Health, Wellbeing and Local Government Committee
HWLG(3)-18-10-p1 - 17 November 2010

APPENDIX 1

NORTH WALES CLINICAL STRATEGY MEETING

Notes from the 2nd session – Wednesday 15th October 2008

Situation

The North Wales NHS community, together with local authorities, community health councils, voluntary organisations and representatives from the Welsh Assembly Government met together on Friday 10th October to openly discuss the following:

"What is the optimal balance of health care for acute, community-based primary and tertiary services and mental health services across North Wales?"

This first meeting examined the models of care from the point of view of patient stories. Attendees were sat in professional groups and asked to produce a short list of important issues arising from the discussion around the patient stories. In the afternoon the discussion was around the possible utilisation of community services, including community hospitals, together with the effect that any movement into the community of health-related services would have on the construct and services provided by the acute hospitals. A document was produced summarising these discussions and circulated to attendees for their information.

A second meeting has been arranged to discuss this document, the areas of possible agreement, areas of disagreement and issues that had not been fully discussed. It is anticipated that further discussion would highlight those areas that required more specific work and that a series of work streams would emerge for recommendation to the North Wales Health Planning Forum.

Background

The aim of the second session was threefold:

- To discuss the main outcomes of the first session in terms of degrees of support including discussion of those areas where there was no agreement;
- to identify the areas where work streams could develop solutions and options around the balanced model of care and
- to agree the time scales around the work streams.

The established work streams around the ministerial reviews would be able to use this work in their own deliberations.

Initial discussions at the end of the first day identified some key questions that needed to be addressed and tested for degrees of support in the second session:

1. What did we agree upon?
    a. Moving to an increasingly community based, multi-agency care model.
    b. We have to move towards a 24/7 service model in health and social care.
    c. Acute hospitals are likely to be smaller. (The demographic effect may negate this but the need for increased efficiency and modernised services remain essential to future success).
    d. There is scope to actively consider rationalisation of elective surgery to fewer sites – Also, some minor surgery could become more local. There are opportunities to repatriate some tertiary work.
    e. An expansion of locally based midwifery led care with a potential reduction in the number of obstetric units and implications for neonatal care.
    f. There was general agreement on a number of issues that were felt to be important – e.g. information and information technology, estates – generally infrastructure issues.
    g. Workforce issues are important – a generic workforce.
    h. Transport issues.
2. What did we not agree on at this stage?
    a. The overall use of community hospitals, e.g. outpatient clinics.
    b. We did not achieve clarity over the A&E / emergency surgery issue.
3. What didn't we discuss in the necessary detail?
    a. Pathways were mentioned a lot, but the reality is that primary and secondary care do not engage well on this topic – this is likely to be fundamental to the work of the work streams.
4. What further work is required to take forward the issues identified by the above questions?

<u>Assessment</u>

Individual tables, comprising a mix of attendees from the various representative groups, were asked to examined the points (a) to (g) in the list of issues where there was considered to be **a fair degree of agreement** and score out the agreement to the statement out of a possible 10 points. Of the 12 tables, one scored 10 against all the points, four scored 9, four scored 8,

two scored 7 points and one scored six points. The following issues arose during the feedback from the tables:

(a):

- Should this be community focussed rather than community based?
- Some services are not appropriate to be done in community. There needs to be a balance with safety
- Need a shared understanding of what is meant by community based services.
- Need for clarity around the term 'single point of access' and what this means for patients and services.

(b):

- Be inclusive of all services – not just social services but include all local authority services and third sector.
- Is it 24/7 or more extended access 7 days a week – we need to be clear what we aspire to achieve

(c):

- Should we refer to more efficient rather than smaller acute hospitals?
- Should refer to bed utilisation, rather than size of acute hospital.
- Acute hospitals should not be defined by bed numbers – lots of other services are located there.
- There may be areas of acute activity which will expand – eg previous tertiary work, "hot clinics", one stop clinics. Therefore for each component of the sector we need a clear vision
- Must not decommission acute beds until alternative services are in place

(d)

- Should this specify high tech elective surgery on fewer sites rather than 'just' elective surgery? – opportunity around specialist services
- Seen to be clinically dangerous
- This should be 'elements of elective care'
- Support for minor surgery at local level
- Need to consider repatriation of routine elective surgery taking place outside North Wales.
- This does not mean a reduction in the total number of sites undertaking elective surgery

(e):

- Political issues with changing obstetric/midwifery care.
- Should be midwifery led births rather than care.
- Need to emphasise low risk births
- Most midwifery already community based.
- Impact on gynaecology should be considered
- Can we have an A and E service on site without obstetric back up?
- Fine balance between geography and throughput to maintain skills.
- Can't cease obstetric service in the East as births would go to COCH and this won't be politically acceptable.

(f):

- There was a high degree of agreement with the statement about infrastructure issues.

(g):

- Be more specific – discuss front line generic worker, and core skills required
- Over reliance on pathways limits ability to develop generic workers – we want to be too safe and not allow staff discretion in decision making.
- Should be about the development of a generic support workforce with generic skill base – these are qualified staff.
- This potentially applies at all levels of the workforce not just support roles

(h):

- There was unanimous agreement that transport was a major issue.

The tables were asked to discuss four areas that were emerging as areas where there was **no agreement at this stage**:

- Accident and Emergency
- Emergency Surgical Provision
- Maternity and Obstetric Services
- The use of Community Hospitals

Attendees were asked to rank these areas in terms of greatest to least challenging and to identify issues that might be preventing them being taken forward:

<u>Accident and Emergency</u>

- Don't use the phrase 'A and E' – talk about urgent care/unscheduled care. Look at agreeing a broader model of unscheduled care and consider issues such as access (travel time versus safety).
- Agreement about unscheduled care model will predetermine what 'lies behind' the front doors of an 'A and E'
- Remember we used to have 4 A and Es (and Llandudno MIU is medically staffed 24/7)
- Difficult to see a reduction in the number of 'front doors' from 3 but what is behind them may be different.
- Volume of medical and surgical takes is higher than admission via A and E.
- First question we need to ask is: do we have 3 sites which take 24/7 unselected emergencies rather than do we have 3 A and Es. If the answer is yes, then what are the operational issues to arise from this (such as the surgical rota issue).
- Need to give consideration to public and political acceptability
- Perhaps learn from mental health – crisis intervention service provides urgent care rather than attendance at A and E – could other services learn from this.

- Overall this discussion confirmed the position consulted on in DfNW (except for the greater role for Llandudno as outlined in the Burns report)

Community hospitals

- Community hospitals mean different things to different people – start instead with an agreement about what 'core' community services should be.
- Where are the clinical champions and leaders for community hospitals – some general practitioners are very involved in community hospitals; others less so. How do we develop nurse led care/discharge and how do we enable nurses?
- Governance issues are important, particularly with regard to 24 hour care
- Therapy services are as important to develop as medical and nursing care.
- Be clear – what do we want a community hospital to do?
- Do we always mean facilities with beds? – some parts of north Wales do not have that legacy and our thinking needs to reflect that.

Maternity Services

- We need to get an Obstetrician view and gain their professional support for the debate.
- The birth rate is rising.
- Midwifery led care/births is the default position – most pregnancies are normal.
- The evidence base is strong for risk assessed midwifery led births
- What are the consequences with respect to A&E provision if no obstetric services on site
- How do we deal with Gynaecology – closely linked to Obstetrics?
- Can we continue to provide 60 hours a week Consultant cover for Delivery Suites in the East and Central areas?
- We need to be clear whether immediate access to Obstetrics is required for a 24/7 unselected emergency take

General Points

- Look at the needs of the local population first.
- What we plan and how the public perceive safe services may not be the same – engage the public early.
- We need evidence to back up decisions but not all decisions can be 100% rationale – other variables come into play so we will make compromises. Evidence base may not take into account applicability to North Wales geography so there will always be a balance of judgement.
- Concern about the impact of NHS restructuring and the fear that the focus upon primary care will get lost. Concern also that intermediate care will be at risk as well.

- The resource framework within which decisions have to be made has not featured in the debate. This must be introduced before we progress.
- Engagement is a very time consuming process – don't underestimate this.
- Need to ensure robust evidence base to support decision making and be aware that evidence can be contradictory and often anecdotal rather than factual.

Recognising that there would be work streams arising from this meeting the tables were asked whether there were **any principles that would apply across the various work streams**. The following list was produced at feedback:

- Citizen centred
- Equitable services
- Safe and evidence based services
- Trained staff
- Coherent management with resources
- Lose parochialism
- Make decisions
- Have clear and measurable outcomes (wider than just morbidity and mortality indicators, consider quality of life, minimising disability)
- Recognise that all changes will benefit some and for some, things will be worse
- Who decides the level of risk that will be acceptable ?
- Cost-effectiveness
- Agree what is non-negotiable (e.g. level of safety of services; political imperatives)
- Consider the law (health and safety; employment including EWTD)
- Guidelines – both current and those from 'future gazing'
- Patient safety to be at the heart of everything
- Communications between work streams and with wider audience to be clear
- Performance issues (ministerial influences)
- Keeping people in 'a steady state' and reducing dependency
- Working in partnership across all sectors
- Be clear about and agree the definitions we use (e.g. what do we mean by single point of access?)
- Consider role of new technology and new drugs
- The role of carers in providing care
- Bottom up design
- Flexibility in the model of care – may have to be iterative and opportunistic if transitional funding not available. Don't wait until everyone can do something before attempting change.
- Don't lose the memory of the past and what has gone wrong before, particularly in relation to engagement and consultation.
- Power of politics – have a work stream looking at how to 'sell' changes from the outset

The facilitator then summarised some issues that he felt were pertinent to taking the work forward:

- Resistance to change is normal – address it up front.
- Consider the role of clinical and professional leadership in changes
- Consider how we get the workforce to do what is needed rather than what they want to do
- Think about how changes will be implemented as you are identifying the changes needed

Recommendation

This document is to form the basis of a discussion to inform the choice of work streams to take this strategy forward.

D I Gozzard / 15th October 2008

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APPENDIX 2

Paper to North Wales Planning Forum, December 2008, Stakeholder Engagement to support North Wales Workstreams

Stakeholder Engagement to Support North Wales Workstreams

1 Overview

Recent Interim guidance issued on 7th October (*Guidance for Engagement and Consultation on Changes to Health Service*) outlined the interim process to be adopted by NHS Wales when reviewing health services which may result in service change. In line with the spirit and content of this interim guidance, this paper outlines the approach that it is proposed to adopt to ensure that stakeholder engagement is an integral part of the work of the 3 workstreams to be set up by the North Wales Planning Forum (NWPF). These proposals have been discussed and agreed with the 5 Chief Officers of the North Wales Community Health Councils.

A 'charter' for each workstream is being developed for agreement by the NWPF which outlines the specific question to be addressed; the process to be adopted (a modified version of the 90 day Research and Development Cycle); and, an outline of the membership of the 'core' group that will take forward the work. A summary of the three questions to be asked is given below –

Unscheduled Care – "How should the hospital element of unscheduled care in North Wales, be delivered?"
This workstream will examine the detailed service delivery model for hospital emergency care in North Wales taking into account the role of the three main hospital sites and Llandudno.

Mental Health – "What is the model for the delivery of adult mental health services in North Wales?"
This workstream will seek to define how adult mental health services will be delivered in North Wales in the future. The workstream will not include Learning Disability which will be addressed as a subsequent piece of work.

Community Services – "What is the model for community services in North Wales?"
This workstream will encompass primary care and community services and will seek to define the type of services that all residents in North Wales should expect to access in the future.

Attached to this paper is an outline of the modified 90 day cycle process that will be adopted. This indicates that there will be extensive stakeholder engagement before, during and the end of the modified 90 day cycle. In reality, this will therefore mean that the complete process will take 120 days.

This paper provides an overview of the modified 90 day cycle and describes the proposed process to ensure inclusive and proactive stakeholder engagement during the modified 90 day cycle. This includes clarifying those stakeholders that are to be engaged during the process.

2 Overview of Modified 90 day cycle

It is envisaged that the process will commence in February 2009 and will be completed by June 2009.

- The cycle will commence with a briefing meeting to which all stakeholders will be invited. This briefing meeting will be held in early February 2009. The aim of this briefing meeting will be to provide a wide understanding of both the reasons for and the remit of the 3 workstreams. Invitees to this briefing event will include (a) members of the three core workstreams; (b) members of an 'expert' group (see Section 3 below); and, (c) members of a wider stakeholder forum (see Section 4 below).
- Each of the three workstreams will then undertake the first 30 day 'block' of their work. The emphasis will be to gather and consider all the evidence relating to the work of the particular workstream, the evidence being local, national and international. At the end of the first 30 days, the work of the three workstreams will then be reported back over the course of one day first to the 'expert' group and then to the wider stakeholder forum for feedback, thoughts and views. There will then be a period of 14 days for the 'expert' group and wider stakeholder forum to provide feedback to the three core workstreams.
- The feedback from the Groups will then be fed into the second 30 day 'block' of work of each workstream .The focus of this second block of work will be to focus on the options for addressing and answering the specific questions given to each workstream. At the end of the second 30 days, the output of this element of the three workstreams work will again be reported back over the course of the same day first to the 'expert' group and then to the wider stakeholder forum for further feedback, thoughts and views. There will then be a period of 14 days for the 'expert' group and the wider stakeholder forum to provide feedback to the three core workstreams.
- In turn, this further feedback from the Groups will then be fed into the third 30 day 'block' of work for each workstream. At the end of the third 30 days, the output of the workstream which will include recommendations to address and answer the specific question set for each workstream, will then be reported back over the course of a day to all stakeholder groups: members of the core workstreams; the 'expert' group and the wider stakeholder forum. There will then be a period of 14 days for the 'expert' group and the wider stakeholder forum to provide feedback.
- The feedback gathered at this final stakeholder event (and the 14 days following the final event) will be included in the final recommendations that are then taken to the North Wales Planning Forum for discussion and/or endorsement.

It is proposed that to facilitate rapid feedback within 14 days following each 'report back' session, an electronic method of feedback is used. This will allow stakeholders the opportunity to record their comments and submit them to the core team. Comments will only be invited from stakeholder group members. Responses will be recorded in an electronic format which allows all interested parties to view the comments from all stakeholders and members of the 'expert' health group.

Any papers issued as a result of the 'report' back sessions to the 'expert' group and the wider stakeholder forum will be bilingual, with translation facilities also available at the 'report back' sessions.

The dates for the initial briefing session, all 'report back' sessions to the 'expert' group and the wider stakeholder forum, and the deadline dates for the wider '14 day feedback' will be issued to all interested parties in advance of the modified 90 day Research and Development cycle commencing.

3 The 'Expert' Group

The 'expert' group's key role will be to provide a gauge for the **applicability** of the ideas emerging from the work of the three workstreams. As such, this Group will act as a professional, multi-disciplinary 'barometer' of professional advice and guidance for the workstreams, providing a feasibility focus for the themes and issues emerging from the workstreams.

It is envisaged that this group will comprise mainly health service staff from across North Wales, inclusive of primary, community and acute staff, including staff side representatives. All clinical specialities encompassing all ages and conditions will be represented, as will all clinical and non-clinical support areas/departments. The Welsh Ambulance Services Trust will also be included in this group. The 'expert' group will also comprise members of the 6 Community Health Councils, Voluntary Services Councils and Social Services across North Wales. An 'expert' patient perspective will also be included in the 'expert' group, potentially by drawing on patients and members of the public already involved in existing patient and public involvement groups within NHS organisations across North Wales.

It is envisaged that both the CHCs and VSCs will be members of both the 'expert' group and the wider stakeholder forum to provide 'cross over' and consistency across both groups. As such, the CHCs and VSCs may wish to consider cross sharing their involvement in the 'expert' group and the wider stakeholder forum.

It is anticipated that the 'expert' group will comprise between 100 and 150 members, with meetings likely to be held at an external venue. There will be a need for expert facilitation of the 'expert' group (and also the wider Stakeholder Forum).

The 'expert' group will be brought together 4 times for a half day during the modified 90 day cycle and will receive feedback from all 3 workstreams. These four meetings are:

- An initial briefing session (intended for all stakeholders)
- After the first 30 days work of the three workstreams
- After the second 30 days work of the three workstreams
- At the end of the third 30 days work of the three worksteams (intended for all stakeholders)

Dates for all 4 meetings will be set and notified in advance.
It is anticipated that a record of the feedback provided by the workstreams and the discussions held at the 'report back' sessions will be documented from which a briefing document will be produced. This briefing document will be shared with the wider stakeholder forum and also issued to all members of the 'expert' group. These members can then use the briefing document to share the work of the workstreams with their existing professional networks to provide feedback within 14 days of each 'report back' session.

4 Wider Stakeholder Forum

The role of the wider stakeholder forum will be to provide a gauge for the **acceptability** of the ideas emerging from the work of the three workstreams. As such, this Group will act as a patient, general public and partner agency 'sounding board' for the output of the workstreams.

It is envisaged that the Stakeholder Forum will include between 100 to 150 individuals with the same external venue and facilitators used as those for the 'expert' group.

The stakeholder forum will include representatives from the following:
- 6 Community Health Councils
- 6 Voluntary Services Councils
- 6 Local Authorities (officials and elected members)
- Nominations from the 6 HSCWB Strategic Partnership Boards (or equivalents)
- Nominations from the 6 Children and Young People's Partnership Boards
- Nominations from the 6 Mental Health Strategic Partnership Boards
- Nominations from the 6 Community Safety Partnerships
- North Wales Race Equality Network
- Patient representatives from existing Patient and Public Involvement Groups within the 6 counties (to be different from those who will be members of the 'expert' patient group to ensure as broad an 'expert' patient perspective is provided as possible).
- Representatives from existing Carer Forums within the 6 counties
- North Wales Police
- North Wales Fire and Rescue service
- Representative of Care Forum Wales (independent sector)
- Representative of Domiciliary Care Providers
- Representative of Further/higher Education

The CHCs agreed that the proposed membership of the Stakeholder Forum would adequately represent both the partner and general public view for the purposes of the work in hand. The CHCs agreed that as the focus of the

workstreams will be on service principles – the what of the future models of care for the NHS in North Wales – rather than on the how (which may or may not imply service changes), the proposed membership of the wider Stakeholder Forum was satisfactory.

The stakeholder forum will be brought together 4 times for a half day during the modified 90 day cycle and will receive feedback from all 3 workstreams. These four meetings are:

- An initial briefing session (intended for all stakeholders)
- After the first 30 days work of the three workstreams
- After the second 30 days work of the three workstreams
- At the end of the third 30 days work of the three worksteams (intended for all stakeholders)

Dates for all 4 meetings will be set and notified in advance.

It is anticipated that a record of the feedback provided by the workstreams and the discussions of the 'report back' sessions will be documented from which a briefing document will be produced. This briefing document will be shared with the 'expert' group and also issued to all members of the Stakeholder Forum. These members can then use the briefing document to share the work of the workstreams within their existing networks to provide feedback within 14 days of each 'report back' session.

5 Potential Wider Public Engagement

Although as noted above, the CHCs felt that the membership of the Stakeholder Forum was adequate to ensure public representation, it was agreed that there is merit in exploring a further method of securing wider direct public engagement in the process proposed.

It was agreed with the CHCs that there may be three avenues for achieving this:

- Seek the support and advice of Participation Cymru as an expert organisation which has both the skills for engaging the public as well as a wide range of existing networks for engaging citizens across Wales. The involvement of Participation Cymru may depend on the capacity of this organisation to support the North Wales work within the timescales agreed.
- An alternative approach may be to seek the support of the 6 Voluntary Services Councils within North Wales in using their networks to seek the wider views of the general public.
- A third alternative means of securing wider public engagement may be to place an advertisement in the local press across North Wales to invite 'expressions of interest.

6 Actions

Based on acceptance by the NWPF of the proposals outlined in this paper, which have been agreed with the 5 CHCs across North Wales, the following actions are also recommended:

- Agree and issue all dates to support completion of the modified R and D cycle. The dates should be issued with at least 6 weeks notice of the first meeting taking place. Dates are required for: the initial briefing session; the three 'report back' sessions for the 'expert' group and the wider Stakeholder Forum; and for the 14 day 'feedback' deadlines following each 'report back' session.
- Arrange venues for all three 'report back' sessions for the 'expert' group and the wider Stakeholder Forum, ensuring a venue capable of accommodating up to 150 individuals at one time with adequate translation facilities.
- Secure the services of an expert facilitation organisation.
- Secure representation on the 'expert' group.
- Secure representation on the wider Stakeholder Forum
- Prepare a briefing pack for all core workstream members, and all members of both the 'expert' group and that wider Stakeholder Forum.

The membership of the three core workstreams will be agreed by each Chief Executive sponsor.

Institute for Healthcare Improvement
90-Day Research and Development Process

Why Test a New R&D Process?

The Institute for Healthcare Improvement (IHI) needed to create a quick way to research innovative ideas and assess their potential for advancing quality improvement. The new method was designed to produce innovation in a reliable and efficient manner, bringing new ideas to action. IHI created a small team with dedicated resources to test a new process — what we refer to as a 90-Day R&D Project — to deliver on this objective. This small team, known as the IHI R&D Team, begins five new projects every 90 days. Projects are selected by IHI's Senior Vice Presidents based on IHI's strategic plan and customer needs and suggestions.

Foundation

The 90-Day R&D Project is based in part on Proctor and Gamble's innovation method (Huston L, Sakkab N. Connect and develop. *Harvard Business Review*. March 2006:58-66). IHI's engine for research and development using the 90-Day R&D Project has the following characteristics:

- A specific question needs to be answered;
- A technical brief has been written that clearly states a problem;
- A network of innovators, along with other traditional methods (e.g., a literature search, prototype testing), is employed to find answers to the problem described in the technical brief;
- A specific time frame is established for investigation, in this case 90 days; and
- A decision is anticipated at the end of 90 days that can include a recommendation to launch a new program, integrate content into an existing program, hold on additional development, or run another R&D Project if further investigation is needed.

Components of an IHI 90-Day R&D Project

Every 90-Day R&D Project is divided roughly into three phases:

- Phase I (Scan): The initial 30 days of the project is spent scanning the literature and conducting key interviews with relevant individuals in organizations, both within and outside of health care, to determine the current landscape — to understand all the dimensions of the problem or issue. At the end of this 30-day period a solid technical brief is produced, including the aim of the project, a description of the current landscape, a set of theories for how to solve the problem, the specifications for an effective solution, and an annotated bibliography.

- Phase II (Focus): The subsequent 30 days is spent testing theories at the front line and refining ideas about what actually works — that is, enlisting health care organizations as prototype sites to help test and develop ideas.

A key activity at this stage is describing the key components of the system that perform "to specification." A goal of this phase is to transition from an early theory about how a new idea works (descriptive theory) to a tested and detailed understanding (normative theory) as described by Carlile and Christensen in *Practice and Malpractice in Management Research* (see Appendix A). IHI believes that one way to make this transition is to create a driver diagram (see Appendices B and C). A driver diagram is a kind of tree diagram, a tool to conceptualize an issue and its system components. The diagram also helps to demonstrate a pathway to achieve the desired outcome. At the conclusion of this phase of work in the 90-Day R&D Project, the technical brief is updated with a list of contacts, people with experience testing in the area, and outcomes of tests.

- Phase III (Summarize and Disseminate): The final 30 days are spent concluding tests, summarizing lessons learned, preparing a final report, and identifying appropriate dissemination products such as IHI programs and publications. The IHI R&D Team also prepares the handover of information gleaned during the project to others for the development of new programs, integration into existing programs, or conduct of further R&D. Project.

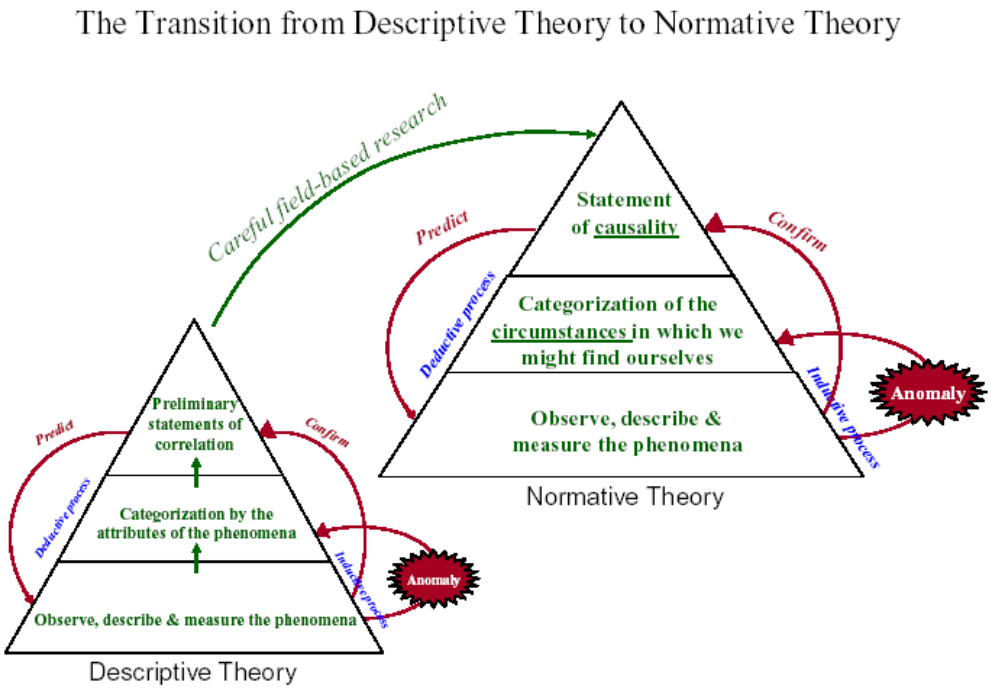
A general process map of 90-Day R&D Project is shown in Appendix D. Each project has a leader and co-leader from the IHI R&D Team. Throughout the 90-Day R&D Project, the project team reports their progress to and receives feedback from the larger IHI Innovation Group that includes the IHI R&D Team, members of the IHI management team, and faculty. Innovation is deeply embedded in IHI's strategy, and IHI leaders carefully attend to the linkages among the Innovation Group, the management team, and the front-line improvers who provide both testing sites and are consumers of R&D projects.

A list of completed 90-Day R&D Projects can be found in Appendix E.

