about desired change effectively and efficiently.

- questions/issues raised through Engagement would be addressed later at the Consultation phase (however, the HB at this point made decisions which were not transparent or fair about what changes constituted major changes and needed to be consulted upon and which were of less significance or would be decided upon later, with or without further consultation
- the Consultation issues, the HB asserted, would be addressed through a 'consultation questionnaire' and this would be the major and more significantly weighted conduit for feedback and public opinion. In the event public opinion was not effectively 'channelled' in the way the HB had hoped for/anticipated. Public response to the Consultation document was overwhelming and spilled over into long, detailed and extensive submissions from huge numbers of individuals and all types of organisations).

10. These omissions were persistently raised with the HB by the CHC: they have been consistently side-lined or 'ducked' by the HB. Certainly, Gunning (ii) has not been fulfilled: the CHC has offered 'informed and intelligent responses' but they have not been heeded. Indeed, the Minutes show that they have, in the main, been summarily dismissed. We reserve judgement as to why this has been the case throughout the consultation process. In our Consultation response, we wrote 'many difficult and challenging questions have not been raised, or, if they have been raised, have not been satisfactorily or convincingly answered. The question of trust in the HB . . . is therefore still a live issue.'

11. The choice of 'agenda' for the (Full) Consultation phase has caused concern in relation to Gunning(i). It was, on the one hand, acknowledged by the CHC that the HB had, in some respects, changed some of its thinking following the Listening and Engagement phase, (evidenced by some improvement in the communication between the HB, the CHC and the public; a move towards a degree of transparency and willingness to 'engage' and importantly, greater recognition of needs, impact and service delivery requirement in rural areas. On the other hand, 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.

12. The outcry from the public, stakeholders, staff and a range of individuals across all sectors and sections of society has been near-unanimous in recognising, like the CHC, a number of substantive areas which:

    - Fell outside the 'territory' covered by the consultation questionnaire – the HB's stated favoured option for feedback and appraisal
    - Were classified by the HB as 'operational' 'yet to be discussed' or 'not part of the Consultation' and 'to be considered by the Implementation Board' (yet to be determined) – in other words, not appropriate areas of discussion under the aegis of Consultation.
    - Were issues raised at the Listening and Engagement phase but either not 'carried over' or not appropriately or only minimally touched upon.

13. At no point were reasons given for the 'agenda' which was chosen for the questionnaire. The CHC was consulted about the questionnaire in terms of content and format, to which it replied negatively. Discussion of the questionnaire ran into the sand in face of the HB's intransigence. It was not at all clear why some questions were inserted and not others: why some questions were very specific, others very generalised, some not clearly linked into the Consultation document, others asking for opinion where detail in the Consultation had been poor. Generally, the questionnaire had the effect of closing down the 'discourse of consultation'. The CHC's objections to the content, format and status (in relation to other HB feedback mechanisms) were treated with a certain amount of disrespect and impatience and the HB pressed ahead regardless with the process. Very little information was provided by the HB about the other methods of obtaining feedback and their target population, sample size selection etc. And it was only when data were collected, collated, weighted and fed back by the organisation funded to report back - Opinion Research Services (ORS) that we were given the opportunity to participate. This was merely an invitation to accept the ORS's resultant work (despite having considerable research and survey expertise within our own ranks and well-evidenced misgivings about the integrity, reliability and validity of the research data as well as the ORS conclusions that were passed to the HB).

14. The conduct of the HB, supported by ORS, at this point, raised serious concerns that the HB was not open to alternatives, that the outcome of consultation was a foregone conclusion and that the feedback process was deeply flawed, to the extent that it had provided the decision-maker with the 'intended result', rather than reflect back the range of negative opinion from consultees about content, process and outcome. We were repeatedly cited the mantra that 'Consultation is not a Referendum'.

15. Overall, accepting the premise that consultation is a 'continuous process' which starts with the HB listening and engaging with the public (which includes individuals, groups, organisations both within, outside and associated with the HB) and continues into a (formal) consultation, it is clear that none of the Gunning principles has been met in fact or indeed, barely in spirit, despite claims to the contrary by the HB. The thousands of responses to the various questionnaires and the several hundred submissions (all of which have been read by the CHC), testify to the overwhelming, considered and well-evidenced opposition to the HB's plans by its diverse publics'/consultees. There is disenchantment if not incredulity that, having engaged in such an extensive process of gathering feedback, (and the very substantial cost thereof) that the HB has 'steam-rollered' ahead, regardless of that feedback and, with unseemly and suspicious haste, rushed through a set of recommendations (unanimously passed by the Board) and hurried on to call the first meeting of its 'Implementation Committee'. Gunning (iv) has in no sense been met. The principle states that there should be a 'conscientious consideration of the fruits of consultation', that the decision-maker has a burden of responsibility to demonstrate at least a 'semi-open ' mind, that the consultation has been treated with 'seriousness, due deliberation and respect towards/ understanding of consultee reaction, involvement, opinions, propositions and alternatives'.