Appendices

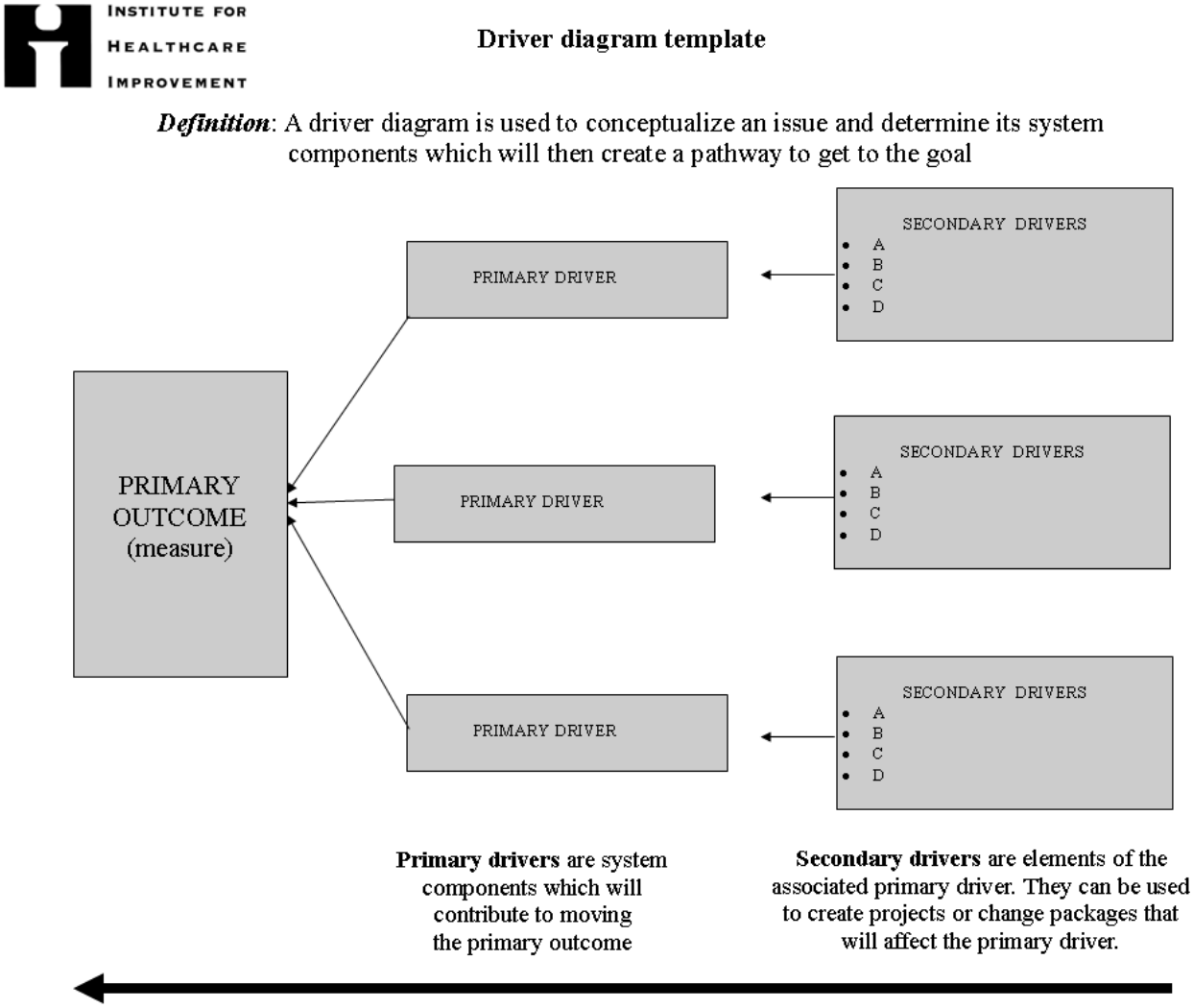
Appendix A: The Transition from Descriptive Theory to Normative Theory
Appendix B: IHI Driver Diagram Template
Appendix C: Example of a Driver Diagram
Appendix D: Generic Process Map for IHI 90-Day R&D Projects
Appendix E: List of Completed IHI 90-Day R&D Projects [see separate document]

Appendix A: The Transition from Descriptive Theory to Normative Theory



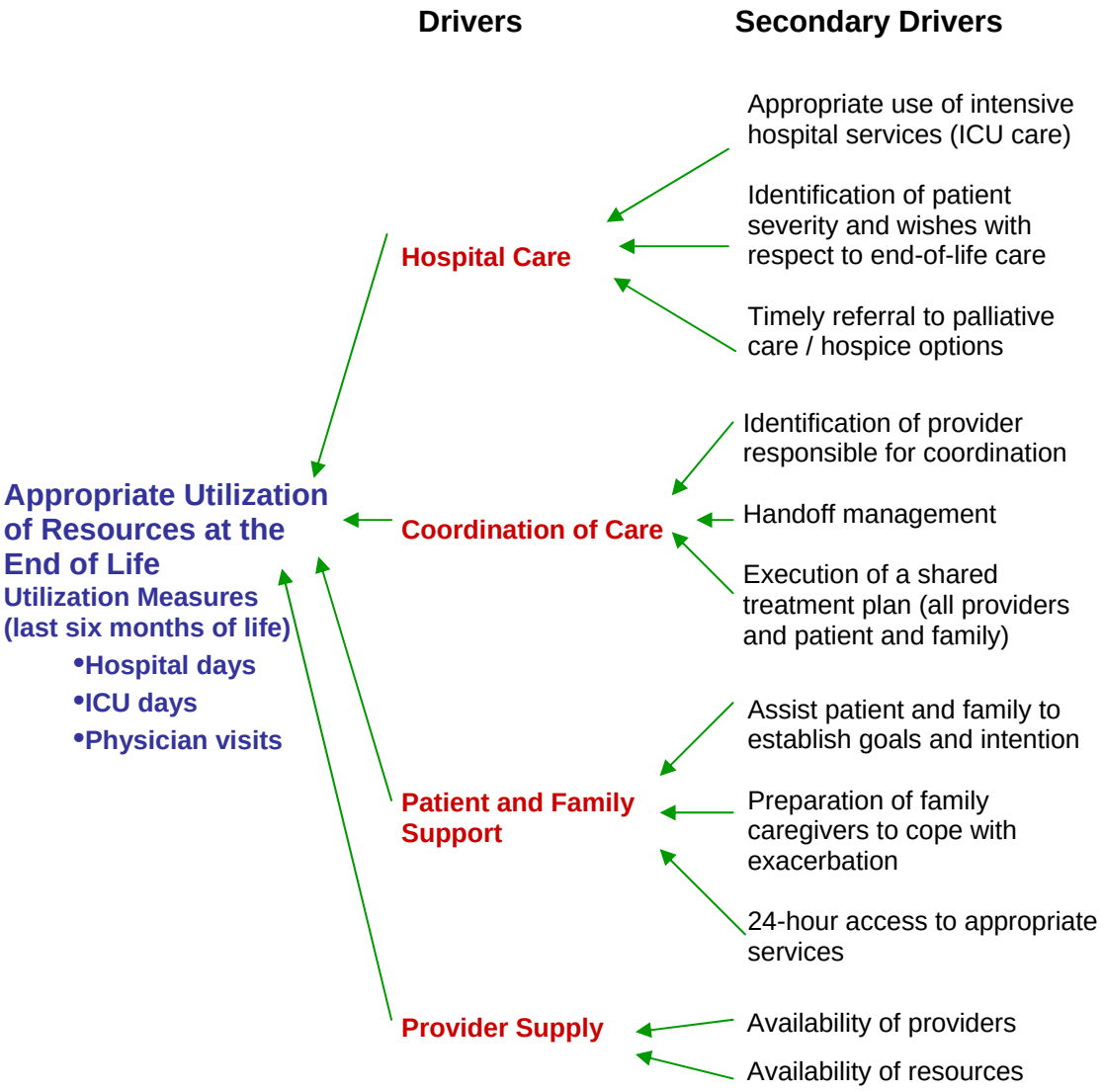
Source: Carlile PR, Christensen CM. *Practice and Malpractice in Management Research*. January 2005. Online information available at http://deming.ces.clemson.edu/pub/den/files/theory_paper_final_jan_06.pdf.

Appendix B: IHI Driver Diagram Template

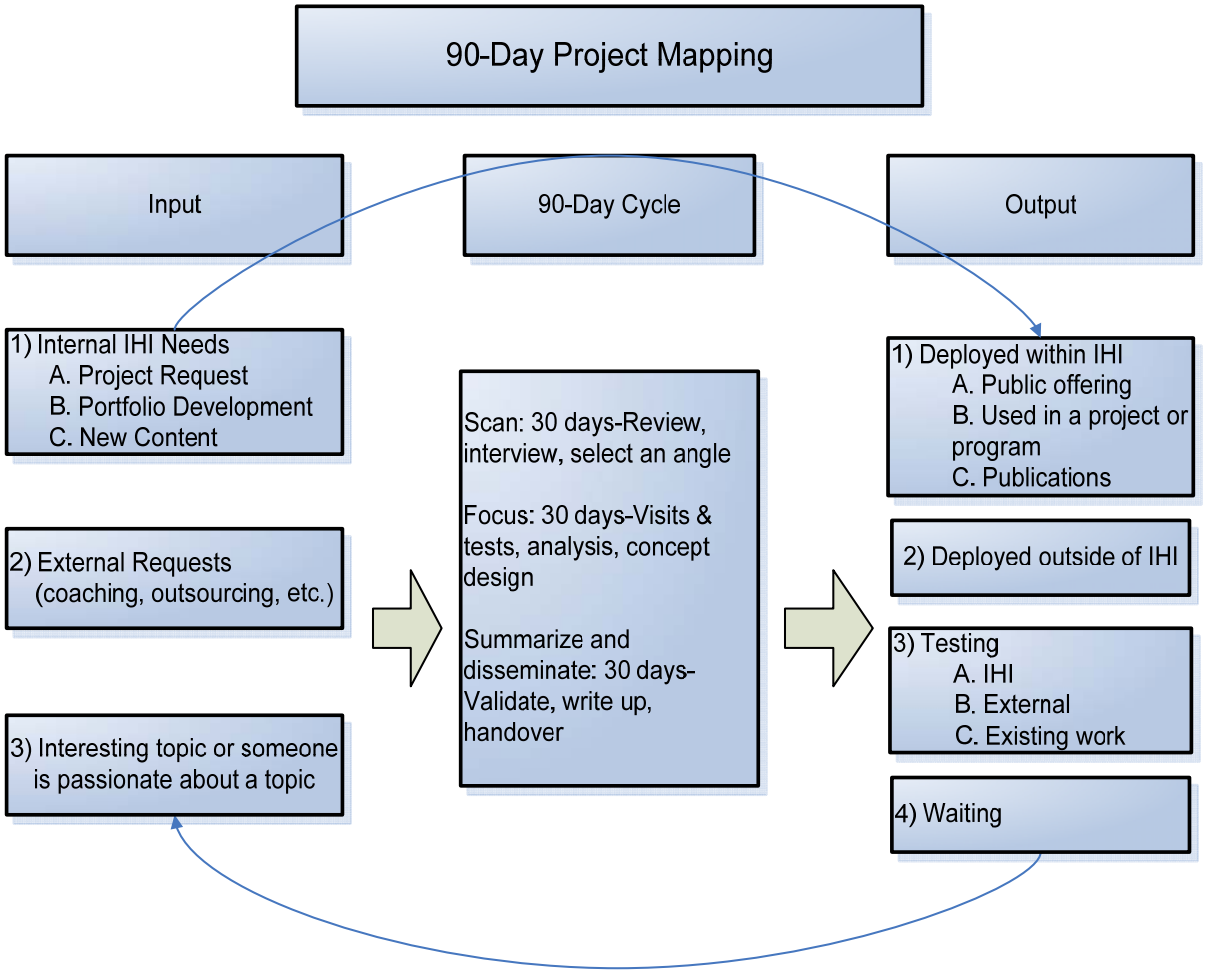


Appendix C: Example of a Driver Diagram

This driver diagram was developed as part of the IHI 90-Day R&D Project on resource utilization at the end of life (as measured by several *Dartmouth Atlas* measures).



Appendix D: Generic Process Map for IHI 90-Day R&D Projects



Appendix E: List of Completed IHI 90-Day R&D Projects

See separate document, available at:
http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/IHI90DayRandDProcess.htm.

APPENDIX 4
Q&A – 3 cycle s, AMs and MPs October

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

3 cycle clinical strategy engagement process
Questions and Answers

1. **What is the 3 cycle engagement process?**
   It is a modified research and development methodology that over 3 cycles, normally taking up to 120 days, identifies solutions to key questions. Evidence, information about services and public health data is brought together and discussed so proposals for service improvement can be developed. The methodology is consistent with the national ***1000 Lives Plus*** programme to reduce harm, variation and waste.

2. **Is the 3 cycle public consultation?**
   No, it is meaningful and genuine engagement with a wide and varied group of stakeholders. It is not public consultation.

3. **Who is involved?**
   Doctors (GPs and consultants), nurses, midwives, therapists, health scientists, administrative and clerical staff, supporting staff, patients, specialist interest groups, voluntary sector, local authority officers, Councillors, service users, carers, etc.

4. **How is this decided?**
   Each review has a project board of clinicians, managers, Community Health Council and Local Authority officers where relevant who discuss the question that needs to be answered. A range of people are then invited to participate in "stakeholder" events to come up with potential answers to the question. The range of people attending these events will depend on the subject being considered for example autistic spectrum disorder will involve certain clinicians and voluntary groups whereas surgical specialties will involve different people.

5. **How exactly does it work?**
   People are invited, information provided and then they are brought together in one place to talk about how services are organised, what international evidence there is on best practice and outcomes for people and through wide ranging discussion, ideas are generated for people to think about and consider.

6. **What happens at the end of the engagement process?**
   Solutions are then considered against a range of set of criteria – timeliness, access, safety, quality, equity. These are then presented to the University Health Board for discussion, debate and decision.

7. **Does public consultation happen automatically?**
   Not always. If the decision is not a change, then there will be no need for consultation. If the decision taken has a significant and material impact on how services are currently provided, then the Health Board will work with the Community Health Council to agree how best to formally consult with the public.

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Ysbyty Gwynedd, Penrhosgarnedd
Bangor, Gwynedd LL57 2PW **Gwefan:** www.pbc.cymru.nhs.uk **/ Web:** www.bcu.wales.nhs.uk

National Leadership and Innovation Agency for Healthcare
Asiantaeth Genedlaethol Arweiniad ac Arloesoldeb dros Ofal Iechyd

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Evaluation Report

Clinical Planning and Engagement in North Wales and use of the 90 day model

November 2009

Contents

1 Introduction

The National Leadership and Innovation Agency for Healthcare (NLIAH) agreed to support the partner organisations in the North Wales health and social care community in an evaluation of the '90 Day model'. The model was employed to achieve clinical and stakeholder engagement and planning in a programme of work carried out from February to June 2009 as preparation for a period of strategic service change.

The support from NLIAH was in the form of independent input from an external management consultancy and Finnamore Limited ("Finnamore") was chosen to provide that input.

Finnamore was founded in 1991 and has established a strong reputation for helping health and care organisations to identify and implement the best solutions to some of the most complex strategic and operational challenges. Our work encompasses all the issues encountered in health and social care today. The assignments we undertake cover the full spectrum including strategy development, strategic change management, organisational development, operational support and service improvement.

The lead partner organisations referred to above are the North Wales and North West Wales Trusts, Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham Local Health Boards (brought together as the Betsi Cadwaladr University Local Health Board), County Borough Councils, Community Health Councils and Voluntary Services Councils. The work was managed through the North Wales Reform Group.

This document is the final report prepared by Finnamore on completion of this evaluation assignment.

2 Executive Summary

Finnamore, a well established company with a strong reputation for helping health and social care organisations with strategic and tactical management consultancy assignments, has carried out an evaluation of the 90 Day model employed to achieve clinical and stakeholder engagement and planning in a programme of work carried out from February through to June 2009 as preparation for a period of strategic service change in North Wales.

The programme's intent, underpinned by the '90 day model', is to support the development of a robust model for primary care and community services, mental health services and the hospital element of unscheduled care to inform the development of a North Wales Service Strategy.

In each of these priority areas a specific question to be answered by the overall programme was defined as follows:

Primary Care and Community Services

"How do we deliver the model for primary and community services in North Wales?"

Mental Health

"How can we improve the quality of our current care for people with mental health needs in North Wales?"

Unscheduled care

"How should the hospital element of unscheduled care be delivered in North Wales?"

It was decided that the appropriate method for clinical and stakeholder engagement and planning should be in line with interim guidance issued by the Welsh Assembly Government on 7 October 2008 (Guidance for Engagement and Consultation on Changes to Health Services). This outlined the interim process to be adopted by NHS Wales when undertaking health service reviews that may result in changes to those services.

Dr David Gozzard, an advocate of innovation and clinical engagement, had put forward the '90 day R & D model' as a general approach for carrying out such clinical and stakeholder engagement and planning. This model was modified after discussion, in particular to fit the requirements of the interim guidance.

Finnamore has carried out the evaluation by answering five questions provided in the Terms of Reference (TOR) originally provided by NLIAH:

1. Did the circumstances faced by the North Wales Health Community merit a major strategic engagement exercise?
2. Was the chosen method suited to the task? Including:
   - 2.a. Did clinicians and stakeholders find the engagement process meaningful and beneficial?
   - 2.b. What was the experience of those working in the core groups?
3. Was the work undertaken appropriately?
4. Does the work fit with current Welsh Assembly guidance on involvement and consultation?
5. Could this process be used in the future?
   - 5.a. How can the model be improved for future use?
   - 5.b. What capacity/skills are needed for self sufficiency in North Wales?

Our approach was to research existing programme documentation and conduct telephone interviews to gather information related to the five TOR questions.

The Finnamore review also encompassed the three Office for Public Management (OPM) reports to the North Wales Reform Group covering the three phases of the 90 day programme and the stakeholder events held in April, May and June 2009, focussing in particular on the feedback from participants.

After gathering the information and feedback, it was analysed and reviewed; conclusions and recommendations were identified to be included in this report and discussed with the parties concerned.

From the interviews undertaken and documentation reviewed, we can confirm a positive conclusion in our evaluation of the 90 day model with respect to the clinical and stakeholder engagement and planning programme in North Wales. All five questions from the Terms of Reference (TOR) are answered in the affirmative.

Also, we believe that carrying out such a thorough exercise within the timescale even in one of the areas chosen, let alone three areas, would have been a major task. To carry out all three with the resulting outcomes to date has been a major achievement.

The work was undertaken appropriately in a very diligent, conscientious and professional way even though there was a huge amount to do in a very tight timescale.

In summary, the 90 day model was completed in line with the WAG guidance and professionally applied and completed in this major programme, resulting in significant clinical and stakeholder engagement, which produced excellent outcomes and future potential.

3 Background

3.1 Strategic planning in North Wales

The intent of the overall programme of work underpinned by the '90 day model' was to support the development of a robust model for primary care and community services, mental health services and the hospital element of unscheduled care to inform the development of a North Wales Service Strategy.

The Acute Services Review of 2006, culminating in the document *Designed for North Wales*, delivered a vision of services and estate for NHS North Wales that has been criticised in some quarters for being too acute focussed.

A one-and-a-half day seminar on clinical strategy was held in North Wales in October 2008, which produced a degree of consensus on the direction for clinical service development, but also highlighted several priority areas which were deemed to require further discussion and clarification.

The first three of these priority areas were agreed by the North Wales Reform Group and in each case the specific question to be answered by the programme was defined as follows:

Primary Care and Community Services

"How do we deliver the model for primary and community services in North Wales?"

This project team encompassed primary care and community services and sought to define the type of services that all residents in North Wales should expect to access in the future.

Mental Health

"How can we improve the quality of our current care for people with mental health needs in North Wales?"

This project team sought to define how adult mental health services will be delivered in North Wales in the future. The project team's remit did not include learning disability services, which it was agreed would be addressed as a subsequent piece of work.

Unscheduled care

"How should the hospital element of unscheduled care be delivered in North Wales?"

This project team explored what the best model for the delivery of the hospital element of unscheduled care in North Wales should be, taking into account the role of the three main acute hospital sites and Llandudno hospital.

For these areas, there was general agreement on the need to develop service principles and a model (or models) of care for North Wales that also had a local focus.

3.2 Stakeholder engagement

Interim guidance issued on 7 October 2008 (Guidance for Engagement and Consultation on Changes to Health Service) outlined the interim process to be adopted by NHS Wales when undertaking health service reviews that may result in service changes.

It was decided that the appropriate method to carry out clinical and stakeholder engagement and planning should be in line with this interim guidance to ensure that it was an integral part of the work of the three project teams to be set up by the North Wales Reform Group (NWRG) to review the three areas defined in 3.1 above.

3.3 The 90 day model – description

Dr David Gozzard (then the Medical Director, North Wales NHS Trust), an advocate of innovation and clinical engagement, had put forward the '90 day R & D model' as a general approach to clinical and stakeholder engagement and planning. This model was modified after discussion, in particular to fit the guidance requirement as in 3.2 above regarding stakeholder engagement.

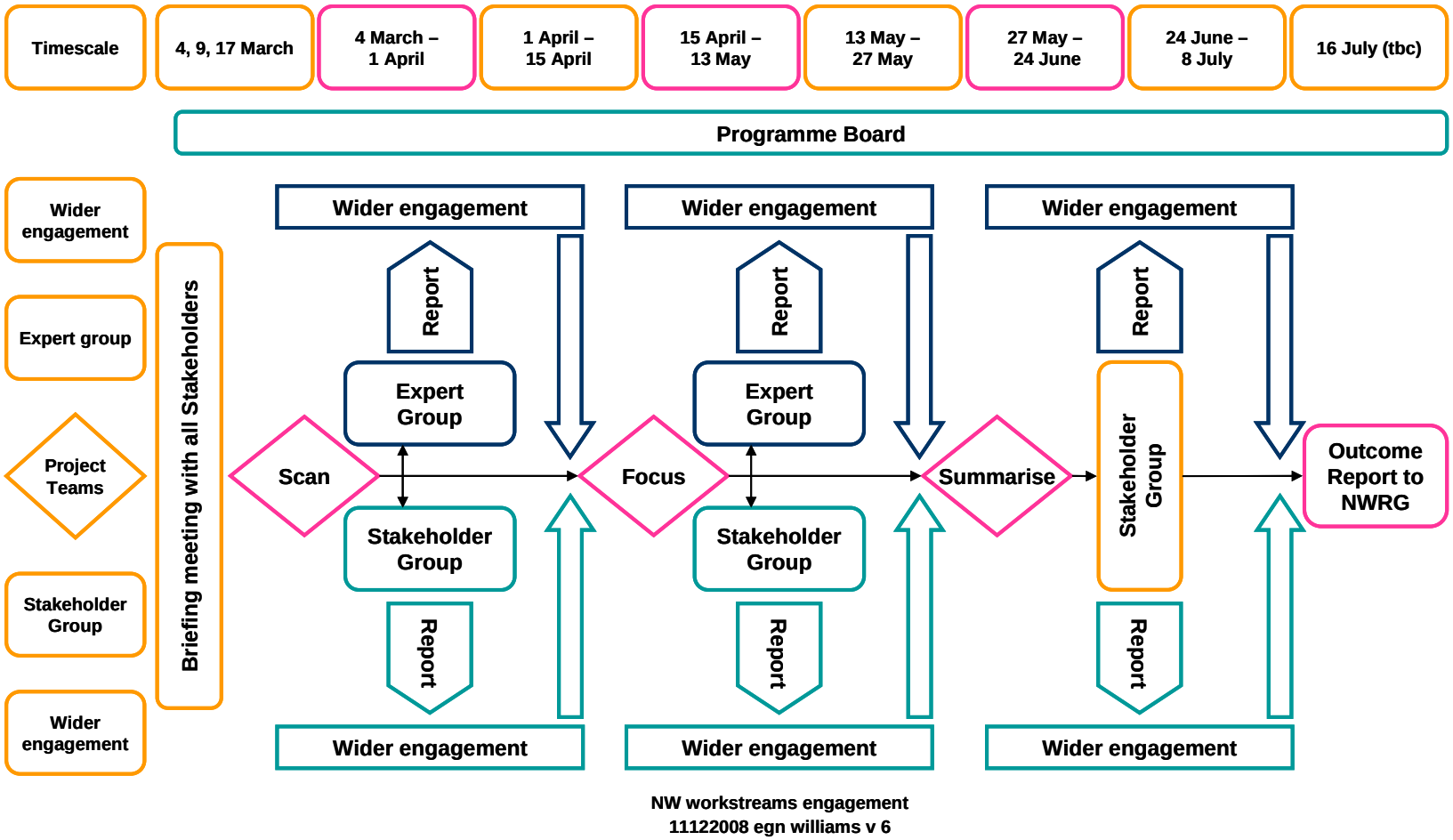
The process commenced in February 2009 and was due to be completed by July 2009. The process adopted was described as follows [Reference: Appendix B (i) item 2 Overview of modified 90 day cycle of the final Project Initiation Document dated March 2009]:

- The cycle will commence with a briefing meeting to which all stakeholders will be invited. This briefing meeting will be held in early February 2009. The aim of this briefing meeting will be to provide a wide understanding of both the reasons for and the remit of the 3 project teams. Invitees to this briefing event will include (a) members of the three core project teams; (b) members of an expert group (see Section 3 below); and, (c) members of a wider Stakeholder Group (see Section 4 below).
- Each of the three project teams will then undertake the first 30 day 'block' of their work. The emphasis will be to gather and consider all the evidence relating to the work of the particular project team, the evidence being local, national and international. At the end of the first 30 days, the work of the three project teams will be reported back over the course of one day - first to the expert group and then to the wider Stakeholder Group for feedback, thoughts and views. There will then be a period of 14 days for the expert group and wider Stakeholder Group to provide feedback to the three core project teams.
- The feedback from the groups will then be fed into the second 30 day 'block' of work of each project team. The focus of this second block will be the options for addressing and answering the specific questions given to each project team. At the end of the second 30 days, the output of this element of the three project teams work will again be reported back over the course of the same day, first to the expert group and then to the wider Stakeholder Group for further feedback, thoughts and views. There will then be a period of 14 days for the expert group and the wider Stakeholder Group to provide feedback to the three core project teams.
- In turn, this further feedback from the Groups will be fed into the third 30 day 'block' of work for each project team. At the end of the third period of 30 days, the output of the project team, which will include recommendations to address and answer the specific question set for each project team, will be reported back over the course of a day to all stakeholder groups: members of the core project teams, the expert group and the wider Stakeholder Group. There will then be a period of 14 days for the expert group and wider Stakeholder Group to provide feedback.

- The feedback gathered at this final stakeholder event (and the 14 days following the final event) will be included in the final recommendations taken to the North Wales Reform Group for discussion and/or endorsement.

NOTE: a diagram of the 90 day model is shown in the following section 3.4 [Reference: Appendix E (i) Overview of modified 90 day cycle of the final Project Initiation Document dated March 2009].

3.4 The 90 day model – diagram



4 Finnamore approach to the assignment

4.1 Terms of reference questions

The high-level approach adopted by Finnamore has been to address specifically the following five questions as listed in the Terms of Reference (TOR) provided by NLIAH:

1. Did the circumstances faced by the North Wales Health Community merit a major strategic engagement exercise?
2. Was the chosen method suited to the task? Including:
   - 2.a. Did clinicians and stakeholders find the engagement process meaningful and beneficial?
   - 2.b. What was the experience of those working in the core groups?
3. Was the work undertaken appropriately?
4. Does the work fit with current Welsh Assembly guidance on involvement and consultation?
5. Could the process be used in the future?
   - 5.a. How can the model be improved for future use?
   - 5.b. What capacity/skills are needed for self sufficiency in North Wales?

4.2 Method

Our approach was to research existing programme documentation and undertake telephone interviews to gather information related to the five TOR questions in the following way:

- Questions 1 & 4 in 4.1 above to be addressed together first and to be considered with respect to the three priority areas:
  - Primary care and community services
  - Mental health
  - The hospital element of unscheduled care
- Questions 2 & 3 in 4.1 above to be addressed together by document review and discussion with identified individuals.

- The final question (number 5 in 4.1 above) to be addressed to determine the 'what next' i.e. to understand the intentions, components, strategies and desired outcome of the 90 day model.

After gathering the information and feedback, it was analysed and reviewed; conclusions and recommendations were identified to be included in this report and discussed with the parties concerned.

4.3 Telephone interviews

Telephone interviews were conducted with the following people (role and job titles relate to positions held in NHS North Wales organisations prior to the creation of the Betsi Cadwaladr University Local Health Board):

- Jane Jones, Project Lead, Mental Health

Joint Strategic Commissioning Manager, Mental Health and Social Care, Conwy and Denbighshire

Email: jane.jones@denbighshirelhb.wales.nhs.uk

Tel: 01745 586425

- Clare Jones, Project Lead, Primary & Community Care

Director of Development and Performance Management, Gwynedd LHB

Email: clare.jones@gwyneddlhb.wales.nhs.uk

Tel: 01286 674242

- Ian Howard, Project Lead, Unscheduled Care

Deputy Director, Strategy Planning and Development, North Wales NHS Trust

Email: ian.howard@wales.nhs.uk

Tel: 01745 589620

- John Darlington, Programme Manager

Director, North Wales Regional Commissioning Unit

Email: john.darlington@wrexhamlhb.wales.nhs.uk

Tel: 01745 589601

- Ellen Greer, Engagement Lead

Associate Director, Head of Planning (Corporate) North Wales NHS Trust

Email: ellen.greer@cd-tr.wales.nhs.uk

Tel: 01745 589970

- Neil Bradshaw, Member of the Programme Board

Director of Strategy, Planning and Development, North Wales NHS Trust

Email: neil.bradshaw@wales.nhs.uk

Tel: 01745 589620

- Geoff Lang, Chief Executive, Wrexham LHB & Director of Primary Care and Community Partnerships, North Wales NHS Trust

Email: geoff.lang@wales.nhs.uk

Tel: 01978 346508

NOTE: The assignment focused on the work of NHS bodies and also included consideration of the three reports produced by the Office of Public Management, which captured the views of stakeholders involved.

5 Interview feedback and Finnamore view

A summary of the information gathered and feedback received during the telephone interviews has been reproduced below under the five TOR question headings:

5.1 Did the circumstances faced by the North Wales Health Community merit a major strategic engagement exercise?

- The St. Asaph North Wales event in October 2008 highlighted a number of priority service areas that merited further exploration with stakeholders, from which three initial service areas were identified: the hospital element of unscheduled care, mental health services; and primary care and community services.
- Given that six LHBs and two Trusts were coming together it was clear that 'partnership' was the key issue to be addressed in looking at the three priority areas. Many felt that the *Designed for North Wales* programme had been too acute focussed and had not taken equal account of primary and community care services.
- There was increasing concern about mental health services, not least because several major incidents had occurred. There was concern that there appeared to be no agreed vision for North Wales mental health services. It was also felt that, due to the range of different organisations involved, there were six different ways of delivering services across North Wales, plus further differences in the rural areas.
- The need to address issues facing the hospital elements of unscheduled care in North Wales were believed to be fundamental strategic issues, such as the number of A&E departments in North Wales.
- In primary care and community services, the engagement needed to include the six Local Authorities and 'locality working' was seen to be a significant issue to resolve.
- The need to agree a strategic model of services across North Wales was believed to be fundamental to planning services locally and to managing service risks within this.

- There had been a political shift in Wales with much more emphasis placed on those providing services to 'listen' more and to ensure that all stakeholders, including the public, have a strong voice.
- There was a need to strengthen and enhance a strategic approach to the planning of services across North Wales.

Finnamore view

The circumstances faced by the North Wales health and social care community certainly did merit a major strategic engagement exercise. The summary bullet points above speak for themselves in this regard. Also, the timing for such an exercise was excellent with respect to the new organisation created in North Wales, the Betsi Cadwaladr University Local Health Board, which became operational in October 2009.

5.2 Was the chosen method suited to the task?

- The process chosen showed everybody that a serious approach was being undertaken, that they were truly part of an 'engagement' process and this definitely provided reassurance.
- What was planned to be done was done – the 90 day model was followed in line with the PID.
- The stakeholder events generated excitement, although there was a realisation that the process was being delivered in a tight timeframe with a huge work requirement.
- It became clear that a key issue for everyone, and particularly clinicians, was how to fit in the work requirement and still do the day job!
- The translation requirement and associated timescale made timing even tighter.
- Using the 90 day model gave 'process and pace' to the programme.
- The 90 day model ensured that the programme was being carried out 'with' people and not 'to' people, which was definitely different from traditional approaches where decisions had already been taken regardless of what surfaced in the programme.

- The chosen method did ensure balanced input and very active engagement – clinical and stakeholder involvement is difficult to get right and, arguably, whilst not perfect it was achieved here.

Finnamore view

The chosen method was suited to the task in general but this was a massive undertaking. To carry out such a thorough clinical and stakeholder engagement and planning exercise even in one of the areas chosen within the timescale, let alone three areas, would have been a major task. To carry out all three with the resulting outcomes to date has been a major achievement and, to our knowledge, has not been carried out elsewhere in Wales.

5.2.1 Did clinicians and stakeholders find the engagement process meaningful and beneficial?

The membership of the three project teams and the overarching Programme Board included clinicians and stakeholders, with extensive clinician and stakeholder engagement also secured through the three stakeholder events. Although direct contact with clinicians and stakeholders did not form part of the work undertaken by Finnamore, there was a review of the detailed reports produced by the Office of Public Management, which contained feedback given by clinicians and stakeholders at each of the three engagement events.

From this, it is possible to draw a number of conclusions about whether clinicians and stakeholders found the engagement process meaningful and beneficial.

- Clinicians and stakeholders turned up to events and kept turning up, indicating a commitment to the process.
- The overall impression gained was that the process was seen by clinicians and stakeholders to be meaningful and beneficial, although there were some caveats in the sense that people wanted to see evidence of having been listened to in the implementation of service changes made as a result of the work undertaken. The proof of the pudding….
- Clinicians and stakeholders found the timescale demanding, particularly regarding time to feedback. Some felt the pace was too fast.

- Time was undoubtedly spent during the programme talking with clinicians and stakeholders across North Wales, although there was a view that, for some clinical and stakeholder groups, representation could have been wider.
- Clinician and stakeholder feedback was predominantly positive. There were many positive comments about how well the process had worked, how stimulating the discussion had been and how good it was to see many people coming together to share ideas. However, people commented on the lack of time to absorb the volume of information and debate the issues. Negative comments that were made seemed to born mainly of general cynicism about the effectiveness of such processes.

Finnamore view

From reviewing the Office of Public Management reports, the general feeling is that clinicians and stakeholders did find the process meaningful and beneficial. Some issues were raised that should inform future engagement processes, mainly relating to concerns about the tight timescales, the difficulty of finding time to read papers and contribute to the debate and the need to ensure wider representation in some areas.

5.2.2 What was the experience of those working in the core groups?

These are some of the specific comments made:

- Challenging, interesting, hard work which actually became full-time and then some!
- People worked well together and the three workstream approach provided a real advantage overall because these areas are definitely intertwined.
- Extremely hard work to hold the events, translate and issue information – would be difficult to sustain over time.
- Very positive and constructive overall but rushed with day jobs to do, time pressured all the time making it a big commitment.
- Enabled range of people to meet and mix who would not otherwise have had that opportunity.

- Core teams brought together very quickly; with more time, establishing expectations and team building could have been done from the start – in certain cases some people did not stay tightly involved whilst others then focused more.
- Executive buy-in not always visible.
- People feel privileged to have been involved.

Finnamore view

The experience of those working in the core groups has been extremely positive. As mentioned, our view is that this was a massive undertaking and required huge effort and commitment from those involved, particularly in the core groups. The experience gained is substantial which can now be built upon in the new organisation. This can all be summed up by words from one person who said they felt privileged to have been a part of the programme.

5.3 Was the work undertaken appropriately?

- Much time was taken before the process commenced in ensuring that the questions explored by the three workstreams were the right questions which would lead to the right outcomes for services in North Wales. This is a key learning point.
- The process was sound, particularly the close working with clinicians and stakeholders. However, a learning point may be to allow more time for feedback after each engagement event to allow stakeholders more time to consult within their networks.
- The PID and 90 day model were followed and activities undertaken professionally.
- It was real consultation with real debates.
- A further learning point may be to consider at the outset the complexity of the issues being addressed which may not all be of equal scope. This may mean that, if more than one workstream is being managed at the same time, the timescales for each workstream may need to be different to reflect different levels of complexity and sensitivity.

Finnamore view

This is a logical process and the work was undertaken appropriately in a very diligent, conscientious and professional way even though there was a huge amount to do in a very tight timescale. Much has been learned and will be applied in future engagements, including:

- Ensuring that enough time is spent at the outset to ask the right questions.
- Providing more time for clinician and stakeholder feedback between engagement events.
- Retain a degree of responsiveness and flexibility within the process, for example considering the need to extend or shorten the timescales set for the workstreams to complete their work as appropriate.

5.4 Does the work fit with current Welsh Assembly guidance on involvement and consultation?

- The interim guidance document of October 2008 [Reference: Ministerial Letter ML 016 08 Revised Interim NHS Consultation Guidance October 2008] was reviewed and discussed in detail with respect to the clinical engagement and planning programme at a very early stage prior to the Project Initiation Document (PID) being developed.
- Dr Gozzard had put forward the 90 day R&D model, which was modified for this programme particularly to include wide engagement (deemed necessary because major changes were expected to be identified out of the engagement) and checked as a fit with the interim guidance document.
- The interim guidance document stresses that engagement should commence at the outset of any discussion about service change and should be an ongoing process throughout the work being undertaken, irrespective of whether a public consultation process is ultimately required or not. Prior to being adopted, the proposed engagement approach was discussed and agreed with the five Community Health Councils as is consistent with the spirit and intent of the guidance.

- It was felt that the seven steps detailed in the guidance were embedded in the modified 90 day model, at the very least in the spirit of the guidance, e.g. extra steps had been included in the modified 90 day model to include stakeholder feedback.

Finnamore view

We are comfortable that the work does fit with the (then) current guidance on engagement and consultation. The work of the 90 day cycle and the engagement of clinicians and stakeholders from across North Wales from the outset of the service reviews undertaken is consistent with WAG guidance. Should there ultimately be a need for a formal public consultation exercise as a result of the work undertaken, WAG would expect those involved to demonstrate that stakeholders had been involved during all stages of the work, particularly in the early pre-consultation stage. This was the intent of the engagement process adopted here.

5.5 Could the process be used in the future?

- The principle is sound, it is a good process overall but very challenging to carry out.
- The issues to be addressed in North Wales needed this type of approach and people have accepted it as 'the process' to be adopted.
- The huge workload must not be underestimated.
- Clinical and stakeholder engagement and planning on a large scale is expensive to carry out and this did have substantial cost – up to 400 people attended three events.
- This process ensured that people were 'brought along' from the outset of the programme.
- The model should be used but adapted as required e.g. for broader public engagement when required.
- The core groups of the three areas are now at different positions and may or may not require further engagement work to be undertaken along the same lines: in mental health the next step is to implement the strategic direction developed, whereas in unscheduled care there is more work to do which will require further engagement with clinicians and stakeholders.

- Huge learning has come from the programme using the 90 day model which can now be built upon.

Finnamore view

We believe it is appropriate to adopt the process for future service reviews to ensure active and inclusive engagement of clinicians and stakeholders from the outset. This should be informed by the huge learning gained. When used in the future, the process should be adapted to fit the situation and requirement, specifically to fit the 'question' being addressed.

5.5.2 How can the model be improved for future use?

- Ensure that sufficient time is spent on getting the question correct before the process commences.
- Adjust the length of time required to complete the process, depending on the topic/issue to be addressed and its complexity.
- Language translation needs to be factored in and timescales increased accordingly.
- Capacity/resource needs to be addressed – needs to be someone's day job, e.g. might be specific part of a planning post responsibility.
- Massive logistics to be managed need specific resource, otherwise senior staff end up doing it with knock-on effects on other functions.
- Ensure that a robust equality monitoring process is built into the work to provide assurance that the clinicians and stakeholders involved are as representative as possible of the wider population.
- Ensure that an equality impact assessment process is embedded in the work of the project teams from the outset.
- Ensure that venues used for engagement events are fully accessible for all stakeholders.
- Recognise that engagement has a significant resource implication, not only in terms of people's time (both those directly involved as well as that of the clinicians and stakeholders) but also in terms of the resources required for production of materials, including ensuring these are bilingual, and hiring of suitable venues accessible to all stakeholders.

Finnamore view

The model can definitely be improved for future use and some examples are included in the summary of this section above. A more detailed description is included in the recommendations - Section 7 of this document.

5.5.3 What capacity/skills are needed for self sufficiency in North Wales?

- The main issue is appropriate resources – the skills already exist.
- Some training/mentoring is required, e.g. facilitation. The events need to be made different and interesting each time to keep people involved and engaged.
- Dedicated administration staff.
- Communication of messages is a critical element and there are external experts outside the NHS who could be used rather than trying to do everything in-house. The public perception of the objectivity and independence of an external organisation could be important.
- Needs to be looked at with respect to the new organisations emerging in Wales.
- Such programmes and implementation of the 90 day model are a major undertaking and cannot be 'bolted on'.
- Depending on the topic/issue to be addressed with each programme, might need specific skills such as professional (knowledge of clinical drivers), business cases, health economics, finance, HR, estates, which could be seconded/contracted.

Finnamore view

Achieving self-sufficiency is primarily an issue of resources. Such a massive undertaking cannot be sustained on an on-going basis. The commitment required from those involved was huge and this was on top of the 'day job' as many of those involved commented. Such work should be carried out by dedicated resources where it is the day job and the required skills can be built up and transferred throughout the team to achieve continuous improvement of the process and its implementation to carry out such engagement programmes effectively.

Recognition is also required that there is a significant resource implication to supporting wide scale engagement of stakeholders from the outset of any service review or change.

Finnamore's experience of engagement and consultation exercises elsewhere, particularly where there are potentially contentious issues to be addressed or they are likely to lead to significant change, is entirely consistent with this conclusion. It is important that such exercises are conducted rigorously and in a way that is demonstrably open and inclusive but the costs of doing so are considerable.

6 Conclusion

From the interviews undertaken and documentation reviewed, including the OPM reports following the stakeholder events, we can confirm a positive conclusion in our evaluation of the 90 day model with respect to the clinical and stakeholder planning and engagement programme in North Wales. All five questions from the Terms of Reference (TOR) are answered in the affirmative:

- The circumstances faced by the North Wales Health community certainly did indeed merit a major strategic engagement exercise.
- The modified 90 day model was suited to the task.
- The work was undertaken appropriately in a very professional, detailed and diligent manner.
- The approach did fit with current Welsh Assembly guidance on involvement and consultation.
- It is appropriate to continue with the process as a general approach to be adapted as required given the programme to be addressed.

Also, to reiterate an earlier statement - to carry out such a thorough clinical and stakeholder engagement and planning exercise even in one of the areas chosen within the timescale, let alone three, would have been a major task; to carry out all three with the resulting outcomes has been a major achievement. The work was undertaken appropriately in a very diligent, conscientious and professional way even though there was a huge amount to do in a very tight timescale.

A key activity for Finnamore is the transformation of pathways and processes in the NHS and associated health organisations. This is achieved carrying out a repeatable methodology which includes advanced facilitation techniques. A foundation of this approach is to carry out the engagement with front-line staff working ‘with’ them and not dictating ‘to’ them. We are therefore pleased to see that these elements are inclusive within the 90 day model.

We have also learned by experience that the best results come from applying our core approach in a 'situational' manner, i.e. that each time we are to apply the methodology we need to take account of the detailed situation we are working within and the specific goal of the overall assignment or programme. Again we are pleased to see that these elements are also included within the 90 day model.

In summary, the 90 day model was delivered in line with the WAG guidance and professionally applied and completed in this major programme, resulting in significant clinical and stakeholder engagement and planning which produced excellent outcomes and future potential.

7 Recommendations

Our recommendations are as follows, split into five categories:

1. Staff resources

- Define and assign specific resources so that this is their day job.
- Ensure that these resources include specific logistics resource to avoid this work all being undertaken by more senior staff.
- Identify other resources to support the staff, including resources required to hire accessible venues and ensure that all events and all materials produced are bi-lingual.

2. Process

- Ensure that sufficient time is spent 'up front' before the process commences to ensure that the right questions are being asked.
- Adapt the process timescales to take account of the topic/issue to be addressed and the complexity of the question to be answered. This includes the complexity and detail of documentation being reviewed.
- Depending on the complexity of the work, adapt the process to allow extra time for language translation; for feedback from stakeholders after each engagement event; and time to read the documents prior to each engagement event.
- Embed equality impact assessment monitoring into the work of the individual project teams.
- Formalise the existing (90 day) model and assign it a version number for review and updating towards continuous improvement.
- Ensure that the model and process includes the use of latest techniques for group workshop facilitation/engagement.

3. Engagement of Stakeholders

- To help support active and inclusive engagement of all stakeholders from the outset, ensure this is as representative as possible through the use of equality monitoring documentation.
- Technology can also assist as part of the engagement process e.g. self-completed consultation using the Internet
- Ensure all venues used for face to face engagement are accessible for all stakeholders.

4. Skills (for self-sufficiency)

- Define specific skills to be developed in-house to include the latest facilitation techniques particularly for group workshop collaboration.
- These skills to be built using learning through doing and knowledge/skills transfer and mentoring rather than multiple training courses.
- Identify techniques and tools (paper-based and software-based) to assist with the capture and communication of information and ideas which are highly visual for maximum communication and collaboration.

5. Materials resources – information/articles/journals/books/tools

- Take advantage of Information based on clinical engagement initiatives and programmes available for general access on the internet; an excellent source is the NHS Institute for Innovation and Improvement which also lists specific articles/journals and books on the topic

http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/clinical_engagement.html.

Betsi Cadwaladr University Health Board **Board Paper 25.3.10 Item 10/031.2**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Subject:	**North Wales Clinical Strategy - The Hospital Element of Unscheduled Care**

Summary or **Issues of Significance**	This paper outlines the strategic conclusions to the question: "How should the hospital element of unscheduled care be delivered in North Wales?" It makes a set of specific recommendations about the model of care and the next steps, for Board approval.

Strategic Theme / Priority addressed by this paper	The paper addresses a fundamental strategic issue for the shape of services in North Wales.

Legislation or Healthcare Standard:	This project is relevant to all four domains of the Healthcare Standards.

Evidence base or other relevant information to inform decision (e.g risks)	As highlighted in the paper, the recommendations are founded on a substantial evidence base which is available in full on the project website (http://www.wales.nhs.uk/sites3/home.cfm?orgid=837)

Consultation with others:	This piece of work has been undertaken with substantial internal and external stakeholder engagement, as outlined in the report.

Equality Impact Assessment (EqIA)		
	Has EqIA screening been undertaken?	Y
	Has a full EqIA been undertaken?	N

Recommendations:	The Board is asked to support the recommendations outlined in the paper.

Author(s)	Ian Howard

Presented by	Neil Bradshaw

Date of report	11th March 2010

Date of meeting	25th March 2010

North Wales Clinical Strategy - The Hospital Element of Unscheduled Care
Betsi Cadwaladr University Health Board Report March 2010

Situation

As part of the development of a North Wales Clinical Strategy, a project has been undertaken to address the following question:

"How should the hospital element of unscheduled care be delivered in North Wales?"

This paper outlines the conclusions of this piece of work, and makes a set of specific recommendations for Board approval.

Background

A successful 1½ day seminar on clinical strategy was held in North Wales in October 2008. This produced a substantial degree of consensus on the direction for clinical service development, but left certain priority areas to be resolved. It was therefore agreed to undertake strategic reviews of the model of care to answer the three following questions:

- How do we deliver the model for primary and community services in North Wales?
- How can we improve the quality of our current care for people with mental health needs in North Wales?
- How should the hospital element of unscheduled care in North Wales be delivered?

The methodology used for these reviews has been an adaptation of the three cycles Research and Development methodology devised by the Institute for Healthcare Improvement. This methodology places great emphasis on both the development of conclusions from a robust evidence base, and extensive stakeholder engagement. The process has been independently reviewed by The National Leadership and Innovation Agency for Healthcare and Innovation in Healthcare (NLIAH), including an evaluation of the feedback given by participants. They reached the following conclusions:

- The circumstances faced by the North Wales Health community certainly did merit a major strategic engagement exercise.
- The modified 3-cycle model was suited to the task.
- The work was undertaken appropriately in a very professional, detailed and diligent manner.
- The approach did fit with current Welsh Assembly guidance on involvement and consultation.
- It is appropriate to continue with the process as a general approach to be adapted as required given the programme to be addressed.

In July 2009 the Shadow Betsi Cadwaladr University Health Board received a report which summarised the progress of work to date. For both Community & Primary Care and Mental Health the way forward was agreed and the North Wales Clinical Strategy work was concluded. The further development and implementation of the models of care in these areas has been taken forward through other means, and are not addressed further in this paper.

For unscheduled care a range of possible models was explored. In July 2009 it was recommended, and agreed, that the complexity and importance of the issue was such that further work was required on these models.

Since July 2009 extensive work has been undertaken. In particular:

- A thorough review has been undertaken of the medical staffing issues, both overall and for key specialties
- Each of the potential models agreed in June 2009 has been analysed against an agreed set of criteria
- High level work has been done on the financial/economic appraisal

This work has been done with substantial further engagement, including:

- A series of semi-structured interviews with doctors, based on the three acute sites, in the specialties which are key to the model of unscheduled care
- A discussion with the Board of Directors
- A meeting with the Expert and Stakeholder reference groups for the project, which was held on the 10th of March. (The opportunity was also taken at that meeting to update stakeholders on progress in Community & Primary and Mental health)

Assessment

The project team presented a detailed summary of the evidence gathered to the Expert and Stakeholder Reference Groups, and made the following recommendations for discussion and agreement:

"An evolutionary approach should be adopted to the development of the hospital element of unscheduled care across North Wales. This would entail substantial service re-design, and include the following elements:

1. The three main District General Hospital sites in North Wales would continue to provide a full A&E service. Within this context the model of care would continue to evolve. For example:

   - There is good evidence that existing clinical networking arrangements (e.g. vascular) are working well and there should be an expansion in clinical networking across North Wales in the future.
   - There should also be greater sub-specialisation. This may allow patients who currently have to go to England for tertiary services to be treated in one of the hospitals in North Wales.

- There are advantages to the separate streaming of emergency and elective work and the implementation of this approach across North Wales should be explored further.

2. There should be a move to a consultant and GP-delivered service, with a reduced reliance on trainee medical staff. This would require parallel system investment in both GPs and consultants.

3. Specifically, Emergency Medicine across North Wales should move to a consultant-delivered model of care.

4. There should be substantial role and workforce redesign, including extending the role of nurses and other health professions in delivering unscheduled care.

5. There should be a greater emphasis on, and investment in, services provided in the community and closer to home. This should reduce the acute bed base over time.

6. Further work should be undertaken on the interface with the Ambulance service."

These recommendations were discussed at length by the stakeholder and expert stakeholder groups and received general support. The following key elements of the model of care were also generally supported:

1. A hospital with a full A&E service has:
   - An Emergency Department and Emergency Medicine
   - Unselected Acute Medicine including Care of the Elderly
   - Anaesthetics and Critical Care services
   - General Surgery including unselected emergency general surgery
   - A routine Trauma service
   - 24/7 access to Radiology and Laboratory Services

2. Other emergency services may be provided on a networked basis. This needs to be considered on a specialty-by specialty basis.

The rationale for all of these recommendations, and the extensive evidence base on which they are founded, is available on the project website (http://www.wales.nhs.uk/sites3/home.cfm?orgid=837).

There were extensive discussions on the key issues in implementing this model, including:

- The importance of taking a whole systems view of unscheduled care including social care and the voluntary sector, and ensuring that A&E is used appropriately
- The need to look at whether care for the rare cases of multiply injured patients (as opposed to routine trauma) should be delivered in a specialist centre or centres
- The importance of IT in supporting clinical care, particularly in rural areas

- The need to avoid a shift of costs to primary care without the accompanying resources being transferred
- The importance of the communications hub development which is currently being explored in primary and community care

The full feedback from the meeting will be captured in a separate document.