On the process alone, and on Gunning (iv) alone, the Hywel Dda Health Board fails. Few would accept that engagement has been meaningful, constructive, transparent or competent. The HB claims it meets the Gunning principles but the weight of evidence points the other way. Worryingly, the HB requires the co-operation of the public, its staff, its stakeholders and organisations such as the CHC to successfully enact its proposals; 'a more open relationship with the people of Wales' to engender trust upon which to predicate the service delivered. 'The proposals describe a sea change in the way

health services and patient care is provided. They do not (yet) adequately or comprehensively address the major queries that were detailed by the CHC (and other representative bodies) and the public at the Engagement stage earlier this year, nor do they address how the necessary culture and behavioural change on the part of staff, carers and patients, is to be achieved'. (Hywel Dda CHC Reponse to HDHB's *Your Health, Your Future*, October 2012).

CONSULTATION: CONTENT AND OUTCOME

We, the Hywel Dda Community Health Council, are not satisfied that Hywel Dda's 'proposals for substantial changes to health services', in the manner and detail in which they have been presented to the public, are acceptable. The HB has constantly responded that we 'must make an act of faith' and accept that their plans will ensure safe, sustainable outcomes for patients within the available resource envelope. We cannot do this if we are to execute our duty to the public in a way which reflects their views, mitigates their anxieties, work constructively with the Health Board and satisfies ourselves that the HB's proposals will result in safe, sustainable and high quality service delivery, accessible and equitable for its diverse and essentially rural populations.

Following Section 5.37 of the Guidance and using legally advocated check-lists, and applying General Public Law Principles, we make the following observations.

1. The Board of Hywel Dda Health Board should not have passed the Consultation proposals (unanimously and without discussion) on 15th January 2013 knowing that the Hywel Dda CHC had lodged well-evidenced and closely argued objections at many points of the Listening and Engagement and Consultation processes. At that point it had been made very clear that Gunning (iv) ('conscientious consideration of the fruits of consultation and a convincing demonstration that engagement had been meaningful, constructive and transparent') had not been fulfilled. Additionally, at that point the Terms of Reference, Membership and the calling of the inaugural meeting of its Implementation Board, should not have occurred.

2. The HB has failed to demonstrate proper appraisal of many alternative options offered to its proposals through the submissions and feedback (in various forms) from the huge numbers of consultees that participated in the Consultation exercise. We refer specifically to the alternatives concerning Women and Children, to Accident and Emergency services for Llanelli/Prince Philip Hospital, and a range of suggestions regarding provision of speciality services that would better satisfy concerns around equity, access, safety and quality.

3. The HB has failed to provide sufficient information on several areas fundamental to its proposals, with the consequence that the questions put to consultees were meaningless beyond the aspirational because of inadequate detailing. Obviously, in a question asking whether respondents would like 'care closer to home' there is an implicit 'prompt' to answer affirmatively. Other questions in the consultation questionnaire which e.g. start with … 'to what extent do you agree or disagree . . .' were, as the CHC pointed out to the HB, (see notes of meeting of 01.08. 2013) invalid because consultees were given no information base concerning, especially, financial data to inform their answers. Moreover, e.g., in the question relating to the proposed closure of Mynydd Mawr Hospital, no alternative proposal was put forward by the HB because the public was given no reassurance that there were or could be adequate replacement services or indeed, whether any replacement services might be available before closure took place.

4. Another question concerned Minor Injuries services at Tenby, the wording of which made two assumptions: (i) that local GPs' surgeries would take over this service and (ii) the affected Nurse Practitioners would be redeployed. These assumptions were misleading: whilst it was stated in the Consultation document that GPs would take over the service, this had not been agreed at that point with the GPs (and nor has it still), and neither did the Health Board mention that this would only be for eight weeks, or that other providers might take on the service, or that plans were in place for any staff redeployment. These two questions are illustrative of the CHC's claim that the HB did not provide consultees with the necessary elements to enable an 'informed and intelligent' response (see earlier reference to Gunning ((ii).)