In terms of the next steps, this service model will be further developed and delivered through the Clinical Programme Groups (CPGs) and a series of cross-cutting projects. Specifically it has been agreed to undertake a series of individual service reviews in the next year. These reviews will look at how specific specialties should develop in the context of this overall strategy and will examine elective as well as unscheduled care. The first two reviews will cover Obstetrics and Orthopaedics. This model of care will give a stable platform for the future development of services, including the current review of Llandudno hospital and the refurbishment of Glan Clwyd.

It is also proposed that the 3-cycle methodology, which is currently being used for Llandudno hospital, is adopted as standard practice for major service reviews.

Recommendation

It is proposed that the Board:

- approves the model of unscheduled care outlined in this paper
- endorses the next steps
- adopts the three cycle model as standard practice for major service reviews

Betsi Cadwaladr University Health Board **Board Paper 25.3.10 Item 10/031.2**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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It is also proposed that the 3-cycle methodology, which is currently being used for Llandudno hospital, is adopted as standard practice for major service reviews.

Recommendation

It is proposed that the Board:

- approves the model of unscheduled care outlined in this paper
- endorses the next steps
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APPENDIX 7

NORTH WALES REFORM GROUP

Project Initiation Document for the development of Models of Care for Primary Care & Community Services, Mental Health and Unscheduled Care Services

1 Aim

The intent of this programme of work is to support the development of a robust model for Primary Care & Community, Mental Health and Unscheduled care services to inform the production of a North Wales Service Strategy.

2 Background Information

The Acute Services Review of 2006, culminating in the document *Designed for North Wales*, delivered a vision of services and estate for NHS North Wales that was rightly criticised for being acute focussed.

Little attention was made to the effects of radical change in the provision of acute care on either community services, social care services or primary care.

A 1½ day seminar on clinical strategy was held in North Wales in October 2008. This produced a degree of consensus on the direction for clinical service development but left several priority areas to be resolved. The first of these priorities have been agreed by the North Wales Reform Group and are follows:

- Primary Care & Community Services
- Mental Health
- Unscheduled care

For the above areas, there was general agreement of the need to develop service principles and a model (or models) of care for North Wales but with a local focus.

For each of the 3 priority areas a Charter describing the individual projects has been prepared and are included in **Appendix A.** These provide details of the intent and aim of each project, the question to be answered and the proposed approach in preparing final recommendations.

This work programme will have a regional focus and will form a generic overview of future service provision. The next phase will be to take these forward into specific service recommendations at a county and locality level.

3 Principles

A number of principles were identified at the seminar which will underpin the programme of work, namely:

- Focus on the person – keep people independent and re-able them when needed;
- Give as much care as possible in community settings. Admit people to the acute hospital only if necessary, and for as short a time as possible;
- Give highest quality clinical care by the right person, in the right place – first time;
- Make sure that people are safe;
- Look after the mind, body and spirit;
- Get the design right for the most vulnerable in society and, in that way, for everybody.

4 Objectives

The over-riding objective is to gain consensus upon appropriate and evidence based models of care and as part of this to ensure that:

- statutory guidelines are followed in the development of models of care and production of the Service Strategy, through clear project management arrangements;
- the appropriate mechanisms are in place to allow successful interagency working, joint ownership and involvement of all relevant organisations;
- the strategy formulation is underpinned by a robust evidence base and holistic assessment of the health and well-being needs of the local community taking into account future demographic changes;
- patients, service users, carers, and the public, including the vulnerable and disadvantaged, are actively involved in strategy formulation
- the models of care and clinical strategy is firmly linked to other local strategies;
- appropriate consideration is given to national strategies and priorities;
- the models of care form the strategic outline for the local planning of service provision and linking to local government functions, such as social services, as well as all health services.

5 Scope

The scope of the project includes the 3 Project Teams to develop models of care for the following key areas:-

- Primary Care and Community Services
- Mental Health Services
- Unscheduled care Services

Each of the above Project Teams will require consistent levels of project management so that they are undertaken in a timely manner and also interlink to ensure that the overall aim of producing a final clinical strategy is achieved.

Thereafter the service strategy will have to be developed, implemented, monitored and reviewed. These phases are not included in the scope of this project but will be for further consideration at a later stage.

6 Input from Other Agencies

As set out in the Assembly guidance local co-operation, involvement and ownership of key organisations including 'expert patient' input is vital in the success of this project.

Appendix B sets out:

(i) Stakeholder Engagement Process
(ii) Stakeholder Briefing and Membership
(iii) Expert Group Briefing
(iv) Expert Group Membership
(v) Facilitation and Communication

7 Constraints

The capacity to deliver the Strategy is constrained by:

- Securing resource for effective programme and project infrastructure.
- The identification of and protected time commitment from key leads and members of Project Teams;
- The active support and involvement of the key partner organisations;
- The ability to encourage the public, including vulnerable and marginalized groups, to be involved and ensure their contributions are valued;
- The timely completion of the research methodology based on the modified 90 day R&D cycle;
- The achievement of key milestones as set in the specific work-stream terms of reference;
- Impact of clinical activity to meet targets and the creation of the single North Wales organisation.

8 Benefits

The project management arrangements proposed will ensure models of care to ensure the realisation of the main benefits of a North Wales strategy that is taken forward at the local level which include:

- A partnership approach and therefore a jointly owned strategy, that all relevant organisations can adopt and implement.
- Strategic planning and prioritisation underpinned by comprehensive health and well-being needs assessment.
- The full range of issues that affect the health and well-being of the population will be considered.
- Actions required to improve health and reduce health inequalities are identified locally, promoting local solutions for local problems.
- Addresses the public health agenda at local level.
- Supports and compliments other local strategies and frameworks.
- Develops the prevention role of local authority services and health services.
- Provides the basis for the service strategy for the 3 priority areas.
- Provides strategic context for annual operational planning.
- Encourages and supports joint planning, review and performance management.

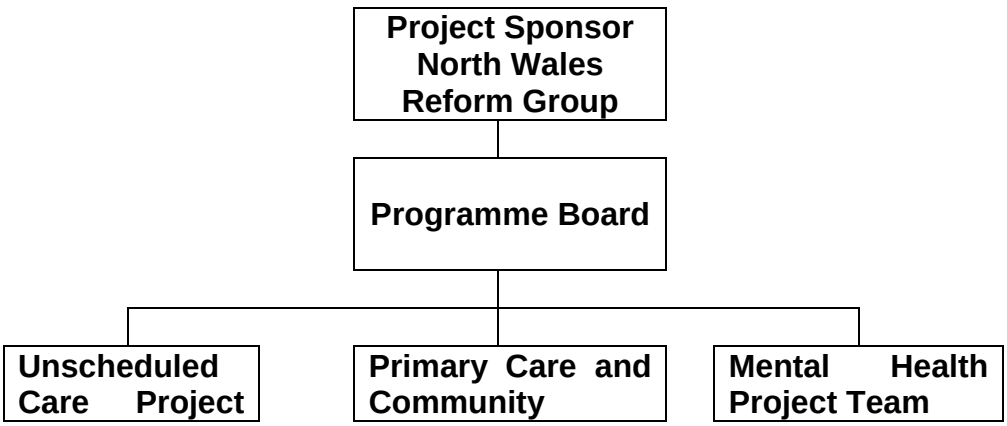
9 Project Structure and Project Management Arrangements

The **Project Sponsor** is the North Wales Reform Group (NWRG),

The **Programme Board** will co-ordinate and manage overall projects, co-ordinated through the Programme Manager, Stakeholder and communications manager and the 3 Project Team Managers**.**

Individual **Project Teams** will lead each of the 3 project teams led by Chairs and Project Managers who report to the Programme Board.

Programme Management support will be through the North Wales Regional Commissioning Unit.



Team	**Services Project Team**	

9.1 Terms of Reference and Membership

Terms of reference for both the Programme Board and Project Teams are set out in **Appendix C.**

10 Resources

There is commitment from the North Wales Reform Group (as Project Sponsor) comprising of North Wales Regional Office, Local Health Boards and NHS Trusts to allocate sufficient resource to ensure the delivery of the project within the stated timescale. However an understanding of the contributions and responsibilities of key officers all organisations has to be further agreed.

It is also recognised that other partners have a vital part to play and consultation regarding their contribution needs to take place.

Resource required

- Programme Board comprising of 3 Project team group chairs/ Project Team Managers, Programme Manager, Stakeholder and Communications Manager, Medical Directors, NPHS Regional Director, Trust Leads, Project Sponsor.
- 3 Project Teams
- Research capacity including input from Director of Public Health
- Venues (likely to be external) for 'expert' group and stakeholder group – memberships are defined in a separate stakeholder engagement proposal (See Appendix Bii).
- Translation facilities (rapid turnaround)
- External Facilitation of expert group and stakeholder group
- Communication strategy
- Secretarial support
- Allocated time commitment and input of other key project team members.
- Allocated time commitment and input of key partner agencies as appropriate.
- Staff contribution from other partners.
- Non-recurring funding to support stakeholder group and consultation / stakeholder engagement processes and communication / facilitation processes. Stakeholder group to include CHC, Vol sector, LA elected members, public.

11 Assumptions

In achieving the aim of the project, it is assumed that:

- Key staff are released for them to fully engage as appropriate within project teams and expert groups in line with project plan and key milestones;
- Timely identification and input from planning leads and members of groups;
- agreed timescales are met;
- key partners jointly agree the approach taken and the structures to be put in place;
- the Partnership members can agree on the models of care and priorities to be take forward as part of North Wales Service Strategy.

12 Review and Communication

The Programme Board will meet at least on a monthly basis and in line with key project milestone dates to review progress against agreed milestones, with flexibility to schedule meetings to coincide with significant stages within the overall programme of this project.

The 3 Project Teams will meet weekly initially in order to ensure that the agreed timetable for achieving the project. i.e. the completion of the R&D cycle is achieved.

A highlight report will be prepared for the Programme Board (see **Appendix D**) as required, including an updated action plan report. The Chair(s) will be notified as soon as reasonably possible of any significant variance in terms of time, partner co-operation and cost.

Overall programme progress, risk and exceptions will be reported to the Project Sponsor as appropriate.

13 Risk Management

Project Risk Management sets the context in which project risks will be actively managed throughout the project. All identified risks will be included within a *Risk Register*. The Risk Register is owned by 3 Project Managers and overall Programme Manager.

It is essential that the risks in achieving the aim of this project are identified at the outset so that steps to manage and lessen them can be put in place wherever possible.

It is the collective responsibility of the Programme Sponsor, Programme Manager and Board, Project Teams and Project Managers to manage and mitigate these and any new risks as they arise to ensure the successful conclusion of the project.

Preparing and formulating a North Wales Service Strategy is a major undertaking. The risks noted below are not exhaustive, the project being a dynamic process may result in further risks which will need to be addressed.

Risk	**Proposed control measure**
Inadequate resource to implement project.	Identify resource requirement. Identify key players in partner organisation who can contribute to the work of the project.
Lack of commitment/co-operation amongst partners.	Ensure commitment at the highest level through Project Sponsor.
Disagreement with the end result by senior clinical staff	Actively Involve all relevant clinicians throughout process. Send a monthly update to all clinical staff (primary and secondary care) as part of a communications strategy.
Failure to achieve agreed milestones	Develop a management control plan for each project setting out detailed actions to be taken, lead officers and timescales highlighting key milestones which must be achieved for the overall programme and each individual project Report major slippage to Programme Board with appropriate recommendations for ensuring that the final report is delivered to time.
Proactive and optimum involvement of the public, including vulnerable groups	Develop an engagement process and stakeholder engagement group to support the programme.
Inability to identify key staff	Ensure flexibility for key individuals to be involved in this process.
Media Misrepresentation	Communications Strategy developed
Political Acceptability	Facilitation and engagement / communications strategy

These risks will be actively controlled, monitored and reviewed as an integral and embedded part of the project review process. The Risk Register will be continuously updated to include all the identified risks and will detail plans of how each will be reduced / mitigated, including the actions on individuals and the current status.

14 Project Controls

Each Project Team will manage within the 90 day R&D cycle process set out in **Appendix E (i)** (+/- 3 days), however the presentation milestones in **Appendix E (ii)** are absolute dates with cannot be over-run. Progress will be detailed in the monthly highlight reports.

Where tolerance is likely to be exceeded, the Project Manager will discuss the implications with the Chair(s) of each of the Project Teams in the first instance. Where a significant deviation from the plan is envisaged a formal Programme Board meeting will be arranged.

15 Products and Milestones

The finalisation of the R&D cycle and development of models of care must be completed as stated in the set timescale.

To achieve this key milestones have to be met as detailed in the management control plans. (see Risk Management section 12).

It is proposed that the Programme Board develop project management arrangements based on good practice and produce detailed staged plans as to how each milestone will be achieved. Monthly highlight reports should then be developed based on performance against these plans.

Within the context of this, project management will be used to ensure:

- records will be maintained for all *Products;*
- each *Product* will have a unique identifier and version number, for both printed and electronically stored versions;
- changes to *Products* will be controlled through a formal Change Management process (once declared complete by the originator);
- where changes are requested to *Products* these will be assessed and their impact determined before approval;

- the links / dependencies between the various *Products* will be clearly identified to ensure they are developed / delivered in the correct sequence and changes are not made in isolation, and
- the status of *Products* will be managed, including responsibilities for their achievement and target completion dates.

Documents which will be used to support the management process include :

- *Product List*. Maintains details of all the *Products*, their owner, current version, current status and pre-requisites. This will be a Master Document maintained by the Project Manager.
- *Change Management Form*. The form used for requesting, assessing and approving changes to *Products*.
- *Product Change History Log*. The log of changes made to specific *Products*.

In addition to controlling the paper-based *Products* and project documentation a formal document naming convention will also be applied to electronically stored versions of the *Products* and project documents. This consists of a character description, that includes a key descriptor of the document type and the version number. Copies of all versions of documents will be maintained electronically by each Project Manager and the Programme Manager.

Document Type	Description	Proposed Naming
PID	Project Initiation Document	PID v1.doc PID v2.doc etc.

16 Document Control

Document Issue Control
This is a controlled document. When new copies or versions are issued then previous versions should be destroyed.

Revision History
A record of any changes will be maintained by the Project Manager.

Revision	Date	Summary of changes	Author

Document Approvals

Each key document requires the approval of Programme Manager and Programme Board

Document Distribution

Copies of each document and all changes are distributed to the Programme Board and appropriate Project Teams.

APPENDICES

Appendix A **Project Team Charters**

Appendix B
- **(i) Stakeholder Engagement Process**
- **(ii) Stakeholder Briefing & Membership**
- **(iii) Expert Group Briefing**
- **(iv) Expert Group Membership**
- **(v) Facilitation and Communication**

Appendix C **Terms of Reference for Programme Board & Project Teams**

Appendix D **Project Team Leads Monthly Highlight Report**

Appendix E
- **(i) Modified '90 Day R&D' Cycle**
- **(ii) Programme Timetable**

APPENDIX A

Charter for 90 Day Project
Primary Care & Community Services

1 INTENT AND AIM

1.1 Why is the project needed?

The Acute Services Review of 2006, culminating in the document *Designed for North Wales*, delivered a vision of services and estate for NHS North Wales that was rightly criticised for being acute focussed.

Little attention was made to the effects of radical change in the provision of acute care on either community services, social care services or primary care.

The recent 1½ day seminar on clinical strategy held in North Wales produced a degree of consensus on the direction for clinical service development but left several priority areas to be resolved. The model of care for primary care and community services was one such area. There was general agreement of the need to develop a model (or models) of care for North Wales but with a local focus.

This project is required to describe a model (or models) of care which can be found to deliver services in the community that enable people to be cared for out of acute hospital settings.

Whilst the project will have a regional focus, considering a generic overview of future service provision in the community, the next phase will be to take forward recommendations at a county and locality level.

1.2 How will the project be done?

The project is to be led by Grace Lewis-Parry, CEO Gwynedd LHB with planning support from Clare Jones, Director of Development & Performance (DDPM), Gwynedd LHB, and a clinical lead (to be indentified), working with a core team of representatives from across North Wales. These will include a:

- GP
- Secondary care Physician
- Therapist
- Community Nurse
- Community Services General Manager

- Social Services

Other support will be required from various sources (such as LHBs, Trusts, NPHS) to support the research element of the work, the gathering of data and information, and the engagement process.

The CEOs from each organisation will ensure that information requests are dealt with in a timely manner.

The methodology will be the 90 day R&D method of the Institute for Healthcare Improvement. The core team will present their findings to a meeting of key stakeholders every 30 days and feedback, both immediate and from a wider group of stakeholders, will be incorporated into the work plan of the next 30 days. Reporting will be in SBAR format.

Scope:

This work will take account of services in the community that enable people to be cared for out of acute hospital settings.

- Primary health care services including GP, dental, pharmacy & optometry;
- Chronic Condition Management, from self-management programmes eg. EPP, Xpert Programme, to case management;
- Generic community services such district nurses, health visitors, school nurses and therapists;
- Community Hospitals;
- Housing, residential care and extra care housing;
- Joint working across health and social care;
- Voluntary Sector.

Areas excluded:

- Community midwifery;
- Mental health;
- GMS out of hours services;
- Children's services;
- Primary prevention programmes (HSCWB).

Although community mental health services will be considered in the mental health project team, it will be important to ensure that there is reconciliation across the two project teams.

1.3 What is the 'big picture' goal?

The intent of the project is to provide a robust North Wales model of primary care and community services that will provide a clear strategic

direction for the future delivery of out of acute hospital care. The model will provide specific service design priorities which will then need to be developed at a local level.

The question to be answered by this project is:

How do we deliver the model for primary and community services in North Wales?

2 BACKGROUND

2.1 Other reviews and existing plans that feed into this project:

- York Health Economics (Making the Connections) Report Sept 2008
- Primary Care Estates Strategies (by LHB) – January 2008
- GMS & pharmacy enhanced services currently commissioned
- North Wales Integrated Workforce Plan – under development (deadline March 2009)
- Chronic Conditions Local Action Plans (by LHB) – May 2008
- Community Services Plans 2008/11 (by LHB) – May 2008
- Demand management action plans (? Available by LHB) – 2008/09
- Individual community hospital reviews
- 'Jones' Review – Autumn 2007 (national Primary Care & Community Services Strategy under development)
- 'Investing for health' cost mapping to GP practice level (Gwynedd only)
- HSCWB Strategies & needs assessments 2008/11 (by county)
- Overview of health needs at a North Wales level
- Joint flexibilities projects – a range of joint working initiatives across North Wales
- Baseline review of current services and facilities (as part of the Community Services Plans & estates strategies)
- Joint Commissioning Strategies eg. Older People

2.2 Context, Current landscape and Present Issue

D4NW suggested a three DGH model was the ideal secondary care hospital configuration for North Wales, with a significant shift of some of the current activity into community care settings.

Concerns were voiced by many that, whilst the overall strategic direction was, in the main supported, D4NW did not provide the detail or reassurance as to how this shift would be delivered or funded.

Since D4NW was published a plethora of work has been undertaken by LHBs, current health communities and HSCWB county-based partnerships to move this particular agenda forward (this is detailed in section 2.1).

This work now needs to be further developed and drawn together across North Wales in order that the project question can be answered.

2.3 Clearly articulate the 'why'?

The demand for healthcare services is increasing due to many factors such as an ageing population, development of new technologies and lifestyles.

Current models of care are not sustainable and there is a need to design services and pathways of care that better respond to this growing demand whilst ensuring that they are delivered to an acceptable quality, are safe and where possible provided as locally as possible.

2.4 Clearly articulate the performance gaps

In developing the community services model of care for North Wales, this will not only provide a clarity regarding the service changes and designs required into the future, but also implications for resources and infrastructure.

This work will also inform the other two project teams considering unscheduled care and mental health.

3 LITERATURE RESEARCH

It is anticipated that much literature is available on alternative models of care across the primary-community-secondary care spectrum. Much of this has been assembled for prior reviews (D4NW, Jones Review, York Health Economics Report, Community Services Plans), however further literature searches will be undertaken to ensure all relevant good practice and evidence is captured.

Consideration will also have to be taken of the all-Wales work being undertaken by Dr Chris Jones in order to develop a national Primary Care & Community Services Strategy.

4 POTENTIAL CONTACTS

Because of the relatively recent work already undertaken at county level in considering different models of community care it is not anticipated that a lot of additional research will be required, more that a reconciliation of the current work is undertaken.

However if there are deemed to be knowledge or evidence gaps than sources of information may include:

- Relevant models of care may be found in Northern Ireland and/or Scotland (particularly in relation to the consideration of rurality when service planning)
- Institute for Healthcare Improvement
- Welsh Centre for Health
- NHS Institute for Innovation and Improvement
- Health Foundation

5 KEY DELIVERABLES AND INTENDED RESULTS

5.1 Changes and Design Concepts

It is anticipated that the initial 30 days will investigate the present knowledge on the subject. The second 30 days will address the various models that could satisfy the requirements of the project. The last 30 days will establish the preferred model for community services. The main deliverable will be a document containing the various models, their analysis and the preferred model with evidence. It is acknowledged that time will also be required for public engagement in line with WAG latest guidance.

5.2 IT and Information Implications

It is anticipated that there will be extensive requirement for information across the North Wales community.

5.3 Engagement

Engagement with clinicians, CHCs and the voluntary sector will be undertaken via briefing sessions and the 30 days 'lecture theatre events'.

Engagement with the public will be undertaken via the 30 days stakeholder meetings, supported by an engagement strategy. (see separate paper).

The North Wales CHCs will be involved with developing and implementing the engagement strategy.

Any clinicians associated with the project, particularly from primary care, will require careful use to reduce cost associated with either loss of activity or backfill.

5.4 Final Report

The final report will detail a Primary Care and Community Services Model for North Wales which includes:

- Evidence of best practice in service delivery taken from current literature and local experience;
- A specification of the core minimum services that will be provided in the community (not necessarily how these will be provided), allowing for additional services to suit local circumstances and different needs;
- Implications for future service improvement, including workforce (skills and change management), types of integrated estates/premises, improved access and capacity through demand management, exploiting IT & other technologies;
- Recommendations on specific service design with development priorities;
- Identify potential resource impact.

6 MEMBERSHIP OF PROJECT TEAM

Role	Name	Position
Executive Sponsor	Grace Lewis-Parry	CEO, GLHB
Planning lead	Clare Jones	Director Development & Performance Mgt., GLHB
Clinical lead	Dr Claire Wilkinson	Prof of General Practice (Agreement via NPHS to support NHS North Wales)
Research lead		
GP lead	Dr Lyndon Miles	GP and GLHB Chair
Secondary care lead	Dr Anand Prakash	Consultant Physician/Care of the Elderly, NWT – East. (Member of 'Making the Connections' Project Board)
Therapist	Janice Lovell	SALT, NWT – Central
Community Nurse	Jane Trowman	Director of Nursing, DLHB
Social Services representative	Sue Lewis	Director of Social Services, Flintshire
National Public Health Service representative	Diana Lamb	Principal Public Health Practitioner

Charter for 90 Day Project
Adult Mental Health Services

1 INTENT AND AIM

1.1 Why is this project needed?

In 2006 "Designed for North Wales" delivered a vision of services and estate for North Wales that excluded Mental Health and Learning Disability Services and was rightly criticised for being acute focussed.

The recent one and a half day seminar on clinical strategy held in North Wales produced a degree of consensus on the direction of clinical service development and identified that a model for Mental Health Services needs to be established for North Wales.

A number of reviews of mental health services in Wales have been undertaken in previous years, which outline slow compliance with the National Service Framework, inconsistency of service provision across Wales and issues relating to stigma, user experience and involvement[1].

A project is now required to take forward the plethora of reviews and recommendations to develop and implement a model for Mental Health Services in North Wales.

1.2 How will this project be done?

A small project team will be assembled, led by the Chief Executive of the North Wales NHS Trust, Mary Burrows. The North Wales Mental Health Network will be the reference and steering group for the project.

The methodology will be the 90 day R&D method from the Institute of Healthcare Improvement using a structured stakeholder engagement process involving for example service users, carers, Local Authorities and the voluntary sector.

Scope

The project will consider Adult mental health and forensic services only.

[1] Burrows/Greenwell Review January 2008; Welsh Audit Office Report 2005/6; Iechyd Meddwl Cymru; June 2008

1.3 What is the "big picture" goal ?

To provide a direction and basis for Adult and Older Persons mental health services based on need and in accordance with national guidance. The question to be answered is:

How can we improve the Quality of our Current Care for people with mental health needs in North Wales?

2 BACKGROUND

2.1 Other reviews and existing plans that feed into this project

- "Raising the Standard" the revised Adult Mental Health NSF and Action Plan for Wales October 2005 and the associated AOF requirements
- "The Other End of the Telescope" – Burrows/Greenwell 2007
- Care programme Approach (CPA) and Unified Assessments
- Local Multi-Agency service improvement plans for service areas (by county)
- HSCWB Strategies & Needs Assessment 2008/11 (by county)
- The Strategic Review of Secure Mental Health Services in Wales.
- The emerging NSF and Strategy for Older People in Wales and the Audit Commission Report "Developing Mental Health Services for Older People in Wales".
- Development of North Wales services such as the North Wales Low Secure Project, Eating Disorder Service (EDS) and possibly Personality Disorder (PD)
- The NSF for Older People
- Everybody's Business – Dementia Strategy for England
- NICE Guidance in relation to Older Persons Mental Health issues

2.2 Context, Current Landscape and Present Issues

The profile of mental health has been raised following the introduction and lack of progress of a number of AOF targets for mental health and the debate generated on integrated versus single mental health trust providers.

Future Integrated Health bodies in Wales will have a Deputy Chair responsible for overseeing improvements in mental health, primary care and community services furthering the importance of progress to be made in the field of mental health and well-being.

Services are being developed and in some cases, managed in an integrated way with particular emphasis on partnerships. This is primary to the success of future services.

Mental health allocations have been protected to deliver the requirements of the NSF and to allow for reinvestment in development.

2.3 Clearly articulate the "why"

There is a growing expectation from both the Welsh Assembly Government (WAG) and the people of Wales that services deliver consistent standards across all areas. This is a particular issue within North Wales given its predominantly rural and, in places, sparsely populated geography. The challenges are to provide the same access and standards of care in more urban/mixed-urban areas, particularly within some of the sub-specialities.