5. At the meeting of 8th January 2013 between the CHC, the HB and ORS (called at very short notice by the HB) the development of the consultation document and the associated questionnaire the following were intensively discussed:

   - ORS's and the HB's apologies that two very substantial evidence-based documents from the CHC, together with 19 other submissions from stakeholders and interested groups/organisations, had been omitted from its post-Engagement/pre-Consultation Report
   - Concern about the shortcomings, particularly absence of financial data, business planning and risk analysis in the

consultation document; the very short notice given to the CHC to review information and the undue haste to press on demonstrated by the HB; confusion relating to different versions of the questionnaire and their match with versions of the document; dismay that the final version of the questionnaire showed little evidence that the CHC's constructive and detailed comments had impacted – it still contained 'leading' questions, lack of clarity and explanation to facilitate informed responses designed to reflect attitude rather than choice. In short, no regard had been taken of the CHC's active participation and feedback and no concessions were afforded by the HB because of 'time-tabling and printing deadlines'.

6. 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. Having stressed that the (open) consultation questionnaire would be the main conduit of public response (C. Wright HB. 01.08.2013) and following a comprehensive campaign by CHC on behalf of the HB to encourage public participation/questionnaire return, 4, 422 residents and organisations replied. Additionally, a postal survey ('household survey') was sent to 5,000 randomly selected households (the criteria of selection were not shared with the CHC) of which only 14% (697) were returned. At a later date, the CHC were informed by ORS that this (low) return was afforded greater weighting in the final analysis than the 4,422consultation questionnaires, the rationale for which the CHC continues to dispute. Moreover, it has since been revealed that recipient households were merely sent a summary document and not the full consultation document to inform their decision-making.

7. Other elements of the ORS research which informed the HB in its decision-making process were: 7 focus groups consisting of members of the public, 6 focus groups consisting of members of staff and 5 telephone interviews. No information about the criteria for the selection of respondents or any results/information regarding expressed views/responses has been given to the CHC. Importantly, the HB received over 200 submissions from a wide range of professional bodies, public bodies and organisations across all

sectors and representatives of many different groups and opinions. Many were extremely detailed and substantial. In theory, the HB 'shared' these with the CHC ; in practice, this process was flawed, incomplete and chaotic; ORS claimed to have extrapolated the emergent main themes; it was asserted by the HB that 'inevitably, the nature of consultation means far more negative than positive submissions'.

8. The CHC has repeatedly asserted that the very large number of submissions indicates the huge and widely experienced frustration with the content of the HB proposals, the substantive and methodological flaws in the consultation process, the lack of transparency regarding the choice of consultation topics, themes and specific questions and the patent disregard for most of the data emanating from the Listening and Engagement exercise. In particular, the CHC has grave reservations about the constructiveness and seriousness of the dialogue which it has attempted over an extended period, to conduct with the HB.

   The CHC has read all the submissions shared incrementally and irregularly by the HB and conducted its own analysis. Our considered view is that the ORS's research fails the normal tests of validity, reliability and representativeness, whilst the HB has ignored the fact that it has not received the necessary mandate from professional bodies, public bodies, statutory organisations (like the CHC), the different publics, voluntary organisations and concerned individuals. Major weaknesses have been exposed which are discussed below. These are, inter alia:

- Absence of financial data

- Absence of detail regarding 'care in the community/community and primary care'

- Absence of reassurance regarding feasibility and sustainability

- No genuine consideration of alternative options regarding controversial topics such as replacing Llanelli's A & E services with a nurse-staffed urgent care centre and an emergency medical admissions unit, as well as closure of Mynydd Mawr Community Hospital

- No evidence that genuine dialogue has been conducted with the regulatory and advisory bodies, with GPs (essential) to the realisation of 'care in the community'.

These are all detailed in the following section.

THE LHB PROPOSALS AND CHC CONCERNS

The specific outstanding concerns to the Hywel Dda CHC are as follows:

1. Minor Injuries Units

   There are two minor injuries units that the HB wishes to close and to provide services in an alternative setting, both of these being in south Pembrokeshire, one in Pembroke Dock and one in the seaside town of Tenby. In principle this CHC can support these closures in the longer term but only when adequate alternatives are available as has been referred to earlier within this document.