Existing services therefore need review to consider whether there is the potential to provide services differently. For example pooling specialist and/or in-patient services may provide safer, more conducive environments of care or services.

Mental health services in Wales have been criticised for inconsistent delivery of its NSF. The NHS's AOF has, over recent years, developed a number of mental health-related targets that reflect the NSF. Indications suggest that this will continue to be the case.

This has led to greater attention of mental health services but equally to a greater degree of scrutiny and performance. This has highlighted areas of strength and those that require further development. This holds true for North Wales. This project will allow reflection of issues and to spread good practice.

A North Wales approach provides an opportunity to utilise our collective resources and thinking into creating a greater pool of expertise. The development of a North Wales strategy will need supports it and the delivery and development of services.

3 LITERATURE RESEARCH

See section on reviews and existing plans. Literature searches will need to cover national, UK-wide and international studies and publications

4 POTENTIAL CONTACTS

Review existing policies, NSFs and guidance in order to be clear on both the requirements and our aspirations. In so doing we may wish to liaise with colleagues within NLIAH and other WAG resources as well as CSIP/NIMHE, and the Sainsbury Centre for Mental Health etc within England.

5 KEY DELIVERABLES AND INTENDED RESULTS

5.1 Changes and design concepts

The initial 30 days will investigate the present knowledge on the subject and a review of the services in place. The second 30 days will investigate the various models that could satisfy the requirements of the project. The last 30 days will identify options to improve the quality of services. for mental health. The main deliverable will be a document containing the various options, their analysis and recommendations for implementation supported by relevant evidence.

5.2 IT and information implications

There will be a significant information requirement across the North Wales community to populate the first phase of study

5.3 Engagement

Engagement with clinicians, CHCs and the voluntary sector will be undertaken via briefing sessions and the 30 days 'lecture theatre events'.

Engagement with the public will be undertaken via the 30 days stakeholder meetings, supported by an engagement strategy. (see separate paper).

The North Wales CHCs will be involved with developing and implementing the engagement strategy.

Any clinicians associated with the project, particularly from primary care, will require careful use to reduce cost associated with either loss of activity or backfill.

5.4 Final Report

The final report will make recommendations to improve the quality of current mental health services in North Wales and will identify:

- Evidence of best practice and policy implementation requirements, from current literature
- Examples of good practice across North Wales
- The drivers for change:

    1. Patient Safety
    2. Patient Centredness
    3. Efficiency
    4. Effectiveness
    5. Timeliness

6. Equity
7. Empowerment

- Recommendations to improve quality in North Wales

For Adult Mental Health Services the review will focus on the following areas:

- Psychological Therapies
- Acute Care, including Inpatient & Home Treatment
- Social Inclusion, including employment and housing
- Community Mental Health Teams

The priority areas for Older People's Mental Health Services will be identified following an initial literature review, but the following areas have been highlighted initially:

- The rise in the number of people with dementia
- How this demand can be met by a range of options including, but not exclusively, Mental Health Services
- Models of Care in Adult Services and their applicability for Older People, including the interface with Social Services
- Transitional arrangements between Adult and Older People's services

6 MEMBERSHIP OF AMH PROJECT TEAM

Position	Name	Telephone	Email
Executive Sponsor	Mary Burrows	01745 583910	Mary.Burrows@new-tr.wales.nhs.uk
Planning Lead	Jane Jones	01745 582721	Jane.jones@denbighshirelhb.wales.nhs.uk
Clinical lead	Dr Giles Harbourne	01978 727336	Giles.harbourne@new-tr.wales.nhs.uk
Project Team specific support	Dr Peter Stevenson	01978 263406 0r 01352 803311	peter.stevenson@nphs.wales.nhs.uk
Project Team specific support	Medwyn Williams	01248 682510	Medwyn.williams@nww-tr.wales.nhs.uk
Project Team specific support	Steve Cottrell	01745 443312	Steve.cottrell@cd-tr.wales.nhs.uk
Project Team specific support	Alys M Jones	01286 679716	AlysMjones@gwynedd.gov.uk
Project Team specific support	Vicky Forman	01352 702514	vicky_forman@flintshire.gov.uk
Project Team specific support	Equalities Lead (tbc)		
Administrative support	TBC		

6 MEMBERSHIP OF EMH PROJECT TEAM

Position	Name	Telephone	Email
Executive Sponsor	Mary Burrows	01745 583910	Mary.Burrows@new-tr.wales.nhs.uk
Planning Lead	Jane Jones	01745 582721	Jane.jones@denbighshirelhb.wales.nhs.uk
Clinical lead	Dr Tony Roberts	01248 682510	Tony.roberts@nww-tr.wales.nhs.uk
Project Team specific support	Dr Peter Stevenson	01978 263406 0r 01352 803311	peter.stevenson@nphs.wales.nhs.uk
Project Team specific support (AMH)	Neil Ayling	01824 706581	Neil.ayling@denbighshire.gov.uk
Project Team specific support	Helen Thomas	01492 575603	Helen.thomas@conwy.gov.uk
Project Team specific support	Martin Davidson	01286 674240	Martin.davidson@gwyneddlhb.wales.nhs.uk
Project Team specific support	Simon Pyke	01978 727357	Simon.pyke@new-tr.wales.nhs.uk
Project Team specific support	Equalities Lead (tbc)		
Administrative support	Gillian Roberts	01248 682510	Gillian.roberts@nww-tr.wales.nhs.uk

Charter for 90 Day Project
Unscheduled Care

1 INTENT AND AIM

1.1. Why is the Project Needed?

D4NW supported a three acute hospitals model for North Wales. However, the 1½ day seminar on clinical strategy held in North Wales in the autumn of 2008 concluded that this model requires revisiting in light of:

a] the various reviews within North Wales, including the Frank Burns review of Llandudno Hospital.

b] the difficulties in sustaining a surgical on-call rota to support three accident and emergency departments taking unselected medical and surgical admissions. This is essentially due to the increasing specialisation of surgery, reducing the number of surgeons available for an unselected surgical on call service.

This project is therefore required to establish what the model should be to deliver hospital element of unscheduled care.

1.2 How will the Project be done?

The project is to be led by Sally Baxter, Chief Executive, Denbighshire LHB with planning support from Ian Howard, Deputy Director of Strategy, Planning and Development North Wales NHS Trust and clinical leads, Dr Paul Birch, Medical Director North West Wales NHS Trust and Mr Mark Scriven, Deputy Medical Director North Wales NHS Trust, working with a core team of representatives from across North Wales. These will include:

Secondary care clinicians – medical and surgical
Unscheduled care lead
Public Health lead
Ambulance Trust lead

There will be input from primary care and social services colleagues also.

Support is also being provided from the National Public Health Service (NPHS) to lead the research element of the work and the gathering of data and information.

1.3 What is the 'Big Picture' Goal?

The intent of the project is to support the development of a robust unscheduled care service by exploring whether the current 3 A and E model is sustainable, and if not what the best alternative model is. This in turn will assist in the production of a North Wales clinical strategy document and underpin the development of DECS/MUCS across North Wales.

The question to be answered by this project is:

How should the hospital element of the model of Unscheduled Care be delivered across North Wales?

By developing the model of care for the hospital element of unscheduled care, this will not only provide a clarity regarding the service changes and designs required into the future, but also implications for resources and infrastructure.

This work will also inform, and be informed by, the other two project teams considering primary and community services and mental health

2 BACKGROUND

2.1. Other reviews that feed into this project

- The North Wales Acute Services Review
- The Frank Burns Review of Llandudno Hospital
- The Dr. Chris Jones Review of D4NW

2.2. Context, Current Landscape and Present Issue

D4NW supported a three DGH model for North Wales. However, it is now felt that this result requires revisiting in light of the various reviews within North Wales, particularly the Frank Burns review of Llandudno Hospital. In particular, the 3 A&E model requires testing to see whether models of care can be delivered within the constraints of available manpower, especially surgical emergency cover.

2.3. Clearly articulate the "why"?

The three A&E model, a key element of the current structure for access to emergency care for the population of North Wales, is under scrutiny because of manpower issues arising from the reduction in surgical on-call cover (consequent upon the development of specialist surgical training programmes that do not lead to generalist surgical skills adequate for an unselected surgical on call service).

Secondly, alternative models of care may be possible to give the same degree of safety and quality in the delivery of emergency care. In addition, the Welsh Assembly Government has extensively invested in the capital program for NHS Wales and the planned capital investment into North Wales need to be seen to give best value against alternative models of service provision.

2.4. Clearly articulate the performance gaps

Over the last two years NHS Wales has committed to a community model of health provision, via chronic disease management and intermediate care, that requires further description. Only once these models of service provision are understood and agreed can a secondary care model be fully described. A second work stream is under way to evaluate the possible models of care and utilisation of community resources for provision of health care.

3 LITERATURE SEARCH

It is anticipated that much literature is available on alternative models of care across the primary-community-secondary care spectrum. Much of this has been assembled for prior reviews (D4NW, Frank Burns Review of Llandudno).

4 POTENTIAL CONTACTS

- Because of its rurality, it is anticipated that relevant models of care may be found in Northern Ireland and/or Scotland.
- Institute for Healthcare Improvement
- Welsh Centre for Health
- NHS Institute for Innovation and Improvement
- Health Foundation

5 KEY DELIVERABLES AND INTENDED RESULTS

5.1. Changes and Design Concepts

It is anticipated that the initial 30 days will investigate the present knowledge on the subject. The second 30 days will address the various

models that could satisfy the requirements of the project. The last 30 days will establish the preferred model for unscheduled care. It is acknowledged that time will also be required for engagement in line with WAG's latest guidance.

5.2. IT and Information Implications

It is anticipated that there will be extensive requirement for information across the North Wales community.

5.3. Engagement

Engagement with clinicians, CHCs and the voluntary sector will be undertaken via briefing sessions and the 30 days 'lecture theatre events'.

Engagement with the public will be undertaken via the 30 days stakeholder meetings, supported by an engagement strategy. (see separate paper).

The North Wales CHCs will be involved with developing and implementing the engagement strategy.

Any clinicians associated with the project, particularly from primary care, will require careful use to reduce cost associated with either loss of activity or backfill.

5.4. Final Report

The final report will detail a recommended model for the hospital element of unscheduled care which includes:

- Evidence of best practice in service delivery taken from current literature and local experience;
- An explicit conclusion about the number and nature of A&Es which should be provided in North Wales
- Recommendations on specific service design with development priorities;
- Potential resource impact.

6 MEMBERSHIP OF PROJECT TEAM

Role	Name	Position
Executive Sponsor	Sally Baxter	Chief Executive, Denbighshire LHB
Planning lead	Ian Howard	Deputy Director of Planning, North Wales Trust (Central)
Planning	Dr Eileen Williams	Consultant Anaesthetist, North Wales Trust (Central)
Joint Clinical leads	Dr Paul Birch Dr Mark Scriven	Medical Director, North West Wales Trust Deputy Medical Director, North Wales Trust
Welsh Ambulance Services Lead	Dafydd Jones-Morris	Regional Director
Unscheduled care lead	Shirley Whiteway	Unscheduled Care Manager, North Wales Trust (Central)
National Public Health Service representative	Dr Rob Atenstaedt	Local Director of Public Health, Conwy and Denbighshire
Clinical Director leads	Dr John Harvey Dr Brian Tehan Dr Wyn Greenway Mr Tony Shambrook Dr Andy Fowell	Clinical Director – Medicine, North Wales Trust (East) Clinical Director – Surgery, North Wales Trust (Central) Clinical Director – Medicine, North Wales Trust (Central) Clinical Director – Surgery, North West Wales Trust Clinical Director – Medicine, North West Wales Trust
Primary Care Lead	Dr Liz Bowen	Gwynedd GP

APPENDIX B (i)

Stakeholder Engagement to Support North Wales Project Teams

1 Overview

Recent Interim guidance issued on 7th October (*Guidance for Engagement and Consultation on Changes to Health Service*) outlined the interim process to be adopted by NHS Wales when reviewing health services which may result in service change. In line with the spirit and content of this interim guidance, this paper outlines the approach that it is proposed to adopt to ensure that stakeholder engagement is an integral part of the work of the 3 project teams to be set up by the North Wales Reform Group (NWRG). These proposals have been discussed and agreed with the 5 Chief Officers of the North Wales Community Health Councils.

A 'charter' for each project team is being developed for agreement by the NWRG which outlines the specific question to be addressed; the process to be adopted (a modified version of the 90 day Research and Development Cycle); and, an outline of the membership of the 'core' group that will take forward the work. A summary of the three questions to be asked is given below –

Unscheduled Care – "How should the hospital element of unscheduled care in North Wales, be delivered?"
This project team will examine the detailed service delivery model for hospital emergency care in North Wales taking into account the role of the three main hospital sites and Llandudno.

Mental Health – "What is the model for the delivery of adult mental health services in North Wales?"
This project team will seek to define how adult mental health services will be delivered in North Wales in the future. The project team will not include Learning Disability which will be addressed as a subsequent piece of work.

Community Services – "What is the model for community services in North Wales?"
This project team will encompass primary care and community services and will seek to define the type of services that all residents in North Wales should expect to access in the future.

Attached to this paper is an outline of the modified 90 day cycle process that will be adopted. This indicates that there will be extensive stakeholder engagement before, during and the end of the modified 90 day cycle. In reality, this will therefore mean that the complete process will take 120 days.

This paper provides an overview of the modified 90 day cycle and describes the proposed process to ensure inclusive and proactive stakeholder engagement during the modified 90 day cycle. This includes clarifying those stakeholders that are to be engaged during the process.

2 Overview of Modified 90 day cycle

It is envisaged that the process will commence in February 2008 and will be completed by June 2008.

- The cycle will commence with a briefing meeting to which all stakeholders will be invited. This briefing meeting will be held in early February 2008. The aim of this briefing meeting will be to provide a wide understanding of both the reasons for and the remit of the 3 project teams. Invitees to this briefing event will include (a) members of the three core project teams; (b) members of an expert group (see Section 3 below); and, (c) members of a wider Stakeholder Group (see Section 4 below).
- Each of the three project teams will then undertake the first 30 day 'block' of their work. The emphasis will be to gather and consider all the evidence relating to the work of the particular project team, the evidence being local, national and international. At the end of the first 30 days, the work of the three project teams will then be reported back over the course of one day first to the expert group and then to the wider Stakeholder Group for feedback, thoughts and views. There will then be a period of 14 days for the expert group and wider Stakeholder Group to provide feedback to the three core project teams.
- The feedback from the Groups will then be fed into the second 30 day 'block' of work of each project team .The focus of this second block of work will be to focus on the options for addressing and answering the specific questions given to each project team. At the end of the second 30 days, the output of this element of the three project teams work will again be reported back over the course of the same day first to the expert group and then to the wider Stakeholder Group for further feedback, thoughts and views. There will then be a period of 14 days for the expert group and the wider Stakeholder Group to provide feedback to the three core project teams.
- In turn, this further feedback from the Groups will then be fed into the third 30 day 'block' of work for each project team. At the end of the third 30 days, the output of the project team which will include recommendations to address and answer the specific question set for each project team, will then be reported back over the course of a day to all stakeholder groups: members of the core project teams; the expert group and the wider Stakeholder Group. There will then be a period of 14 days for the expert group and the wider Stakeholder Group to provide feedback.
- The feedback gathered at this final stakeholder event (and the 14 days following the final event) will be included in the final recommendations that are then taken to the North Wales Reform Group for discussion and/or endorsement.

It is proposed that to facilitate rapid feedback within 14 days following each 'report back' session, an electronic method of feedback is used. This will allow stakeholders the opportunity to record their comments and submit them to the core team. Comments will only be invited from stakeholder group

members. Responses will be recorded in an electronic format which allows all interested parties to view the comments from all stakeholders and members of the expert group.

Any papers issued as a result of the 'report' back sessions to the expert group and the wider Stakeholder Group will be bilingual, with translation facilities also available at the 'report back' sessions.

The dates for the initial briefing session, all 'report back' sessions to the expert group and the wider Stakeholder Group, and the deadline dates for the wider '14 day feedback' will be issued to all interested parties in advance of the modified 90 day Research and Development cycle commencing.

3 The Expert Group

The expert group's key role will be to provide a gauge for the **applicability** of the ideas emerging from the work of the three project teams. As such, this Group will act as a professional, multi-disciplinary 'barometer' of professional advice and guidance for the project teams, providing a feasibility focus for the themes and issues emerging from the project teams.

It is envisaged that this group will comprise mainly health service staff from across North Wales, inclusive of primary, community and acute staff, including staff side representatives. All clinical specialities encompassing all ages and conditions will be represented, as will all clinical and non-clinical support areas/departments. The expert group will also comprise members of the 6 Community Health Councils, Voluntary Services Councils and Social Services across North Wales. An 'expert' patient perspective will also be included in the expert group, potentially by drawing on patients and members of the public already involved in existing patient and public involvement groups within NHS organisations across North Wales.

It is envisaged that both the CHCs and VSCs will be members of both the expert group and the wider Stakeholder Group to provide 'cross over' and consistency across both groups. As such, the CHCs and VSCs may wish to consider cross sharing their involvement in the expert group and the wider Stakeholder Group.

It is anticipated that the expert group will comprise between 100 and 150 members, with meetings likely to be held at an external venue. There will be a need for expert facilitation of the 'expert' patient group (and also the wider Stakeholder Group).

The expert group will be brought together 4 times for a half day during the modified 90 day cycle and will receive feedback from all 3 project teams. These four meetings are:

- An initial briefing session (intended for all stakeholders)
- After the first 30 days work of the three project teams
- After the second 30 days work of the three project teams

- At the end of the third 30 days work of the three worksteams (intended for all stakeholders)

Dates for all 4 meetings will be set and notified in advance.

It is anticipated that a record of the feedback provided by the project teams and the discussions held at the 'report back' sessions will be documented from which a briefing document will be produced. This briefing document will be shared with the wider Stakeholder Group and also issued to all members of the expert group. These members can then use the briefing document to share the work of the project teams with their existing professional networks to provide feedback within 14 days of each 'report back' session.

4 Wider Stakeholder Group

The role of the wider Stakeholder Group will be to provide a gauge for the **acceptability** of the ideas emerging from the work of the three project teams. As such, this Group will act as a patient, general public and partner agency 'sounding board' for the output of the project teams.

It is envisaged that the Stakeholder Group will include between 100 to 150 individuals with the same external venue and facilitators used as those for the expert group.

The Stakeholder Group will include representatives from the following:

- 6 Community Health Councils
- 6 Voluntary Services Councils
- 6 Local Authorities (officials and elected members)
- Nominations from the 6 HSCWB Strategic Partnership Boards (or equivalents)
- Nominations from the 6 Children and Young People's Partnership Boards
- Nominations from the 6 Mental Health Strategic Partnership Boards
- Nominations from the 6 Community Safety Partnerships
- North Wales Race Equality Network
- Patient representatives from existing Patient and Public Involvement Groups within the 6 counties (to be different from those who will be members of the 'expert' patient group to ensure as broad an 'expert' patient perspective is provided as possible).
- Representatives from existing Carer Forums within the 6 counties
- Welsh Ambulance Service
- North Wales Police
- North Wales Fire and Rescue service
- Representative of Care Forum Wales (independent sector)
- Representative of Domiciliary Care Providers
- Representative of Further/higher Education

The CHCs agreed that the proposed membership of the Stakeholder Group would adequately represent both the partner and general public view for the purposes of the work in hand. The CHCs agreed that as the focus of the

project teams will be on service principles – the what of the future models of care for the NHS in North Wales – rather than on the how (which may or may not imply service changes), the proposed membership of the wider Stakeholder Group was satisfactory.

The Stakeholder Group will be brought together 4 times for a half day during the modified 90 day cycle and will receive feedback from all 3 project teams. These four meetings are:

- An initial briefing session (intended for all stakeholders)
- After the first 30 days work of the three project teams
- After the second 30 days work of the three project teams
- At the end of the third 30 days work of the three worksteams (intended for all stakeholders)

Dates for all 4 meetings will be set and notified in advance.

It is anticipated that a record of the feedback provided by the project teams and the discussions of the 'report back' sessions will be documented from which a briefing document will be produced. This briefing document will be shared with the expert group and also issued to all members of the Stakeholder Group. These members can then use the briefing document to share the work of the project teams within their existing networks to provide feedback within 14 days of each 'report back' session.

5 Potential Wider Public Engagement

Although as noted above, the CHCs felt that the membership of the Stakeholder Group was adequate to ensure public representation, it was agreed that there is merit in exploring a further method of securing wider direct public engagement in the process proposed.

It was agreed with the CHCs that there may be three avenues for achieving this:

- Seek the support and advice of Participation Cymru as an expert organisation which has both the skills for engaging the public as well as a wide range of existing networks for engaging citizens across Wales. The involvement of Participation Cymru may depend on the capacity of this organisation to support the North Wales work within the timescales agreed.
- An alternative approach may be to seek the support of the 6 Voluntary Services Councils within North Wales in using their networks to seek the wider views of the general public.
- A third alternative means of securing wider public engagement may be to place an advertisement in the local press across North Wales to invite 'expressions of interest.

6 Actions

Based on acceptance by the NWRG of the proposals outlined in this paper, which have been agreed with the 5 CHCs across North Wales, the following actions are also recommended:

- Agree and issue all dates to support completion of the modified R and D cycle. The dates should be issued with at least 6 weeks notice of the first meeting taking place. Dates are required for: the initial briefing session; the three 'report back' sessions for the expert group and the wider Stakeholder Group; and for the 14 day 'feedback' deadlines following each 'report back' session.
- Arrange venues for all three 'report back' sessions for the expert group and the wider Stakeholder Group, ensuring a venue capable of accommodating up to 150 individuals at one time with adequate translation facilities.
- Secure the services of an expert facilitation organisation.
- Secure representation on the expert group.
- Secure representation on the wider Stakeholder Group
- Prepare a briefing pack for all core project team members, and all members of both the expert group and that wider Stakeholder Group.

The membership of the three core project teams will be agreed by each Chief Executive sponsor.

APPENDIX B (ii)

STAKEHOLDER BRIEFING NOTE & MEMBERSHIP

1 Overview

A North Wales Strategic Planning event was held over a period of 2 days during October 2008 and was arranged by the North Wales Health Planning Forum, now known as the North Wales Health Reform Group (NWRG). This event was a collaborative venture between all NHS organisations in North Wales which sought to review health and healthcare strategy for North Wales. The event was attended by senior primary, community and acute clinicians from across North Wales, together with senior managerial staff and representatives of the Community Health Councils, Voluntary Services Councils and Local Authorities across North Wales. The event was informed by a number of key strategic documents already produced for the NHS in North Wales including: *Designed for North Wales* and a number of reports produced as a result of reviews commissioned by the Minister for Health and Social Services. These included *the Llandudno Hospital Review* (completed by Frank Burns) and *the Community Services Review* (completed by Dr Chris Jones).

Based on the output of the discussions held at the October Strategic Planning event, the NWRG has now established three core project teams to explore in detail three key themes to emerge from the event:

Unscheduled Care Project team
This project team will explore the question: 'How should the hospital element of unscheduled care in North Wales, be delivered?'

Mental Health Project team
This project team will explore the question: 'How can we improve the quality of our current care for people with mental health needs in North Wales?'

Primary and Community Services Project team
This project team will explore the question: 'How do we deliver the model for primary and community services in North Wales?'.

Each of these core project teams will comprise clinical and managerial staff from across the NHS in North Wales, and each project team will be overseen by a Chief Executive sponsor. A short briefing note on each project team is included in this briefing pack.

2 Membership of the Stakeholder Group

The Stakeholder Group will include over 200 individuals, comprising representation from across North Wales of the following:

- Service users/patients and carers
- Community Health Councils
- Voluntary Services Councils
- Local Authorities

- Health, Social Care and Well Being Strategic Partnerships
- Children and Young People's Partnerships
- Mental Health Strategic Partnerships
- Older People's Strategic Partnerships
- Community Safety Partnerships
- North Wales Race Equality Network
- North Wales Police
- North Wales Fire and Rescue Service
- Care Forum Wales (independent sector)
- Domiciliary Care Providers
- Schools of Nursing/North Wales Clinical School
- Countess of Chester Hospital

3 Role of the Stakeholder Group

The Stakeholder Group's key role will be to provide a gauge for the **acceptability** of the ideas emerging from each of the three '30 day' cycles of work of the three project teams.

As such, the Stakeholder Group will act as a patient, public and partner agency 'sounding board' for the output of the project teams.

4 Commitment Required

The Stakeholder Group will be brought together on 4 occasions between March and June 2009, commencing with attendance at a day time briefing event on 17th March 2009. This will be followed by 2 half day (afternoon) meetings of the Group on 1st April and 13th May and a third fuller day (10am-4pm) on 24th June which will be a joint meeting with an Expert Group. At these 3 meetings, the Stakeholder Group will receive feedback from each of the three project teams and be encouraged to debate, discuss and contribute to the work of the three project teams.

In addition to attending the day time briefing event in March and the three meetings, members of the Stakeholder Group will be expected to seek the views of their wider contacts, networks and organisations and 'feed' these into the ongoing work of the project teams after each of the meetings in April, May and June. This feedback will be required within 14 days of each meeting and will be facilitated through access to specific pages on the websites of the health organisations across North Wales. Written feedback will also be accepted.

5 Personal Commitment to Membership of the Stakeholder Group

- Members of the Stakeholder Group will provide a partner agency or public/patient/carer perspective on the work of the project teams as this emerges, depending on their experience, knowledge and expertise.
- It is vital that members of the Stakeholder Group attend the initial briefing session and all 3 'report back' sessions. This is important to ensure that all members of the Stakeholder Group have the same level of understanding about the emerging themes of the project teams. It is

anticipated that, where relevant, the host organisation of members of the Group will support members to attend the Stakeholder Group.

- Members of the Stakeholder Group will also be required to share the outputs of the project teams within their own contacts, networks and organisations in order to secure further views and feedback for the project teams. A summary briefing document will be produced after each 'report back' meeting to help members of the Stakeholder Group with this.
- Each member of the Stakeholder Group will be expected to respect and give equal consideration to all the views expressed by both the three project teams as well as the views of other members of the Stakeholder Group.

APPENDIX B(iii)

BRIEFING NOTE FOR MEMBERS OF THE 'EXPERT' GROUP

1 Overview

A North Wales Strategic Planning event was held over a period of 2 days during October 2008 and was arranged by the North Wales Health Planning Forum, now known as the North Wales Health Reform Group (NWRG). This event was a collaborative venture between all NHS organisations in North Wales which sought to review health and healthcare strategy for North Wales. The event was attended by senior primary, community and acute clinicians from across North Wales, together with senior managerial staff and representatives of the Community Health Councils, Voluntary Services Councils and Local Authorities across North Wales. The event was informed by a number of key strategic documents already produced for the NHS in North Wales including: *Designed for North Wales* and a number of reports produced as a result of reviews commissioned by the Minister for Health and Social Services. These included *the Llandudno Hospital Review* (completed by Frank Burns) and *the Community Services Review* (completed by Dr Chris Jones).

Based on the output of the discussions held at the October Strategic Planning event, the NWRG has now established three core project teams to explore in detail three key themes to emerge from the event:

Unscheduled Care Core Project Team
This project team will explore the question: 'How should the hospital element of unscheduled care in North Wales be delivered?'

Mental Health Core Project Team
This project team will explore the question: 'How can we improve the quality of our current care for people with mental health needs in North Wales?'

Primary and Community Services Core Project Team
This project team will explore the question: 'How do we deliver the model for primary and community services in North Wales?'.

Each core project team will comprise clinical and managerial staff from across the NHS in North Wales, and each project team will be overseen by a Chief Executive sponsor. A short briefing note on each project team is included in this briefing pack.

2 Membership of the 'Expert' Group

The expert group comprises mainly health service staff from across the NHS in North Wales, inclusive of primary, community and acute healthcare staff, and staff side representatives. All clinical specialties encompassing all ages and health conditions are represented, as are all clinical and non-clinical support areas/departments.

In addition, the expert group also has representatives of the Community Health Councils, Voluntary Services Councils and Social Services Departments of the Local Authorities across North Wales. The 'expert' patient perspective is also included in the membership of the Group with the inclusion of a number of patients, carers and service users with an interest in and knowledge of the areas being explored by all three project teams.

In total, the invited membership of the Expert Group comprises over 230 individuals.

3 Remit of the Expert Group

The Expert group's key role is to provide a gauge for the **applicability** of the ideas emerging from each of the three '30 day' cycles of the three project teams. As such, this Group will act as a professional, multi-disciplinary 'barometer' giving expert professional and patient advice and guidance to the project teams, thus providing a feasibility focus for the themes and issues emerging from the work of the three project teams.

4 Commitment Required

The Expert group will be brought together on 4 occasions between March and June 2009, commencing with attendance at either a day time (17th March) or one of 6 shorter evening (4th and 9th March) briefing sessions. This will then be followed by 2 half day (morning) meetings of the Group on 1st April and 13th May and a fuller third day (10am-4pm) on 24th June which will be a joint meeting with a Stakeholder Group.

At these three meetings, the Expert Group will receive feedback from each of the three project teams and be encouraged to debate, discuss and contribute to the work of the three project teams.

In addition to the day or evening briefing sessions and three meetings, members of the Expert Group will be expected to seek the views of their wider contacts and professional networks and 'feed' these into the ongoing work of the project teams after each of the meetings in April, May and June. This feedback will be required within 14 days of each meeting and will be facilitated through access to specific pages on the websites of the health organisations across North Wales. Written feedback will also be accepted.

5 Personal Commitment to Membership of the Expert Group

- Members of the Expert Group will provide a professional or user perspective on the work of the project teams as this emerges, based on their experience, expertise and knowledge. Professionals who are members of the Expert Group thus represent their profession rather than belonging to the Group to provide their own individual professional or organisational perspective.
- It is vital that members of the Expert Group attend the initial briefing session (clinical and other commitments allowing) and all 3 'report back' sessions. This is important to ensure that all members of the Expert Group have the same level of understanding about the emerging themes

of the project teams. Individual organisations will support members of the Expert Group to attend meetings of the Group.

- Members of the Expert Group will also be required to share the outputs of the project teams within their wider professional networks in order to secure further views and feedback for the project teams. A summary briefing document will be produced after each 'report back' session to help members of the Expert Group with this.
- Each member of the 'expert' group will be expected to respect and give equal consideration to all the views expressed by both the three project teams as well as the views of other members of the Expert Group.

APPENDIX B (iv)

Expert Group membership

1. Aim

A prerequisite for the success of this 90 day modified engagement process and ultimately that of the project, will be to ensure that senior medical, nursing and managerial colleagues from primary, community and secondary care are not only fully included in the process, but also to ensure that they do not feel excluded.

It will be better to arrange the expert stakeholder meetings in a venue large enough to accommodate as many representatives as is manageable to facilitate, rather that limit the numbers by selecting too small a venue.

This attendance proposal estimates an audience of 200-250 throughout the sessions.

Expert Group core members

NPHS Lead
CEOs, Medical, Nursing Directors, Directors of Planning (Six LHBs, NWT and NWWT)
Medical advisors of GP Out of Hours services
Senior HR managers NWT, NWWT and BSP

Clinical Directors or chiefs of staff, Heads of Nursing, General Managers NWT and NWWT of relevant directorates
Staff side representative/s (NWT and NWWT)
2-3 GPs from each of six LHB areas, including Regional and Local Medical committee representative/s
(Radiology and Laboratory Services from NWT and NWWT)

Therapy leads NWT and NWWT
WAST
Director of Social Services x 6
Medicines Management leads

Independent sector representative

CHC representative/s (lead officer / chairs)
VSC representative/s (these could be the HSCWB facilitators)
Carer and patient representative/s including mental and physical health issues, including expert patients

Observers

Regional Office (observer)
NLIAH (observer)
Regional Officer NHS Centre for Equality and Human Rights (observer)

Special Interest members of Expert Group

1. Unscheduled care - UPDATED 10 FEB 09

1-3 consultants from each of the following specialties, from each of NWT and NWWT:

- Emergency Medicine (A&E)
- Anaesthetics and Intensive Care
- Paediatrics
- General Medicine including cardiology, stroke services, respiratory medicine and Care of the Elderly
- General surgery, vascular surgery and urology
- Trauma and orthopaedics
- Obstetrics and Gynaecology

Senior Nursing or PAMS staff from NWT and NWWT, from
- Emergency Medicine (A&E)
- Theatres and Intensive Care
- Paediatrics
- Midwifery
- Medical and Surgical wards

Radiology, Pharmacy and laboratory services from NWT and NWWT

2. Primary & Community

Domiciliary Care Provider

Chronic Conditions management leads
Social Services team leaders
Intermediate care leads / cardiac rehab leads

2-3 consultants from NWT and NWWT, with a cross representation from the following specialties:

- Emergency Medicine (A&E)

- General Medicine and Care of the Elderly / Diabetology / Cardiology / Dermatology

- Senior Managerial and Nursing staff from NWT and NWWT(up to 5 per Trust) community hospitals
-

3. Mental Health

Mental Adult Mental Health Partnership Advisory Service representative
Integrated Mental Health Strategic Partnership Board representative
Elderly Mental Health Services representative

District Nurses, Health visitors, Community Psychiatric Nurses, Community psychology leads from each locality

2-3 consultants, senior nurses and general or resource managers from NWT and NWWT, from each of the following specialties:

- Adult and adolescent mental health, including substance misuse
- EMI services
- Clinical Psychology
- Learning disability (Adult)

Mental health therapy leads
Primary Care counselling leads

- Emergency Medicine (A&E)
- General Medicine and Care of the Elderly

Senior Nursing staff from NWT and NWWT, from
- Emergency Medicine (A&E)
- Psychiatric in-patient wards

APPENDIX B (v)

The approach to Facilitation and Communication in the development of Models of Care for Primary and Community Services, Mental Health and Unscheduled Care Services

Purpose

The purposes of this paper are: to explore the approach to both facilitation and communication in this project, and to recommend to the North Wales Reform Group the way forward.

Facilitation

Both the expert group and the stakeholder forum will be very large, with 150-200 members each. They will also bring together individuals and groups with very strong and potentially opposing views. It is therefore clear that this process will require facilitation of the highest quality.

It is recommended that this should be provided by an external organisation with a proven track record in this area. As well as bringing a high level of expertise, an external facilitator will be regarded as an objective voice, or honest broker. This is essential if the process is to work, and if the outcomes from it are to be accepted.

The programme board is currently compiling a short list of companies which have the relevant experience (including those on the Public Services Management Wales Framework Contract). It is proposed to agree a specification and selection criteria, and undertake a tender process that will be complete by the 19th of January 2009.

Communication

The project's approach to communication has to be considered alongside its engagement strategy. As outlined in section 5 of the paper "Stakeholder Engagement to Support the North Wales Workstreams", there needs to be agreement on how wide public engagement should be at this stage.

To take two scenarios, and explore their impact on the approach to communication:

Scenario 1: Engagement is undertaken purely through the expert group and the stakeholder forum, with no further communication with the public until the 90/120 day cycle is completed. The nature of further public engagement and/or consultation after this will be dependent on the outcome of the first piece of work.

In this scenario communication work will be largely limited to that between the various groups, as outlined in the Stakeholder Engagement Paper. However the scale of this task should not be underestimated. There will need to be a

systematic approach to ensuring that the staff/members of each organisation involved in the project are kept informed of progress. There will also be a need for the following administrative functions:

- The collation of the documents that are the outcomes of the various workstreams
- Translation of these documents
- Translation facilities for the various meetings
- Ensuring that the contact details of all group members (over 300) are accurate and kept up-to-date
- The collation of the electronic feedback from each of the cycles of work

In terms of **external communication**, it is highly likely (inevitable?) that members of the reference groups will discuss work in progress with the media, resulting in ad hoc media coverage. Even if there is no active strategy of media engagement, there will need to be a clear strategy for handling media interest.

Scenario 2: There is active communication with the wider public throughout this process, including regular media updates of the outputs of the various groups.

In addition to the internal communication outlined in the first scenario, this would require an active strategy of media engagement. There are clear advantages in terms of the process being inclusive and transparent. However there are risks in actively updating the public on work in progress. For example, the list of options being considered as part of the 2nd 30-day cycle could be reported in the media as firm plans, or as a hidden agenda, and may provoke protests against possible solutions which were not, ultimately, going to be recommended.

Conclusion on Communication

There needs to be an explicit communications plan/strategy.

Communication between the various groups in the project will be a major undertaking and will require administrative support.

In terms of external communication, there is a choice to be made about the approach. The real difference between the 2 scenarios in this paper is not whether the project will engage with the media, but whether there is an active strategy of using the media as part of engagement, or a reactive strategy of firefighting as stories break. There may also be something in-between – e.g. a public launch (including asking for interested people to get involved?) and some form of regular update (similar to the Llandudno project board).

Even (arguably especially) the reactive strategy requires specialist expertise. External professional support may be required to advise on the best

approach, and to contribute to the production and delivery the communications strategy.

Summary of Recommendations

- An external consultancy firm should be appointed through competitive tender to support facilitation.

- A communications strategy and protocol should be devised.

- Consideration should be given to appointing external consultancy support to help devise and deliver the communication strategy.

- Further consideration should be given to the extent of public communication before, during and after the 90/120 day cycle

- As part of the project management support, dedicated managerial/administrative time should be provided from within the NHS to support communications.

Appendix C

NORTH WALES REFORM GROUP (SPONSOR)

PROGRAMME BOARD

Terms of Reference

1 PURPOSE

A seminar on service strategy held in North Wales produced a degree of consensus on the direction for service development but left several priority areas to be resolved.

The first of these priorities for consideration have been agreed by the Project Sponsor - North Wales Reform Group (NWRG) and are as follows:

- Unscheduled Care
- Mental Health
- Primary Care & Community Services

A Project Team will lead the detailed work of each priority area in producing a final report for consideration by the North Wales Reform Group by July 2009 as set out in each approved individual Charter and Project Initiation Document.

The Programme Board will co-ordinate and manage overall the three projects, co-ordinated through the Programme Manager, Stakeholder and communications manager and the 3 Project Team managers (Planning leads)**.**

2 OBJECTIVES

The Programme Board will:

- Review the progress of each of the Project Teams, agreeing any necessary actions required to ensure milestones and timescales are met. As part of this process the monthly highlight reports will be considered.

- Consider any project issues raised by the Project Teams which require a response or decision

- Ensure the delivery of all necessary actions in terms of facilitating stakeholder and expert group events eg, agreeing funding implications, venues, appointment of external consultants etc.

- Where circumstances require for the agreed timescale to be amended, make recommendations to the Project Sponsor (NWRG) to approve the changes.

- Ensure sound communication of progress to all staff and interested parties across North Wales.

- Provide monthly progress reports to the Project Sponsor (NWRG).

3. PRINCIPLES

The members of Programme Board will adhere to the following principles:

- All members of the group will be responsible for feeding back any information to other relevant parties as agreed;

- It is important that all members of the group recognise that some issues discussed are sensitive and they demonstrate respect for colleagues, patients, carers and the public;

- If confidentiality is requested then it is of utmost importance that this is respected and no discussion takes place outside the meeting;

- If objectives are set within the group then each member of the group has responsibility to undertake the work requested.

- Recognise that the Programme Board has no authority to make decisions in the final report produced, but should prepare a set of recommendations for consideration by the Project Sponsor (NWRG)

4. MEMBERSHIP

4.1 The membership of the Programme Board consists of:

Position	Name
Project Sponsor (NWRG) Rep (Chair)	Geoff Lang
Programme Manager	John Darlington
3 x medical directors (2 Trust; 1 LHB)	Paul Birch David Gozzard Gwyn Pierce-Williams
2 x Trust Exec Planning Leads	Craig Barton Neil Bradshaw
NPHS Regional Director	Andrew Jones
3 x Project team managers (Planning Leads)	Clare Jones Jane Jones Ian Howard
Project Team Chairs Rep	Grace Lewis-Parry Mary Burrows Sally Baxter
Communication & Stakeholder Lead	Andy Scotson
Administrative support	RCU

4.2 In addition to the core membership, other members may be invited to attend for specific topics as agreed by the Chair.

4.3 Organisations may nominate deputies. Individuals deputising for core members of the group must be of appropriate grade and seniority.

4.4 The Board will be Chaired by the Project Sponsor (NWRG) Representative . A deputy Chair will be nominated by the Board.

5. QUORUM

Meetings of the group will be considered quorate if 8 members are present.

Given the strategic importance of the project for the North Wales health community, all members must make every effort to attend all the meetings.

6. ADMINSTRATIVE ARRANGEMENTS

6.1 Meetings of the group will be held as required to ensure timely progress.

6.2 The Programme Manager will prepare a progress report for the Board based on project teams monthly highlight reports.

6.3 Agendas and supporting papers will be distributed no less than 2 working days before the meeting.

6.4. The group will be serviced by a nominated administrator.

6.5. Action notes of the meetings will be kept, which identify the lead officer/organisation and a date by which the agreed action will be completed.

7. ACCOUNTABILITY

Each Project Team (via the planning lead) will report progress to the Programme Board using an agreed reporting template, on a weekly basis.

The Programme Board (with representation from each Project Team) will provide monthly progress reports to the Project Sponsor (NWRG).

A final report, with recommendations, will be presented to the Project Sponsor to agree final recommendations to be presented to each NHS Board in North Wales.

NORTH WALES REFORM BOARD (SPONSOR)

PROJECT TEAM

Terms of Reference

1 PURPOSE

A seminar on service strategy held in North Wales produced a degree of consensus on the direction for service development but left several priority areas to be resolved.

The first of these priorities for consideration have been agreed by the Project Sponsor - North Wales Reform Group (NWRG) and are as follows:

- Unscheduled Care
- Mental Health
- Primary Care & Community Services

A Project Team will lead the detailed work of each priority area in producing a final report for consideration by the North Wales Reform Group by July 2009 as set out in each approved individual Charter and Project Initiation Document. The following terms of reference are provided for each of the project teams.

2 OBJECTIVES

The Project Team will:

- Consider all recent reviews and existing plans relevant to their particular project;
- Follow the agreed methodology associated with a '90-day R&D Model';
- Undertake a thorough literature review of relevant, evidence-based, best practice;
- Participate in, and support the agreed processes for engagement with clinicians, stakeholders and the public;
- Produce a final report for the Project Sponsor (NWRG) by July 2009 as detailed in the approved Charter (see attached).
- Ensure that equality and diversity is taken into account throughout the process.

3. PRINCIPLES

The members of each project team will adhere to the following principles:

- Each member has been asked to join the project team because of their own particular area of expertise, experience and knowledge. They are expected to contribute to the work of the Project Team based on these abilities, considering services across North Wales as a whole and should not focus soley on their own locality or current organisation;

- All members of the Project Team will be responsible for feeding back any information to other relevant parties as agreed;

- It is important that all members of the Project Team recognise that some issues discussed are sensitive and they demonstrate respect for colleagues, patients, carers and the public;

- If confidentiality is requested then it is of utmost importance that this is respected and no discussion takes place outside the meeting;

- If objectives are set within the Project Team then each member of the Project Team has responsibility to undertake the work requested.

- Recognise that the project team has no authority to make decisions in the final report produced, but should prepare a set of recommendations for consideration by the Project Sponsor (NWRG) .

4. MEMBERSHIP

4.1 The membership of the Project Team consists of:

Position	Name	Telephone	Email
Executive Sponsor (Chair)			
Planning lead			
Clinical lead			
Project Team specific support			
Project Team specific support			
Project Team specific support			
Project Team specific support			
Administrative support			

4.5 In addition to the core membership, other members may be invited to attend for specific topics as agreed by the Chair.

4.6 Organisations may nominate deputies. Individuals deputising for core members of the Project Team must be of appropriate grade and seniority.

4.7 The Project Team will be supported outside the meetings by officers from various organisations such as NPHS and the NHS Trusts (eg. Information leads)

4.8 The Project Team will be Chaired by the Executive Sponsor. A deputy Chair will be nominated by the team.

5. QUORUM

Meetings of the Project Team will be considered quorate if 5 members are present.

Given the strategic importance of the project for the North Wales health community, all members must make every effort to attend all the meetings.

6. ADMINSTRATIVE ARRANGEMENTS

6.1 Meetings of the Project Team will be held as required to ensure timely progress.

6.2 Each planning lead will prepare a weekly progress report for the Project Team.

6.3 Agendas and supporting papers will be distributed no less than 2 working days before the meeting.

6.4. The Project Team will be serviced by a nominated administrator.

6.5. Action notes of the meetings will be kept, which identify the lead officer/organisation and a date by which the agreed action will be completed.

7. ACCOUNTABILITY

Each Project Team (via the planning lead) will report progress to the Programme Board using an agreed reporting template, on a weekly basis.

The Programme Board (with representation from each Project Team) will provide monthly progress reports to the Project Sponsor (NWRG).

A final report, with recommendations, will be presented to the Project Sponsor to agree final recommendations to be presented to each NHS Board in North Wales.

APPENDIX D

HIGHLIGHT REPORT

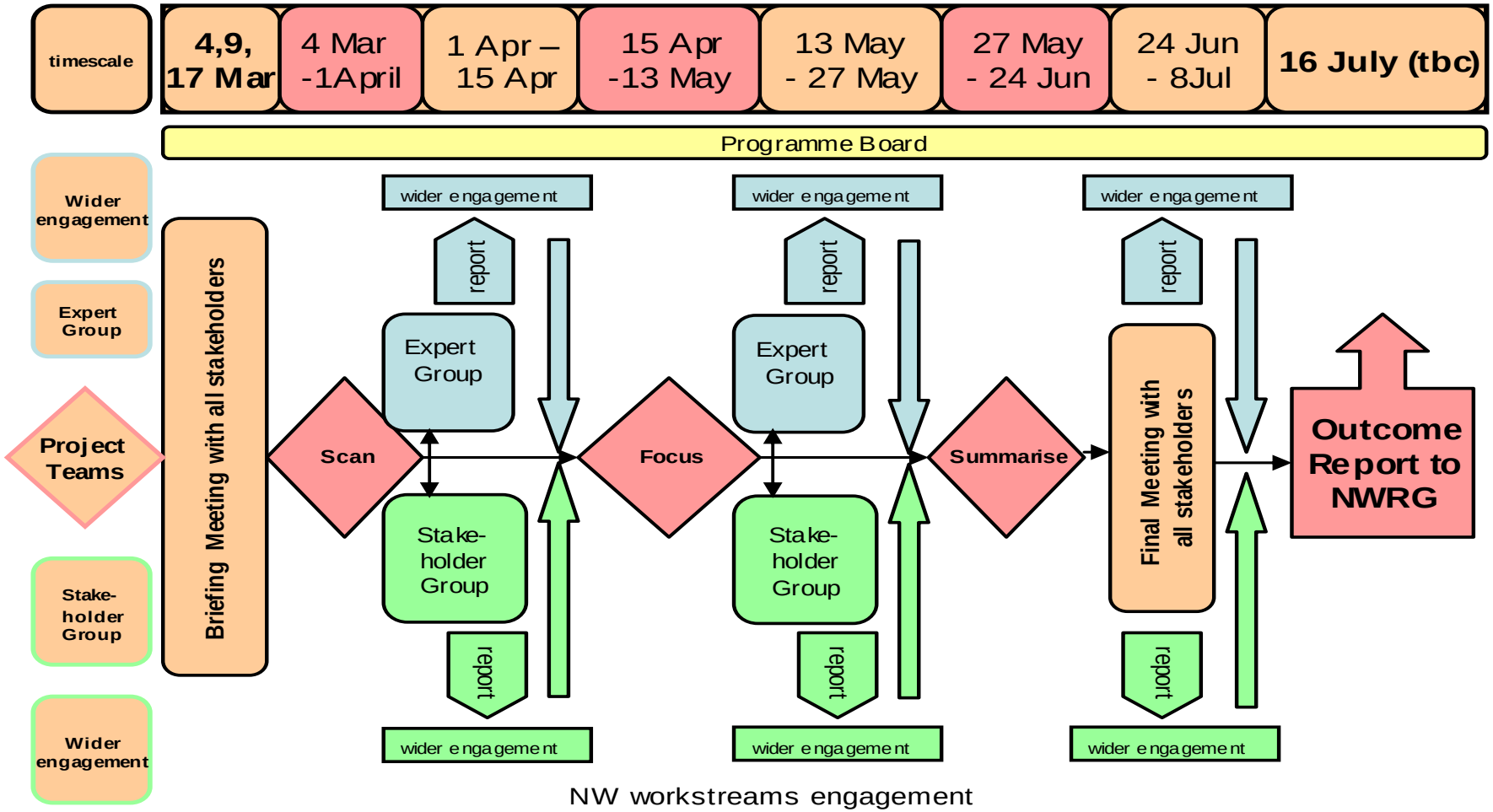
The purpose of this highlight report is to provide the Programme Board with a summary of the project status at regular intervals, including any potential problems.

The Programme Board will use the report to monitor progress and ensure that the project is running to schedule.

The content of the report will include:

- Date of report and period covered
- Schedule status
- Tasks/actions completed during the period
- Actual or potential problems
- Tasks/actions completed during the next period
- Any project issues requiring a response or decision
- Schedule or budget impact of any changes

Modified 90 day process: engagement pathway – Appendix E (i)



NW workstreams engagement
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Appendix E ii

Key Milestones	By When
December /January Pre-work	
Finalise Project Structure	18th December 2008
Project Membership (Programme Board and Project Teams)	18th December 2008
Complete Tendering for Facilitation work	6th February 2009
Map out dates and book venues for all meetings/ workshops	31st December 2008
Stakeholder Identification	31st December 2008
Identify Expert Group Members and Contact - 6 weeks notice	30th January 2008
Appoint Communication Lead and develop communication and Public engagement Strategy	30th January 2009
90 Day R&D Cycle Training for Project Team Members	30th January 2009
February	
Initial Project Team meetings / Commence 1st 30 day cycle	Week Beginning 2nd February 2009
March	
Evening Briefing	**On 4th and 9th March 2009**
Initial Briefing Stakeholder and Expert Groups	**On Tuesday 17th March 2009**
April	
1st Presentation 30 day cycle	**On Wednesday 1st April 2009**
Commence 2nd 30 day cycle	15th April 2009
May	
2nd Presentation	**On Wednesday 13th May 2009**
Commence 3rd 30 day cycle	27th May 2009
June	
3rd Presentation	**On Wednesday 24th June 2009**
July	
Final Stakeholder comments	8th July 2009
NWRG Outcome Report	**On 16th July 2009 (TBC)**
September	
Approval by LHB and Trust Boards	

Contributions:

Craig Barton
Paul Birch
Neil Bradshaw
Mary Burrows
John Darlington
David Gozzard
Ellen Greer
Ian Howard
Clare Jones
Geoff Lang
Grace Lewis-Parry
Eileen Williams
Gwyn P. Williams

APPENDIX 8
NORTH WALES CLINICAL SERVICES STRATEGY
Summary of attendance at engagement events
Note: NHS Trust and LHB figures include clinical and non-clinical staff

4 March 2009: Expert briefing sessions (Bodelwyddan)	
NHS Trust	11
LHB	5
Primary Care	2
National Public Health Service	2
Local Authority	2
	22
9 March 2009: Expert briefing sessions (Bangor)	
NHS Trust	27
LHB	4
Primary Care	4
National Public Health Service	1
Community Health Council	1
	37
9 March 2009: Expert briefing sessions (Wrexham)	
NHS Trust	19
LHB	7
Primary Care	4
Community Partnership	1
Patient Representative	1
Third sector	7
	39
17 March 2009: Stakeholder briefing session (Llandudno)	
NHS Trust	32
LHB	18
Primary Care	5
National Public Health Service	1
Community Health Council	7
Community Partnership	29
Third sector	20
Education	1
Police	1
Local Authority	4
Patient Representatives	4
WAG Regional Office	1
Independent	5
	128

1 April 2009: Expert engagement session (Llandudno)	
NHS Trust	73
LHB	31
Primary Care	18
National Public Health Service	6
Community Health Council	4
Community Partnership	2
Third sector	9
Local Authority	3
Patient Representatives	2
WAG Regional Office	1
Independent	1
	150
1 April 2009: Stakeholder engagement session (Llandudno)	
NHS Trust	5
LHB	6
National Public Health Service	1
Community Health Council	8
Community Partnership	29
Third sector	36
Education	2
Police	1
Local Authority	7
Patient Representatives	10
Independent	5
Equality Network	1
	111
13 May 2009: Expert engagement session (Llandudno)	
NHS Trust	87
LHB	28
Primary Care	16
National Public Health Service	3
Community Health Council	6
Community Partnership	4
Third sector	10
Local Authority	5
Patient Representatives	3
WAG Regional Office	1
Centre for Equality & Human Rights	1
	164

13 May 2009: Stakeholder engagement session (Llandudno)	
NHS Trust	8
LHB	6
National Public Health Service	2
Community Health Council	6
Community Partnership	22
Third sector	34
Education	2
Police	2
Local Authority	4
Patient Representatives	11
Independent	5
Equality Network	1
NLIAH	1
	104
24 June 2009: Combined expert and stakeholder engagement session (Llandudno)	
NHS Trust	76
LHB	29
Primary Care	14
National Public Health Service	6
Community Health Council	7
Community Partnership	27
Third sector	29
Education	1
Local Authority	8
Patient Representatives	10
WAG Regional Office	1
Independent	6
Equality Network/CEHR	2
NLIAH	1
	217

10 March 2010: Combined expert and stakeholder engagement session (Llandudno)	
NHS Trust	59
LHB	18
Primary Care	4
National Public Health Service	6
Community Health Council	5
Community Partnership	15
Third sector	15
Education	0
Police	0
Local Authority	9
Patient Representatives	10
WAG Regional Office	2
Independent	4
Equality Network/CEHR	2
NLIAH	0
	149

APPENDIX 9

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Development of 5 Year Orthopaedic Clinical Services Plan

Project Initiation Document

PID v9.doc

06th July 2010

Table of contents

Page

Summary and Purpose of this Project

This Project and initiation document has been prepared to ensure a structured process in place to deliver short and long term strategic change across orthopaedic services in North Wales.