   At present discussions are still on-going with the GP practice within the town of Pembroke Dock as to the provision of MIU services; these are much in an early stage and there is no detail available as to the hours of provision and as to whether this will include any late evenings and any form of weekend cover. We recognise that this is a 'communities first' area with large pockets of deprivation. We need detail and cannot accept this blank canvas. We desire a model which will provide greater 'out of hours' provision.

   Within Tenby the situation is even direr at this time with both the local GP practices currently distancing themselves from any form of MIU cover, and even reporting publicly that they are opposed to the closure of the MIU. Tenby itself has a large elderly population, being seen as a retirement destination, and it is also recognised that approximately 50% of persons using the MIU facility are tourists and holidaymakers; Tenby has also become a year round travel destination for coach parties etc. The HB is intending to provide MIU cover via the GPs in their core working hours (still to be agreed) only and to provide 8 weeks of summer MIU cover by some other means, likely with a third party provider which has yet to be identified and agreed. We are asking the HB to redraft its plans for this closure and to develop an alternative model which will provide a much longer period of year round cover, this to include weekends and bank holidays, and consider the 8 week mid-summer model to be inappropriate.

2. Community Hospitals

   We understand the rationale for the closing of the Mynydd Mawr Hospital but express concern at the loss of the community bed capacity without knowing detail as to how the alternative model will provide care via the community and through 'virtual wards'.

3. A & E Services in Prince Philip Hospital (PPH), Llanelli

Whilst we accept that a full A & E service is unlikely to be reinstated at PPH Llanelli but do believe that, given the population size of this large urban conurbation and its surrounding catchment area, that it is unacceptable merely to have the emergency care service provided by nursing staff. Accordingly it is our considered opinion that a fully trained/qualified doctor must be available at the facility at all times, on a 24/7 basis to see and review all emergency arrivals, apart those who are routed directly to the hospital's medical admissions unit. Such a doctor would be able to interface with other colleagues across Hywel Dda and signpost patients to the most appropriate setting, whether that is within PPH or elsewhere. We are aware of an alternative model now being considered and that discussions are underway between the HB and with various stakeholders. We also understand that clinicians within the hospital are opposed to the downgrade plan and should be consulted and their clear opinions taken into account prior to a solution being finalised.

4. Referrals Outside of Hywel Dda

This CHC recognises that patients within the Hywel Dda region currently access secondary care services in adjacent Health Board areas, and that similarly patients from elsewhere access services within the Hywel Dda region. This cross border access is at its greatest in the south east of the region, primarily in Llanelli and district, and where large numbers of patients attend the secondary care services provided in the ABMU Health Board region and the hospitals at Singleton and Morriston in Swansea. A large volume of women's and children's and particularly maternity services are provided via ABMU, a location which patients favour and where access (travel and transport) is easier. There is a concern that the Hywel Dda HB may in the longer term seek to reduce/remove such access to patients, and particularly if new services are developed within Hywel Dda. Within the CHC we need an assurance from the HB that this freedom of choice and access will continue and should there be any intention to change this in future then that this will be subject to further public consultation.

5. Neonatal Services

The CHC believes that the HBs ambition to develop a Neonatal Level 2 Unit at Glangwili Hospital in Carmarthen is an inappropriate and indeed an unattainable one in the current circumstances.

We are of the opinion that such a development and capital investment is unjustified given the statistics which reveal that only a very small volume of patients that would require such a facility, and neither has recognition been given to the close proximity of Morriston Hospital (approximately 20 minutes under blue light) where ABMU intend developing a new level 3 Neonatal facility. Additionally the Glangwili model is considered inappropriate given present medical/consultant recruitment difficulties that exist, that are well documented, and that are anticipated to continue for the foreseeable future. Neither does the model recognise the rurality across Hywel Dda and the associated poor transport links and infrastructure.

Additionally there is concern that the current HB proposal, if implemented, would have an unacceptable and detrimental impact upon patient services at Withybush Hospital in particular because:

- All paediatric referrals – outpatient, inpatient and emergency – would need to go to Glangwili in Carmarthen, this causing stress for both patients and parents; there would also be the risk to seriously ill children having to be transported a long distance before treatment.
- The scenario would also cause the A&E Department at Withybush to be downgraded because the 24/7 presence of a paediatrician is of course required for a fully functioning A&E Department.
- A paediatrician also has to be available within a 10 minute call time for an obstetric department and for a midwife led unit an obstetrician has to be available within a 20 minute call out time (these figures are taken from the technical documents which were published by the HB in support of its consultation process) The absence of a paediatrician would also remove the ability of the hospital to stabilise at risk babies prior to any transfer.