The work on efficiency and productivity across north Wales has identified areas for improvement. However, large scale service change is required, alongside the structural change to support this.

There needs to be an emphasis upon 'action now', to reflect on the challenges and observe and learn from work undertaken to date including the positives and determine the key strategic issues and solutions. This Project Initiation Document therefore recognises the need for a balanced strategic approach between short term action and longer term strategic change.

Effective early planning is key to tackling the key strategic issues which must be managed alongside the short term work to improve efficiency and productivity. Historically, many proposals were unsuitable to go ahead because the blend was incorrect.

This project aims therefore to challenge and rethink on how our services are delivered, with the use of our asset base explored to ensure resources are utilised innovatively, as the long term position must not be compromised.

Optimistic planning is required but with realistic timescales and achievable delivery plans. The challenge is to continue to discuss the best possible way to move forward the rapid spread of improvement across North Wales.

Finally, there is importantly an inherent need to spread a consistent message to as many people do not fully understand the challenge ahead of the organisation. We need to identify and document solutions and ensure these are not just working on housekeeping or medium term solutions.

Mark Common
Chair - Orthopaedic Project Board

(Director of Improvement and Business Support)

1. Project Aim and key strategic questions

To consolidate national and local strategies and key drivers in relation to Orthopaedic Services and to develop and implement a 5 Year Strategic plan that delivers tangible change in North Wales.

Key strategic questions to be addressed through this work are;-

(i) What is the model for elective and emergency orthopaedic services for North Wales?

(ii) Within the elective model, how should day case surgery be configured?

2. Strategic Direction

The BCUHB approved its' Strategic Direction document *"Bringing people and services together for North Wales"* in October 2009. The strategic direction contained within the document sets out the Board's blueprint for providing future care services in North Wales; these are aligned to five local strategic themes as follows:

- *Making it better*
- *Making it safe*
- *Making it work*
- *Making it happen*
- *Making it sound*

It states the aims, objectives and underlining principles for the Health Board based on equity and access to high quality care. Most importantly, it establishes the Clinical Programme Group (CPG) as the driver for clinically led, safe and effective services using transformational change, best practice and innovation to deliver the highest standards of care.

Local strategic planning is aligned with the national AOF strategic objectives and the CPG priorities are consistent with ensuring the delivery of the AOF for 2010/11, while also promoting the 14 high value opportunities to further improve services.

3. Background Information

Orthopaedics is a key service within the BCU Health Board Surgical and Dental CPG and makes an invaluable contribution to improving the health and well-being of the population we serve.

Over recent years the strategic principle, both locally and nationally, has been to provide safe, quality services as locally as possible and where possible, to relieve the growing demand on acute hospitals. Whilst previous orthopaedic plans took into account modernisation plans to improve efficiency and productivity, they were incremental in nature and developed in the context of 3 separate acute trusts in North Wales. The establishment of BCU health Board now provides opportunity to pursue safe and effective clinical services through both continuous improvement and the future transformational change required to deliver sustainable services.

The Annual Framework and specifically Access 2009 agenda has been a key driver in the application of resource for orthopaedic services across North Wales. This has not only included activity delivered in house but also through English providers and the independent sector. For 2010/11 the AOF asks NHS Wales to focus on:

- Upstream prevention and well-being;
- Improving patient care in the community;
- Reducing waste, harm and variation;
- Efficiency and productivity;
- Operating within available financial resources;
- Delivering through an effective workforce;
- Improving patient care and safety through the use of ICT;
- Improving the quality of core services and delivering the national targets.

and includes 14 high level opportunities:

- Develop new settings of care and improve long-term care pathways.
- Improve quality of continuing care through health and social care integration.
- Implement cross-system patient information and informatics.
- Develop improved unscheduled care pathways.
- Stop wasteful clinical interventions.
- Improve acute care performance and decrease length of stay.
- Improve primary and community care performance.
- Improve mental health service provision.
- Manage medicines more effectively.
- Improve procurement and supply chain.
- Drive highest-value prevention campaigns.
- Streamline and refocus the centre.
- Establish service line management and patient level costing.
- Modernise the workforce.

Service Development and Commissioning Directives issued by WAG to drive improvements in service also include;

- Chronic Non-malignant Pain
- Arthritis and Chronic Musculoskeletal Conditions

A ‘twin track’ approach is therefore required to ensure we have a plan that can deliver both in the short term (to meet 2010/11 AoF requirements in Appendix A) and importantly to ensure the transformational change required to deliver sustainable services across North Wales over the next 5 years is achieved.

This PID has been developed therefore to ensure that there is a robust process in place to manage this complex process. It will require a comprehensive and systematic review and plan for future Trauma and Orthopaedic services in line with the agreed aims and scope of this project. This process will therefore essentially test previous assumptions, refresh existing plans and develop and implement the new strategic direction for Orthopaedic services for the future.

It is well recognised that the NHS cannot make the necessary changes in isolation and the continued need to work jointly and openly with key partners, such as the local authorities, voluntary sector and independent sector, is essential in tackling this priority. Whilst the focus of this project will be predominantly upon the internal clinical structures and processes of BCU, opportunities for the service to be designed and delivered across health and social care must be embraced.

4. Principles

A number of principles (taken from previous 3 cycle R&D Clinical Strategy work) will underpin this programme of work, namely:

- Focus on the person – keep people independent and re-able them when needed;
- Give as much care as possible in community settings. Admit people to the acute hospital only if necessary, and for as short a time as possible;
- Give highest quality clinical care by the right person, in the right place – first time;
- Make sure that people are safe;
- Look after the mind, body and spirit;
- Get the design right for the most vulnerable in society and, in that way, for everybody.

When considering the model of care for Orthopaedic services it is useful to drill down and develop 'design principles' pertinent to these services. The suggested design principles are described below.

We need to:

- Develop and provide services that are evidence based, cost effective and sustainable;
- Develop mechanisms to actively evaluate and review service provision to ensure a level of quality is provided and that services are responsive to the needs of the population.
- Empower individuals to maintain their own health and well-being by promoting prevention and self-management;
- Treat patients and not diseases. As the majority of people have more than one problem we need to avoid situations where specialists take responsibility for components of care or disease groups;
- Better integrate services across health, local government, the voluntary and independent sectors;
- Ensure that the patient/client is cared for by the most appropriate professional;
- Provide a first point of contact which is readily accessible and responsive to meeting peoples needs day or night;
- Remove the need for hospitals to act as the gatekeeper for the majority of diagnostic tests;
- Create incentives for alternative ways of delivering services and providing 'contact' with care providers, such as telephone consultations, e-booking appointments and so on;
- Further develop services and roles, which provide alternatives for patients and reduce demands on staff.

5 Objectives

The following objectives have been identified in taking forward this process and development of strategic plans:

- statutory guidelines are followed in the development and implementation of the Project through clear project management arrangements;
- the appropriate mechanisms are in place to allow successful clinical leadership and engagement , joint ownership and involvement of all relevant disciplines;
- the strategy formulation and implementation is underpinned by a robust evidence base and holistic assessment of the health and well-being needs of the local community taking into account future demographic changes;
- patients, service users, carers, and the public, including the vulnerable and disadvantaged, are where appropriately involved in development and delivery of local plans;
- the delivery of the Programme is firmly linked to other local strategies and plans e.g. Llandudno project;
- appropriate consideration is given to related national strategies and priorities.

6 Project Scope

The project will include a 'twin track' approach to ensure both implementation of immediate and 2010/11 CPG plans that supports the strategic direction of travel together with the development and implementation of the 5 year strategic plan:

(i) Short term (Implementation of 2010/11 Plan)

Key areas for focus include:

- Emphasis upon safe and high quality clinical services, building quality into service planning and delivery e.g. surgical site infection, Joint registry, national hip fracture database, patient reported outcome measures e.g. oxford hip and knee.
- further improvement of demand management systems and processes, e.g. CAT, CADMs, TEAMs, referral triage, including evidence based guidelines and treatment thresholds.
- examination of elective activity requirements following application of efficiency plans, developing robust interim plans for 'in house' and externalized activity.
- pursue opportunities for improved English contract efficiency, e.g. through flexibility around payment by results in 2010/11.
- continued development of information technology systems and supporting infrastructure, including electronic referral system.
- A focused implementation and more comprehensive approach to the redesign and transformation of clinical pathways.
- Facilitate a wholesale review of orthopaedic implants, purchasing and cost with a view to facilitating increased levels of efficiency.
- improved levels of efficiency and productivity through continued development and implementation of efficiency plans across BCU and rapid spread of best practice.
- greater engagement with the public to assist them in better understanding their rights, roles and responsibilities within elective care, e.g. reducing patient DNAs, outpatient new to review ratios.
- Development of service line reporting to support improved efficiency and benchmarking.

(ii) 5 Year Strategic Plan

Key objective is to develop a 5 year strategic development plan for orthopaedic services across BCU with clear annual milestones that takes into account patient need, workforce, ICT and estate infrastructure requirements within resources available to BCU Health Board.

(iii) Key Strategic Questions

Questions to be addressed through this work are;-

(ii) What is the model for elective and emergency orthopaedic services for North Wales?

(ii) Within the elective model, how should day case surgery be configured?

(iv) Key deliverables

The project will be required to clarify our future Trauma and Orthopaedic service model, with detail of site, activity and case mix. This will take into account and link information from previous projects and programmes including the Llandudno and Abergele Hospitals reviews.

7 Input from Other Agencies and Equality Impact Assessment

As set out in the Assembly guidance local co-operation, involvement and ownership of key organisations including 'expert patient' input is vital in the success of this project.

Attention needs to be given to communicating the rationale for any change in service in terms of access, convenience and service quality. We need to address public concerns, for example; that changes may be purely financially driven, or that the necessary staffing skills will not be available.

A stakeholder engagement strategy will have to be developed and implemented at an early stage of the Programme.

Equality Impact Assessment

We acknowledge our statutory duty to promote equality. This means we will work to ensure that, as far as possible, arrangements are developed in full recognition of diverse needs, and potential adverse impact or unfavourable effects for some groups are identified and that steps are taken to mitigate these effects. We will therefore ensure that plans are assured in terms of their impact on equality.

8 Constraints

The capacity to deliver the Programme is constrained by:

- Securing resource for effective project infrastructure.
- The identification of and protected time commitment from key leads and members of the Project Teams;
- The active support and involvement of the key partner organisations;
- The ability to encourage the public, including vulnerable and marginalized groups, to be involved and ensure their contributions are valued;
- The achievement of key milestones as set by the specific work-stream/project team terms of reference;

- Impact of clinical activity to meet targets.

9 Benefits

The project management arrangements proposed will ensure the delivery of an Orthopaedic service strategy across BCUHB and the benefits will include:

- Improved access to quality services evidenced by the delivery of local and national performance and efficiency targets;
- Strategic planning, prioritisation and implementation underpinned by comprehensive health and well-being needs assessment;
- Supporting and complimenting other local strategies and frameworks.
- A partnership approach and therefore a jointly owned strategy, that all relevant CPGs can adopt and implement;
- Building upon the prevention role of local authority services and health services;

10 Project Structure and Project Management Arrangements

(i) Project Structure

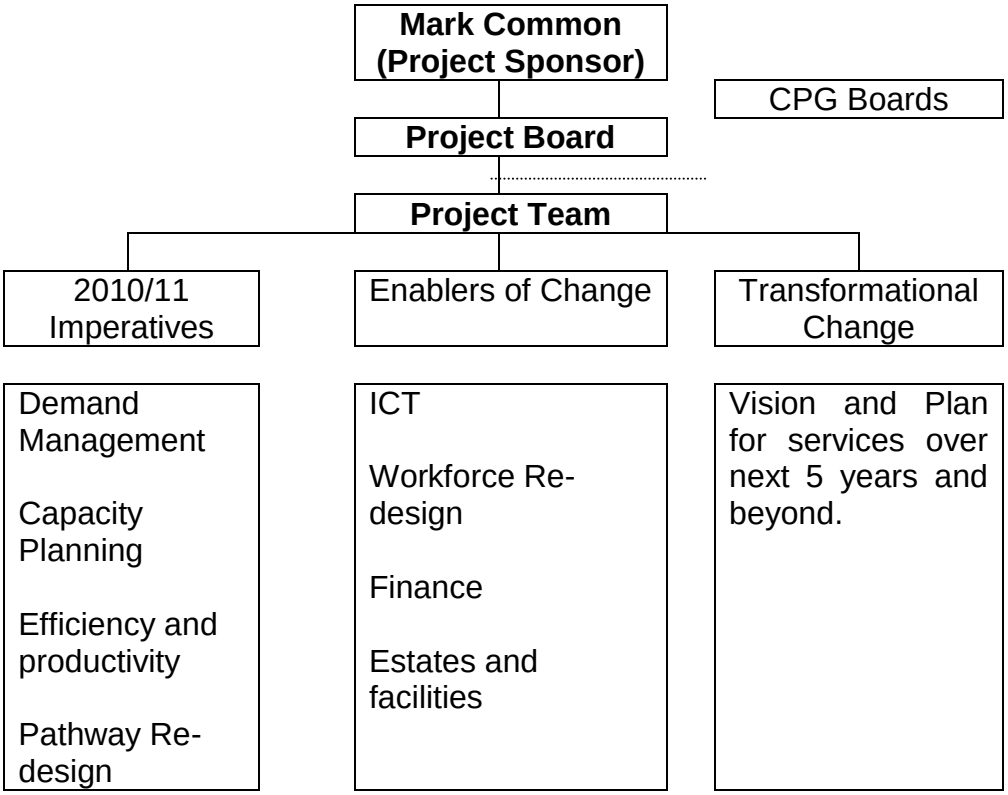
The **Project Sponsor** is Mr M Common. A **Programme Board** will be established to co-ordinate and manage overall project plan, co-ordinated through a Programme Manager, Stakeholder and communications lead and the Project Team Manager**.**

A **Project Team** (including groups already established) will lead on identified project themes and will be led by the Project Team Manager who will report to the Programme Board. The Project Team Manager will work with a core team of representatives from across North Wales. These may include: -

- GP
- Orthopaedic Surgeon
- Other relevant CPG input
- Therapist
- Public Health Wales
- Nurse
- General Manager
- Social Services
- Improvement, Planning, finance, estate support

Other support will be required from various sources to support the gathering of data and information, and the engagement process. A dedicated Information / performance analyst has been identified in support of the project.

Programme Management support will be co-ordinated through the Programme Manager, with additional support to corporate departments such as Planning and Estates, Finance, Workforce and OD and Service Improvement.



(ii) Project Management Arrangements

Overview of three cycle model

- The cycle will commence with a briefing meetings in June 2010. The aim of these briefing meetings will be to provide a wide understanding of both the reasons for and the remit of the workstreams. Invitees to this briefing event will include members of the core workstreams; members of an 'expert' group and, members of a wider stakeholder forum.

- Each of the workstreams will then undertake the first cycle of their work. The emphasis will be to gather and consider all the evidence relating to the work of the particular workstream, the evidence being local, national and international. At the end of the first cycle, the work of the workstreams will then be reported back to the reference group and then to the wider stakeholder forum for feedback, thoughts and views. There will then be a period of 14 days for the 'Reference Group Members' to provide feedback to the core workstreams.

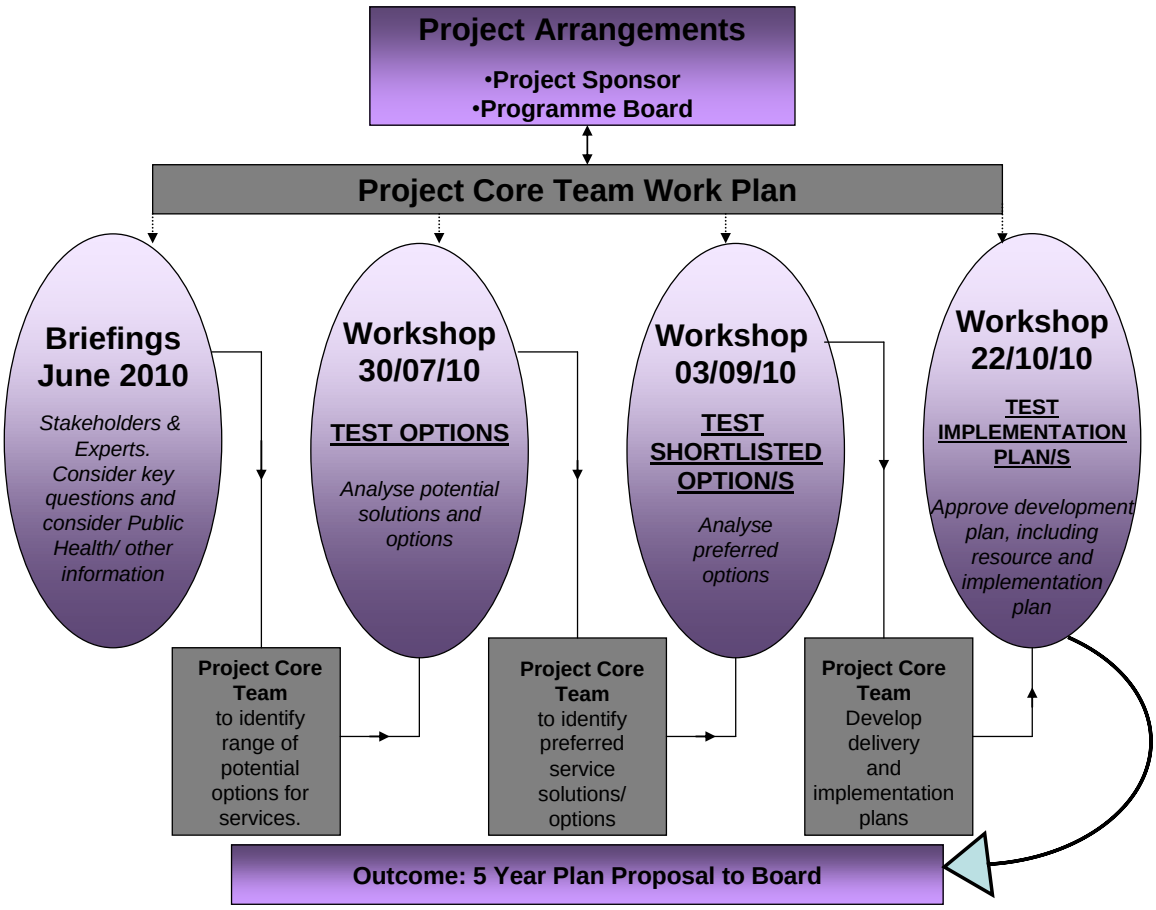
- The feedback from the Groups will then be fed into the second cycle of work of each workstream .The focus of this second block of work will be to focus on the options for addressing and answering the specific questions given to each workstream. At the end of

the second cycle, the output of this element of the three workstreams work will again be reported back to the 'expert' group and then to the wider stakeholder forum for further feedback, thoughts and views.. There will then be a period of 14 days for the 'Reference Group Members' to provide feedback to the core workstreams

- In turn, this further feedback from the Groups will then be fed into the third cycle of work for each workstream. At the end of the third cycle, the output of the workstream which will include recommendations to address and answer the specific question set for each workstream, will then be reported back to all stakeholder groups: members of the core workstreams; the 'expert' group and the wider stakeholder forum. There will then be a period of 14 days for the 'Reference Group Members' to provide feedback to the core workstreams

- The feedback gathered at this final stakeholder event (and the 14 days following the final event) will be included in the final recommendations that are then taken to the North Wales Planning Forum for discussion and/or endorsement.

It is proposed that to facilitate rapid feedback within 14 days following each 'report back' session, an electronic method of feedback is used. This will allow stakeholders the opportunity to record their comments and submit them to the core team. Comments will only be invited from stakeholder group members. Responses will be recorded in an electronic format which allows all interested parties to view the comments from all stakeholders and members of the 'expert' health group.



Reference Group

A prerequisite for the success of the three cycle model, modified engagement process and ultimately that of the project, will be to ensure that experts and stakeholders are provided with opportunities to test and evaluate options and outcomes via the 'Reference Group'. Experts include senior medical, nursing and managerial colleagues from primary, community and secondary care, they will provide expert advice on the **clinical appropriateness** of ideas that emerge form the three cycle process. Stakeholders will provide a gauge for the **acceptability** of the ideas emerging from each of the three cycles of work of the three project teams. As such, the stakeholder members will act as a patient, public and partner agency 'sounding board' for the output of the project teams.

Terms of Reference and Membership

Terms of reference for both the Programme Board and Project Teams are set out in

Appendix B

11 Resources

There is commitment from the Board of Directors (as Project Sponsor) to allocate sufficient resource to ensure the delivery of the project within the stated timescale. However an understanding of the contributions and responsibilities of key officers has to be further agreed. It is also recognised that other partners have a vital part to play and consultation regarding their contribution needs to take place.

Staff Resource required

- Programme Board members
- Project Core Team members
- Information Analyst
- Senior Finance Representative (Finance and Economic appraisal)
- Input from Director of Public Health
- Allocated time commitment and input of other key project team members.
- Allocated time commitment and input of key partner agencies as appropriate.
- Staff contribution from other partners.

Other Resources

- Venues
- Translation facilities
- Secretarial support
- Non-recurring funding to support stakeholder engagement / communication / facilitation processes. Stakeholder group to include CHC, Vol sector, LA elected members, public

12 Assumptions

In achieving the aim of the programme, it is assumed that:

- Key staff are released for them to fully engage as appropriate within project teams and expert groups in line with project plan and key milestones;
- Timely identification and input from planning leads and members of groups;
- agreed timescales are met;

- key partners jointly agree the approach taken and the structures to be put in place;
- the Partnership members can agree on implementation plan priorities to be take forward as part of the North Wales Programme delivery.

13 Review and Communication

The Programme Board will meet at least on a monthly basis and in line with key project milestone dates to review progress against agreed milestones, with flexibility to schedule meetings to coincide with significant stages within the overall programme of this project.

The Project Core Teams will also meet monthly in order to ensure that the agreed timetable for achieving the project.

A highlight report will be prepared by the Programme Board (see **Appendix C**) as required, including an updated action plan report. The Chair(s) will be notified as soon as reasonably possible of any significant variance in terms of time, partner co-operation and cost.

Overall programme progress, risk and exceptions will be reported to the Project Sponsor as appropriate.

14 Risk Management

Project Risk Management sets the context in which project risks will be actively managed throughout the project. All identified risks will be included within a *Risk Register*. The Risk Register is owned by Project Managers and the overall Programme Manager.

It is essential that the risks in achieving the aim of this project are identified at the outset so that steps to manage and lessen them can be put in place wherever possible. It is the collective responsibility of the Programme Sponsor, Programme Manager and Board, Project Teams and Project Managers to manage and mitigate these and any new risks as they arise to ensure the successful conclusion of the project. The successful delivery of this programme is a major undertaking. The risks noted below are not exhaustive, the project being a dynamic process may result in further risks which will need to be addressed.

Risk	***Proposed control measure***
Inadequate resource to implement project.	Identify resource requirement. Identify key players in partner organisation who can contribute to the work of the project.
Lack of commitment/co-operation amongst partners.	Ensure commitment at the highest level through Project Sponsor.
Disagreement with senior clinical staff	Actively Involve all relevant clinicians throughout process. Send a monthly update to all clinical staff (primary and secondary care) as part of a communications strategy.

Failure to achieve agreed milestones	Develop a management control plan for each project setting out detailed actions to be taken, lead officers and timescales highlighting key milestones which must be achieved for the overall programme and each individual project Report major slippage to Programme Board with appropriate recommendations for ensuring that the final report is delivered to time.
Proactive and optimum involvement of the public, including vulnerable groups	Develop an engagement process and stakeholder engagement group to support the programme.
Inability to identify key staff	Ensure flexibility for key individuals to be involved in this process.
Media Misrepresentation	Communications Strategy developed
Political Acceptability	Facilitation and engagement / communications strategy

These risks will be actively controlled, monitored and reviewed as an integral and embedded part of the project review process. The Risk Register will be continuously updated to include all the identified risks and will detail plans of how each will be reduced / mitigated, including the actions on individuals and the current status.

15 Project Controls

Each Project Team will detail progress in the monthly highlight reports. **(Appendix C).** Where tolerance is likely to be exceeded, the Project Manager will discuss the implications with the Chair(s) of each of the Project Teams in the first instance. Where a significant deviation from the plan is envisaged a formal Programme Board meeting will be arranged.