We consider that in such circumstances, if the HB proposals are implemented it could result in a loss of maternity services in their entirety at Withybush and accordingly also a loss of A&E services.

We believe that greater recognition must be taken of the ABMU proposed neonatal model and its close proximity to Hywel Dda, and

accordingly a strengthening and enhancement of the existing model and the Special Care Baby Units therein should be the preferred model for the HB; this is not the status quo but a bolstering and a much improved networking of the existing separate facilities at each hospital.

6. Health Inequalities

From the early stages of the "Your Health Your Future" process, the lack of detailed needs assessment led to concerns that any evolving plans were not sufficiently rooted in the needs of the population. Prior to significant strategic change, other areas of the UK tend to see the production of detailed assessments of need using small geography measures and local health data that build a clearer and more robust understanding on which to base planning.

In addition, concerns have been further exacerbated by the absence of either a comprehensive Equality Impact Assessment (EIA) or portfolio of relevant individual EIAs which contain the necessary depth and breadth of information to assure the CHC that the impacts of such proposals have been adequately understood. Some basic information has been given during presentations post consultation and a descriptive document produced as part of the LHB's 'technical documents'. Such information has not been sufficient to engender full confidence that potential negative impacts have been anticipated and thus whether they can be managed effectively through implementation. We feel that in line with the Equality Act 2010, Equality Impact Assessment should have been developed during the consultation phase but crucially concluded *before* the Board's decision making stage.

7. Community and Primary Care/Care Closer to Home

This describes a locality-based planning and delivery model, with care resources fully integrated into community care teams and services/ resource-centres and introduces the concept of community virtual wards. However, this is a major and crucial part of the HB's vision of the future involving a sea-change in staff working practices, contracts, planning and delivery modelling, training, retraining, changed quality assurance procedures and safety considerations, effective networking,

partnerships, communication, interdisciplinary and inter-agency team-working and the purchase and use of advanced technology.
There is, disappointingly, insufficient information in the Consultation document that unpacks the whole notion of care in the community and about the seamless pathways from hospital into primary and community care that are envisaged.

The public is loud in its questioning of how this will happen and particularly about the experienced discrepancy between current reality and the vision held out in the Consultation document. (Ceredigion, e.g., has long suffered from a history of bed reduction with no discernible increase in community services).

The public wonders whether GPs have the will, capacity or finances to provide the extra work and services this plan requires; there are worries about the definition of 'Localities' i.e. 'of a population size which enables effective and efficient delivery of community services' which is an unclear and unhelpful statement as far as addressing the needs of very rural and remote communities (individuals living in the Hywel Dda area or catchment areas beyond., including those who look to the Bronglais service area from neighbouring Boards/Local Authority areas); the concept of the virtual ward is still puzzling to many, as is unrecognizable the statement 'community virtual wards are currently being embedded within community services'. Finally, it is understood that access works both ways: if service providers 'come to communities' rather than the other way round, these community staff will themselves have large distances to cover between patients, which has knock-on effects for resource use in terms of time, money, effectiveness and outcome.

Similarly, the CHC, on the part of the public, has to ask questions about the intended role for the carer, the patient and the community. It was pointed out in the CHC response to the Listening and Engagement document that there has been no serious consideration given to capacity building within the community (which needs to be part of the initial concept and early planning). How is the sea-change to be effected for the public? How is health status and life-style behaviour to be changed to embrace and make possible the ideas about self-care, self-monitoring, preservation of health and well-being and being an active participant in partnership with health and care professionals? Where do public health initiatives fit in? Community cohesion and engagement, through, inter alia, the Third Sector, is the

other side of the coin to closer service integration. These issues have not been properly addressed in the Consultation document and are fundamental issues being raised by (often very well-informed) members of the public.

The match between the 3 questions in the questionnaire about community care and the content of the Consultation document, is poor: there are 31 pages of text before reaching the questions on 'Community Services and Primary Care.' These questions are confined to one community hospital near Llanelli and minor injuries services at Tenby and South Pembrokeshire Hospital. (This is a psychological 'turn-off' for questionnaire respondents in other parts of Hywel Dda and has been a disincentive to completing the questionnaire: ('not relevant to me"!). The limited scope of the questions does not do justice to the 'Care Closer to Home 'section (and although the HB offer legal reasons for this, this is not a satisfactory situation for the expression of public opinion on this aspect of the Consultation.