16 Products and Milestones

The Project will follow the 3 cycle model as set out in **Appendix D**

It is proposed that the Programme Board develop project management arrangements based on good practice and produce detailed staged plans as to how each milestone will be achieved. Monthly highlight reports should then be developed based on performance against these plans. Within the context of this, project management will be used to ensure:

- records will be maintained for all *Products;*
- each *Product* will have a unique identifier and version number, for both printed and electronically stored versions;
- changes to *Products* will be controlled through a formal Change Management process (once declared complete by the originator);

- where changes are requested to *Products* these will be assessed and their impact determined before approval;
- the links / dependencies between the various *Products* will be clearly identified to ensure they are developed / delivered in the correct sequence and changes are not made in isolation, and
- the status of *Products* will be managed, including responsibilities for their achievement and target completion dates.

Documents which will be used to support the management process include :

- *Product List*. Maintains details of all the *Products*, their owner, current version, current status and pre-requisites. This will be a Master Document maintained by the Project Manager.
- *Change Management Form*. The form used for requesting, assessing and approving changes to *Products*.
- *Product Change History Log*. The log of changes made to specific *Products*.

In addition to controlling the paper-based *Products* and project documentation a formal document naming convention will also be applied to electronically stored versions of the *Products* and project documents. This consists of a character description, that includes a key descriptor of the document type and the version number. Copies of all versions of documents will be maintained electronically by each Project Manager and the Programme Manager.

Document Type	Description	Proposed Naming
PID	Project Initiation Document	PID v1.doc PID v2.doc

17 Document Control

Document Issue Control

This is a controlled document. When new copies or versions are issued then previous versions should be destroyed.

Revision History

A record of any changes will be maintained by the Project Manager.

Revision	Date	Summary of changes	Author

Document Approvals

Each key document requires the approval of Programme Manager and Programme Board

Document Distribution

Copies of each document and all changes are distributed to the Programme Board and appropriate Project Teams.

APPENDICES

Appendix A **AOF Targets 2010/11**

Appendix B **Terms of Reference**

Appendix C **Highlight Report**

Appendix D **3 Cycle Model**

APPENDIX A

ANNUAL OPERATING FRAMEWORK 2010/11 – Specific Targets

	Access
AOF 10	• To maintain a maximum referral to treatment times of 26 weeks. *At least 98% of patients waiting on an open pathway will have waited less than 26 weeks from Quarter 1 onwards.* • To ensure that 100% of patients not treated within 26 weeks, for clinical reasons and/or patient choice, are treated within a maximum of 32 weeks (on an open pathway). • To achieve a maximum waiting time of 8 weeks for specified diagnostic tests and 14 weeks for specified therapy services for all patients who are not on an RTT pathway throughout 2010 /2011.
	Efficiency and Productivity – revised for 2010/2011
AOF 8	To deliver the core efficiency and productivity measures around the following: • Workforce - Sickness and Absence rates; • Average Length of Stay – Elective Care; • Average Length of Stay – Emergency Care; (incorporate development work on admission avoidance, multiple admission and short stay); • Short Stay Surgery 'Basket' Procedure Rates; • Critical Care DTOC; • Theatre Utilisation; • Cancelled Operations; • Outpatient Follow Up Ratios; • Outpatients DNA Rates; • Prescribing National Indicators.
	Finance
AOF 9	To operate within their available resources and maintain financial balance
	Unscheduled Care
AOF 12	To ensure that: • 95% of new patients (including paediatrics) spend no longer than 4 hours in a major A&E department from arrival* until admission, transfer or discharge; and • 99% of patients spend no longer than 8 hours for admission, transfer or discharge. • handover of all patients from an emergency ambulance to major accident and

	emergency departments within 15 minutes.
AOF 14	To achieve the Year 3 reduction of the DToC programme. (See Ministerial letter EH/ML/019/08).

APPENDIX B

PROGRAMME BOARD

Terms of Reference

1 PURPOSE

The purpose of this programme is to consolidate national and local strategies and key drivers in relation to Orthopaedic Services and to develop and oversee the development of a 5 Year Strategic plan that delivers tangible change in North Wales.

The Programme Board will co-ordinate the work of the Project Core Team through the Programme Manager, Communications Manager and the Project Core Team manager (Planning leads)**.**

The Project Core Team will lead the detailed work of each key theme in developing detailed work across the three cycles.

2 OBJECTIVES

The Programme Board will:

- Agree scope of the project and key themes;
- Approve and agree the project core team;
- Review the progress of the Project Core Team and sub groups, agreeing any necessary actions required to ensure milestones and timescales are met. As part of this process SBAR reports will be developed by the Project Core Team Manager;
- Consider any project issues raised by the Project Core Team which require a response or decision
- Ensure the delivery of all necessary actions in terms of facilitating reference group events eg, agreeing funding implications, venues, appointment of external consultants etc.
- Where circumstances require for the agreed timescale to be amended, make recommendations to the Project Sponsor to approve the changes;
- Ensure sound communication of progress to all staff and interested parties across North Wales;
- Provide monthly progress reports to the Project Sponsor;
- Provide progress reports to the CPG Board.

3. PRINCIPLES

The members of Programme Board will adhere to the following principles:

- All members of the group will be responsible for feeding back any information to other relevant parties as agreed;
- It is important that all members of the group recognise that some issues discussed are sensitive and they demonstrate respect for colleagues, patients, carers and the public;
- If confidentiality is requested then it is of utmost importance that this is respected and no discussion takes place outside the meeting;
- If objectives are set within the group then each member of the group has responsibility to undertake the work requested.
- Recognise that the Programme Board has authority to make decisions on behalf of the Project Sponsor

4. MEMBERSHIP

4.1 The membership of the Programme Board consists of:

Position	Name
Chair of Programme Board	Mark Common
Project Clinical Lead, Surgical and Dental CPG	Glynne Andrew
Community Health Council / Patient representation	CHC lead to nominate
Medical Director to nominate medical representation	TBC
Director of Nursing to nominate nursing representation	Anne-Marie Rowlands
Director of Public Health	Andrew Jones
Chief of Staff – Surgical and Dental CPG	Tony Shambrook
Chief of Staff – Anaesthesia, Pain and Critical Care	Dave Council
Operational Associate Chief of Staff	Craig Barton
Therapies & Clinical Services	TBC
Operational Associate Chief of Staff	Graham Alexander
Programme Manager (Deputy Chair of Programme Board)	John Darlington
Project Core Manager	Robin Wiggs
Improvement and Business Support	Jill Newman
Senior Finance Lead	Adrian Butlin
WAG Representative	Lesley Law
Primary Care representative	Clare Jones
GP Representative	Dr Medwyn Williams TBC
Information Lead	TBC
Communications Lead	Dawn Davies
Engagement Lead	Dylan Williams

The core membership may change as new appointments in the BCUHB are made.

In addition to the core membership, other members may be invited to attend for specific topics as agreed by the Chair.

4.2 Individuals deputising for core members of the group must be of appropriate grade and seniority.

4.3 The Programme Board will be Chaired by the Director of Improvement and Business Support. A deputy Chair will be nominated by the Board.

5. QUORUM

Meetings of the group will be considered quorate if 8 members are present.

Given the strategic importance of the project for BCUHB, all members must make every effort to attend all the meetings.

6. ADMINSTRATIVE ARRANGEMENTS

6.1 Meetings of the group will be held as required to ensure timely progress.

6.2 The Programme Manager will prepare a progress report for the Board based on project teams monthly highlight reports / SBAR reports.

6.3 Agendas and supporting papers will be distributed no less than 2 working days before the meeting.

6.4. The group will be serviced by a nominated administrator.

6.5. Action notes of the meetings will be kept, which identify the lead officer/organisation and a date by which the agreed action will be completed.

7. ACCOUNTABILITY

The Project Core Team Manager (via the Programme Manager) will report progress to the Programme Board using an SBAR report following each cycle (ahead of reference group events) and a brief weekly report for Programme Board clarifying progress.

The Programme Board (with representation from the Project Core Team) will provide progress reports to the Board of BCUHB.

PROJECT CORE TEAM

Terms of Reference

1 PURPOSE

The Project Core Team will lead detailed work, oversee agreed work streams for each key theme and will produce and implement local delivery plans. The following terms of reference are provided for each of the project team.

2 OBJECTIVES

The Project Team will:

- Outline and recommend the scope of their key theme at a local level;
- Coordinate and develop implementation plans for their specific key theme in support of the delivery of the project;
- Ensure full engagement and ownership of plans developed across CPGs and partner organisations e.g. voluntary sector, Local Authorities;
- Develop robust project management plans to ensure the delivery of agreed implementation plans;
- Develop outcome targets which can be monitored and which will demonstrate the impact of the service redesign implemented;
- Provide briefs and weekly SBAR report following cycle of work for each event and progress/performance reports to the Programme Manager and Board;
- Ensure that equality and diversity is taken into account throughout the process.

3. PRINCIPLES

The members of each project team will adhere to the following principles:

- Each member has been asked to join the project team because of their own particular area of expertise, experience and knowledge. They are expected to contribute to the work of the Project Core Team based on these abilities.

- All members of the Project Core Team will be responsible for feeding back any information to other relevant parties as agreed;

- It is important that all members of the Project Core Team recognise that some issues discussed are sensitive and they demonstrate respect for colleagues, patients, carers and the public;

- If confidentiality is requested then it is of utmost importance that this is respected and no discussion takes place outside the meeting;

- If objectives are set within the Project Core Team then each member of the Project Team has responsibility to undertake the work requested.

4. MEMBERSHIP

4.1 The membership of the Project Core Team consists of*:*

Position	Name
Project Core Team Manager	Robin Wiggs
Surgical CPG representative	Barry Williams/Alison Davies/Nia Jones
T&O Clinical Director – East	Steve Phillips
T&O Clinical Director – Central	Aeneas O'Kelly
T&O Clinical Director West / Clinical Lead	Glynne Andrew
Clinical Director - Anaesthetics	Emma Hosking
Information Analyst	Kathryn Williams
Finance	Richard Morton
Public Health	Jo Charles
Business & Improvement	Rich Gillett
Surgical Nursing Lead	Wendy Williams
Therapies	Pam Lewis
Diagnostic	Alison Kemp
GP	TBC
Administrative support	Alex Robins

In addition to the core membership, other members may be invited to attend for specific topics as agreed by the Chair.

4.4 Members may nominate deputies. Individuals deputising for core members of the Project Core Team must be of appropriate grade and seniority.

4.5 The Project Core Team will be supported outside the meetings by officers (eg. Information leads, finance, estates)

4.6 The Project Core Team will be Chaired by the Executive Sponsor. A deputy Chair will be nominated by the team.

5. QUORUM

Meetings of the Project Core Team will be considered quorate if 5 members are present.

Given the strategic importance of the project for the North Wales health community, all members must make every effort to attend all the meetings.

6. ADMINSTRATIVE ARRANGEMENTS

6.1 Meetings of the Project Core Team will be held as required to ensure timely progress.

6.2 Each planning lead will prepare a weekly progress report for the Project Core Team.

6.3 Agendas and supporting papers will be distributed no less than 2 working days before the meeting.

6.4. The Project Core Team will be serviced by a nominated administrator.

6.5. Action notes of the meetings will be kept, which identify the lead officer/organisation and a date by which the agreed action will be completed.

7. ACCOUNTABILITY

The Project Core Team Manager (via the Programme Manager) will report progress to the Programme Board using an SBAR report following each cycle (ahead of reference group events) and a brief weekly report for Programme Board clarifying progress.

APPENDIX C

HIGHLIGHT REPORT (SBAR FORMAT)

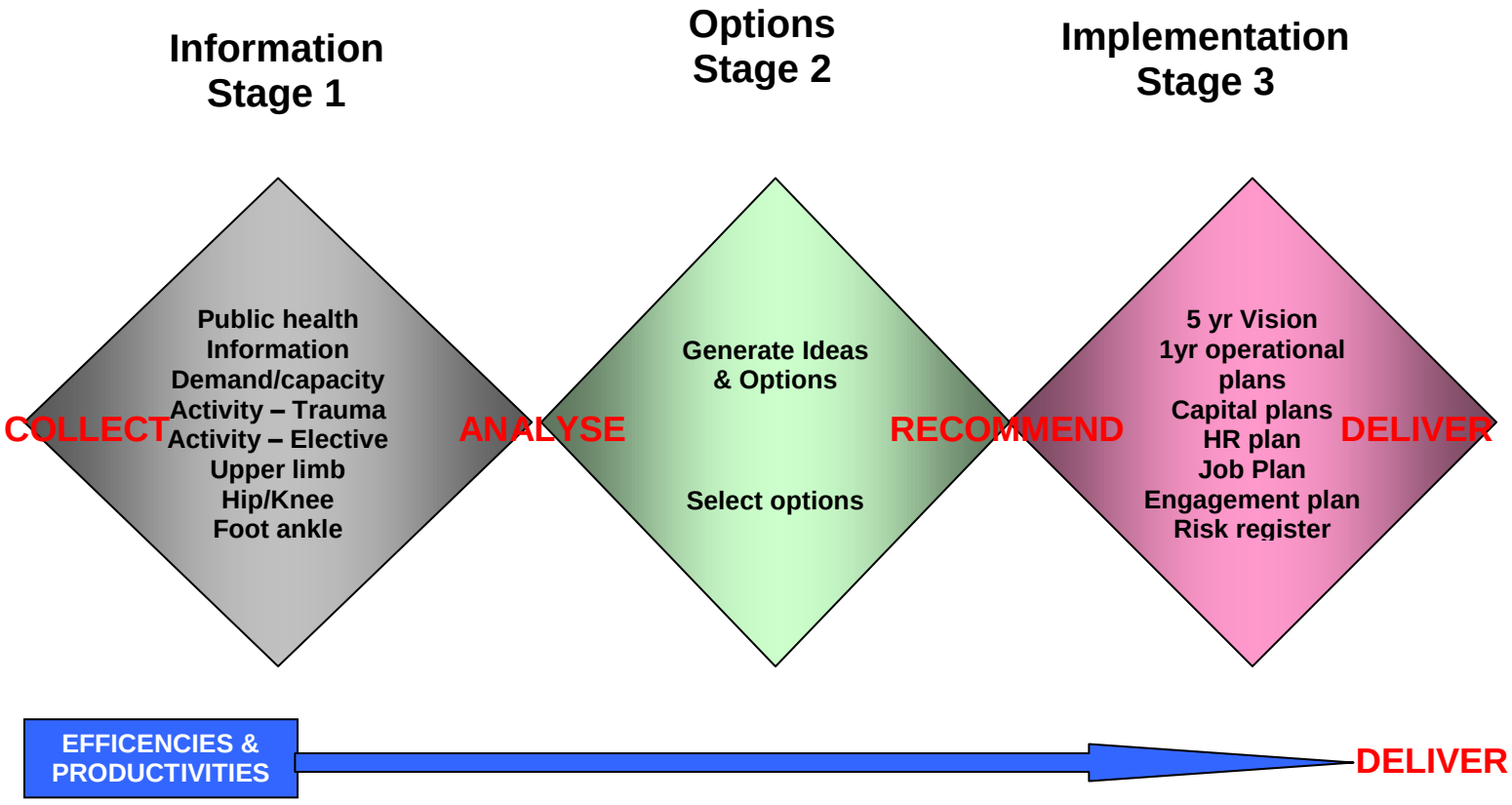
The purpose of this highlight report is to provide the Programme Board with a summary of the project status at regular intervals, including any potential problems.

The Programme Board will use the report to monitor progress and ensure that the project is running to schedule.

The content of the report will include:

- Date of report and period covered
- Schedule status
- Tasks/actions completed during the period
- Actual or potential problems
- Tasks/actions completed during the next period
- Any project issues requiring a response or decision
- Schedule or budget impact of any changes

Strategy for Clinical Engagement for Service Design (SUMMARY)



Partnering for Quality and Safety: Engaging Physicians in a Shared Quality Agenda. Reinertsen, J.L. MD. et al
IHI Engaging Physicians Framework

NOTES

APPENDIX 10

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

5 Year Plan Communications Strategy

Author/s: Andrew Scotson, Corporate Support Manager .
Dylan Williams – Orthopaedic Engagement Lead.

Version: 1.0

Publication/ Distribution:

- Orthopaedic Project Board

Purpose and Summary of Document:

Key strategic questions to be addressed through this work are;-

(i) What is the model for elective and emergency orthopaedic services for North Wales?

(ii) Within the elective model, how should day case surgery be configured?

Key remit:

To consolidate national and local strategies and key drivers in relation to Orthopaedic Services and to develop and implement a 5 Year Strategic plan that delivers tangible change in North Wales. In delivering this remit, the review will need to take account of the impact of the proposed service models on other services, eg links with the elective service, and impacts upon the existing clinical service strategy of the LHB. The review will also need to be cognisant of the potential impact of the outcome of those other service reviews on the orthopaedic services model itself.

The review will be undertaken using a 3 cycle process, underpinned with significant stakeholder engagement.

1 Background

Orthopaedics is a key service within the BCU Health Board Surgical and Dental CPG and makes an invaluable contribution to improving the health and well-being of the population we serve.

Over recent years the strategic principle, both locally and nationally, has been to provide safe, quality services as locally as possible and where possible, to relieve the growing demand on acute hospitals. Whilst previous orthopaedic plans took into account modernisation plans to improve efficiency and productivity, they were incremental in nature and developed in the context of 3 separate acute trusts in North Wales. The establishment of BCU health Board now provides opportunity to pursue safe and effective clinical services through both continuous improvement and the future transformational change required to deliver sustainable services.

The Annual Framework and specifically Access 2009 agenda has been a key driver in the application of resource for orthopaedic services across North Wales. This has not only included activity delivered in house but also through English providers and the independent sector. For 2010/11 the AOF asks NHS Wales to focus on:

- Upstream prevention and well-being;
- Improving patient care in the community;
- Reducing waste, harm and variation;
- Efficiency and productivity;
- Operating within available financial resources;
- Delivering through an effective workforce;
- Improving patient care and safety through the use of ICT;
- Improving the quality of core services and delivering the national targets.

and includes 14 high level opportunities:

- Develop new settings of care and improve long-term care pathways.
- Improve quality of continuing care through health and social care integration.
- Implement cross-system patient information and informatics.
- Develop improved unscheduled care pathways.
- Stop wasteful clinical interventions.
- Improve acute care performance and decrease length of stay.
- Improve primary and community care performance.
- Improve mental health service provision.
- Manage medicines more effectively.
- Improve procurement and supply chain.
- Drive highest-value prevention campaigns.
- Streamline and refocus the centre.
- Establish service line management and patient level costing.
- Modernise the workforce.

Service Development and Commissioning Directives issued by WAG to drive improvements in service also include;

- Chronic Non-malignant Pain
- Arthritis and Chronic Musculoskeletal Conditions

A 'twin track' approach is therefore required to ensure we have a plan that can deliver both in the short term (to meet 2010/11 AoF requirements in Appendix A) and importantly to ensure the transformational change required to deliver sustainable services across North Wales over the next 5 years is achieved.

This communication plan has been developed therefore to ensure that there is a robust process for communication in place to manage this complex process. It is well recognised that the NHS cannot make the necessary changes in isolation and the continued need to work jointly and openly with key partners, such as the local authorities, voluntary sector and independent sector, is essential in tackling this priority. Whilst the focus of this project will be predominantly upon the internal clinical structures and processes of BCU, opportunities for the service to be designed and delivered across health and social care must be embraced.

2 Communication principles

Good communication will require adherence to the following principles:

- Relevant communications between the project team members and stakeholders, partners, the local community and the media should be shared with the rest of the team regularly.

- Effective communication will depend on good working between the members of the project team and partners involved so that they act together and speak with one voice. Therefore, one point of contact with the project team for the media and local community is needed. Robin Wiggs, Head of Planning –, supported by Andrew Scotson, Corporate Support Manager will lead on all communication issues on behalf of the project team.

- All communication with interested parties should be transparent, honest, consistent and use straightforward language in order to build trust. Listening to the concerns of the parties will be crucial in helping them to understand and engage with the process.

- Good communication depends on a mutual understanding of, and respect for, each others perspectives. Actively involving all parties and asking for their input will help promote engagement.

3 Aims

The aims of this communications strategy are:

- Facilitating good working relations between Betsi Cadwaladr University Health Board and its staff, the public, partner organisations, stakeholders, media and key opinion-formers.
- Engaging patients and public so that they are well-informed and receive timely information in a format that is accessible to them.
- Engaging staff so that they are well-informed, and involved.
- Ensure clear communication with all stakeholders to protect the Betsi Cadwaladr University Heath Board from unnecessary reputation damage

4 Target audiences

The following target audiences have been identified:

Directly affected

- Betsi Cadwaladr University Health Board staff
- WAST
- Other CPGs

Stakeholders

- Betsi Cadwaladr University Health Board staff and Board members
- Betsi Cadwaladr Community Health Council
- North Wales Voluntary Services Council and voluntary sector organisations
- Local politicians (local AMs, MPs)
- North Wales Local Authority – Leaders, Chief Executives and Lead members for Social Care, Health & Well-being and briefs to the Regional Partnership Board.
- LMC and primary care contractors
- Public Health Wales
- Welsh Health Specialist Services
- Countess of Chester NHS foundation Hospitals
- Robert Jones and Agnes Hunt Trust
- Hywel Dda Local Health Board

Wider Public

- Local media

5.0 Communication Strategy – Phase one: Overview of three cycle model

This section proposes the strategy for communicating with the staff, local community and media.

5.1 Review and Communication

The Programme Board will meet at least on a monthly basis and in line with key project milestone dates to review progress against agreed milestones, with flexibility to schedule meetings to coincide with significant stages within the overall programme of this project.

The Project Core Teams will also meet monthly in order to ensure that the agreed timetable for achieving the project.

A highlight report will be prepared by the Programme Board as required, including an updated action plan report. The Chair(s) will be notified as soon as reasonably possible of any significant variance in terms of time, partner co-operation and cost.

Overall programme progress, risk and exceptions will be reported to the Project Sponsor as appropriate.

5.2 Three Cycle Model

Letters will be issued to identified stakeholders detailing the 3 Cycle Process. In summary this will include:

- The cycle will commence with a briefing meetings in June 2010. The aim of these briefing meetings will be to provide a wide understanding of both the reasons for and the remit of the workstreams. Invitees to this briefing event will include members of the core workstreams; members of an 'expert' group and, members of a wider stakeholder forum.

- Each of the workstreams will then undertake the first cycle of their work. The emphasis will be to gather and consider all the evidence relating to the work of the particular workstream, the evidence being local, national and international. At the end of the first cycle, the work of the workstreams will then be reported back to the reference group and then to the wider stakeholder forum for feedback, thoughts and views. There will then be a period of 14 days for the 'Reference Group Members' to provide feedback to the core workstreams.

- The feedback from the Groups will then be fed into the second cycle of work of each workstream .The focus of this second block of work will be to focus on the options for addressing and answering the specific questions given to each workstream. At the end of the second cycle, the output of this element of the three workstreams work will again be reported back to the 'expert' group and then to the wider stakeholder forum for further feedback, thoughts and views.. There

will then be a period of 14 days for the 'Reference Group Members' to provide feedback to the core workstreams

- In turn, this further feedback from the Groups will then be fed into the third cycle of work for each workstream. At the end of the third cycle, the output of the workstream which will include recommendations to address and answer the specific question set for each workstream, will then be reported back to all stakeholder groups: members of the core workstreams; the 'expert' group and the wider stakeholder forum. There will then be a period of 14 days for the 'Reference Group Members' to provide feedback to the core workstreams

- The feedback gathered at this final stakeholder event (and the 14 days following the final event) will be included in the final recommendations that are then taken to the North Wales Planning Forum for discussion and/or endorsement.

It is proposed that to facilitate rapid feedback within 14 days following each 'report back' session, an electronic method of feedback is used. This will allow stakeholders the opportunity to record their comments and submit them to the core team. Comments will only be invited from stakeholder group members. Responses will be recorded in an electronic format which allows all interested parties to view the comments from all stakeholders and members of the 'expert' health group.

A briefing meeting was held with affected staff on Tuesday 28 September 2010.

A summary briefing outlining the background and proposed way forward has been circulated to:

- Betsi Cadwaladr University Health Board staff via the Corporate Briefing
- Local politicians (AMs and MP)
- Betsi Cadwaladr Community Health Council
- Other stakeholders

An intranet page has been set up to provide staff with information.

<u>External Stakeholder Briefing Sessions</u>

A number of initial briefing sessions have been arranged for Reference Group members. The key purpose of the briefing sessions it to provide a high level introduction to the project, overview of our service ambitions and explanation of the 3 cycle process which will underpin the workshops. Initial briefing sessions will be held as follows:

- **Tuesday 6th July Boardroom HM Stanley St Asaph (5.30 pm - 6.30pm)**
- **Wednesday 7th July Boardroom 1 & 2 Corporate Wrexham (9.30 – 10.30am)**
- **Tuesday 13th July Anaesthetic Seminar Room Ysbyty Gwynedd (2.30 - 3.30pm)**

In addition to these briefings, information will be available via our web site details of which will follow, and Health Board officers will be available to brief individual groups on request.

5.3 Phase 2: Communicating throughout the project

It is important to ensure communication with the staff local community and stakeholders is open and consistent throughout the project in order to build and maintain engagement and trust.

Therefore:

- Monthly updates will be included in the Betsi Cadwaladr University Health Board Corporate Bulletin
- At least monthly briefing note will be sent to external partners and stakeholders (more often as necessary)
- Updates will be posted on the Betsi Cadwaladr University Health Board intranet
- Links to the updates, associated press releases and any other relevant documents will be included on the website.

5.4 Continued Direct Engagement

It is intended that the Project Team supported by the Communications Team will:

- Issue weekly Staff Briefings;

:

  - ❖ Put on Project page on the Intranet
  - ❖ Put on Central Notice board

- Access to rumour hotline
- Ensure Community Health Council (CHC) is involved via the existing CHC/BCU Strategic Planning Group, liaison Group and the CHC/BCU Board-to-Board.
- Work with the Stakeholder Reference Group of the Board to provide the Health Board with advice and assurance.

6.0 Communications Action Plan

A detailed Action Plan will be developed and maintained by the Communications Lead.