There is currently a great deal of unease across the communities in the context of emphasis on/the shift towards community care. Much discussion has to date been focussed on hospital provision, albeit in a proposed changed form. Many feel that the detail and planning for change in the community should bear equal, (if not greater) weight with that of hospital provision, particularly with an ageing population and increasingly large vulnerable groupings (particularly in the mental health and learning disability and impairment areas). The current standard and quality of community services is noticeable in its patchiness across Hywel Dda: the implementation of cross-sector service integration poses large resourcing, training, contractual and governance issues which people wish to raise now at this Consultation phase. These are the same issues which underlie the integration and desirable increase of public health campaigns, more improved health education/promotion, intersectoral work (health, social services, voluntary services, education through schools etc.). They come down to planning and delivery of a shared, integrated provision, safe and readily accessible. Beyond this are wider issues still such as rural health awareness; planning and delivery cannot be considered in isolation from social, economic, transport, housing and social care matters. These are not within the scope of the HB's Consultation agenda but very much issues in the public consciousness and in the questions currently being asked.

These questions offer a good argument for a further Consultation to be launched around 'Care in the Community' in which the HB addresses, and would be seen to address, the many complexities and challenges inherent in this vision, with some practical 'ways forward'.

8. Financial Plan

The Health Board's consultation proposals are only deliverable if they are financially viable: they are only sustainable if they are financially resilient: they are only convincing if the HB produces a real costings plan in an acceptable and understandable form and only credible if it can be shown that replacement services are safe, of good quality and durable. Unless these conditions are fulfilled, the public perception is likely to remain one of deep distrust that the whole consultation exercise is orchestrated towards 'balancing the books' to satisfy political expediency, particularly as it is widely known that the HB is currently operating with an in-year debt of many millions.

The HB persistently refers us to the SWAFF document and the Technical Annexes. Such financial information as is shown there, alone, fails on Gunning (not specifically focussed on consultation questions; lacking relevancy and accessibility as far as a 'lay public' is concerned; correspondence from the HB of 16.01.13 'dodges the questions'). Our specific concerns are:

- HB's intransigence and reluctance to acknowledge the pivotal role played by finance in achieving their service delivery changes: service delivery change is considered in relation to hospitals but only in the most superficial manner in relation to the massive organisational and financial impact of 'care closer to home', including virtual wards. The wider implications of staff and public attitude change, staff retraining and redeployment, socio-economic factors which embrace quality of housing stock, transport, safety, accessibility, equality etc. require factoring into the financial plan and associated risk strategy plan and it is feared that that 'bottom line accounting ' will prevail over 'safe and sustainable services ', despite the rhetoric and aspiration, as there is little or no evidence that the proposed service changes will cost less to operate or that the in-year savings in the initially proposed 3-5 year time-scale – which has now slipped to '5-7 year' - (HB/CHC meetings 21.02.2013) unless there are significant ring-fenced cash injections from the WG of at least £140m (itself a conservative estimate).

- That the financial 'projections' given to the CHC are no more than 'assumptions', an example of which is the HB's forecasting in-year savings for this year when an overspend is already evidenced.

The HB, in the absence of presenting as part of its consultation processes, at least an outline costed business plan, which comprehensively covers all dimensions of the proposed service changes (as well as transitional arrangements) along the spectrum of acute hospital to chronic community and primary care, fails on all Gunning principles. Assuming that such a plan were offered for further consultation, there would need to be a combined fiscal plan that the County Councils (CCs) agreed to as the CCs will assume the transferred aspects of patient treatment due to take place in 'virtual wards'. This transfer will mean additional duties for the CCs' Health and Welfare officials and their front-line staff which raises the further issue of how CCs will cope with the additional expenditure when their budgets are cut. The other major aspect here is the role of the Third Sector and their ability to participate in the delivery of an integrated system in the context of severe constraint on funding from public and private sources.

The fiscal plan also needs to provide evidence that consideration of associated costings have fully reflected the crucial relationship between staffing, organisational culture, quality and safety. These issues are fully considered in the Longley Report which was produced during the early part of the Consultation process and appears to have been shelved in favour of the (challengeable) data produced by the ORS. Briefly it concerns links between volume and outcome, in hospital provision links between mortality, staff culture and organisation, accessibility good management/ leadership, safety, staffing levels, quality and equity – all of which impact on aspects of any fiscal plan that embraces both hospital provision and community/primary care.