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Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
3 October 2013

Meeting time:
09:15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

Policy: Llinos Madeley
Committee Clerk
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

(09:15 - 09:30 Pre-meeting)

1 Introductions, apologies and substitutions

2 Local Health Board Service Reconfiguration - South Wales Plan: South Wales Programme (09:30 - 11:00) (Pages 1 - 21)

South Wales Programme

- Paul Hollard, Programme Director
- Andrew Goodall, Lead Chief Executive
- Hamish Laing, Director of Clinical Strategy at ABMU/Member of SWP Programme Team

(11:00 - 11:10 Break)

3 Local Health Board Service Reconfiguration - South Wales Plan: Wales Deanery and National Clinical Forum (11:10 - 12:10) (Pages 22 - 43)

Wales Deanery

- Professor Peter Donnelly, Deputy Dean
- Dr Helen Fardy, Reconfiguration Clinical Lead for Paediatrics
- Dr Jeremy Gasson, Reconfiguration Clinical Lead for Obstetrics and Gynecology
- Dr Michael Obiako, Reconfiguration Clinical Lead for Emergency Medicine

National Clinical Forum

- Professor Mike Harmer, Chair

4 Papers to note (Pages 44 - 46)

Social Services and Well-being (Wales) Bill: Letter from the Deputy Minister for Social Services (Pages 47 - 53)

5 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

6 Social Services and Well-being (Wales) Bill: Discussion on order of consideration for Stage 2 proceedings (12:10 - 12:25) (Pages 54 - 58)

Note: Stage 2 proceedings on this Bill will only go ahead if the General Principles are agreed to on 8 October 2013.

7 Discussion on outreach work for the access to medical technologies in Wales inquiry (12:25 - 12:30) (Pages 59 - 63)

(12:30 - 13:30 Break)

8 Preparation for Draft Budget 2014-15 (13:30 - 15:00) (Pages 64 - 92)

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SOUTH WALES PROGRAMME
WRITTEN SUBMISSION FOR HEALTH AND SOCIAL CARE COMMITTEE
THURSDAY 3RD OCTOBER 2013

Background

In November 2011, the then Minister for Health and Social Care published the policy document "Together for Health: A 5 Year Vision for the NHS in Wales". This document set out a vision for healthcare in Wales that challenged the NHS and the communities it serves to aspire to match the standards of the best in the world and to aim at achieving excellence everywhere. The policy described the important challenges that NHS Wales faces now and in the years to come.

Together for Health: South Wales Programme

The South Wales Programme (SWP) is part of the response by Health Boards to create plans for sustainable services and was established in January 2012. The Programme involves five Health Boards including Powys Teaching Local Health Board, though the delivery focus is on the main hospitals in four Boards: Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale and Cwm Taf. In addition, the Wales Ambulance Services Trust is a full partner in the Programme Board and Programme Team. This is the first time within Wales that such a collaborative has been established to share challenges across health board boundaries and to collectively respond to the fragility of some of our most important clinical services. The Programme is based on openness within and across the SWP partners and the public we serve and effective partnership with clinicians and other stakeholders who are critical to the design and delivery of these services. Listening and responding to concerns raised by clinicians regarding the fragility of services and the workforce available to these services has been central to our approach.

The programme does not cover all health services across South Wales but is confined to services that are fragile in terms of the ability to deliver safe and sustainable models of care in the future and are fundamentally unsustainable in some areas.

The South Wales Programme is focussed on a number of relatively small, critical and yet fragile services that make up around 6% of the expenditure of the NHS in South Wales.

- Consultant led Maternity services
- Consultant led Neonatal services
- Inpatient Paediatric services
- Consultant led Emergency Medicine (A&E) services

Each Health Board has a plan for the services it will provide in its own area. These plans include the development of local services, the balance and extension of primary and community services and alternative local models of care, better integration with other public services, such as social services, and the future roles of other local facilities.

Effective primary and community services are a key part of each Health Board's local plans and their development and expansion is the bedrock on which the Programme has considered the future pattern of specialist hospital services. Some Health Boards within the collaborative have been undertaking broader local service consultations alongside the South Wales Programme, whilst others have firm plans already developed and being implemented with their local populations.

The Programme

The main aim of the Programme is to help Health Boards develop a shared view about how to create a sustainable pattern of services for future generations across South Wales for these fragile services.

The Programme has followed a five stage process:

1. Review advice, guidance and evidence about how services should be organised to produce the best care for patients.
2. Test this advice, guidance and evidence with doctors, nurses, midwives and therapists who currently provide care for people in South Wales.
3. Summarise the emerging findings and engage in discussion with the public.
4. Reflect on the themes emerging from the public engagement discussion.
5. Produce proposals for, and undertake, formal public consultation in line with Welsh Government guidance.

The Programme has gathered information about services and the needs of people who use them and looked at advice and guidance about the best ways of organising care. This has included looking at Welsh Government policies such as 'Setting the Direction' (February 2010) and 'Together for Health' (November 2011) and reviewing the advice of professional bodies such as medical, nursing and midwifery Royal Colleges. It has also looked at advice from Welsh and British bodies concerned with the effectiveness and efficiency of public services such as the National Audit Office report "Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland" (June 2012) and the Wales Audit Office report "Health Finances" (July 2012).

In addition, the Programme has considered other evidence, nationally and internationally, that concerns the design and development of sustainable service models in the relevant specialties and how this may impact on patient outcomes.

Principles adopted by the SWP

- Collaborative programme but each constituent LHB retains sovereignty over decision making;

- Service change proposals are grounded in quality, safety and sustainability;
- The Programme will focus only on those matters which the Boards have agreed need to be dealt with at a regional level. All other issues, e.g. primary care, community services and other hospital services, will be planned and managed by individual Health Boards;
- The work of the Programme will be clinically led wherever possible, and incorporate as wide a clinical engagement as feasible;
- Whilst 'Together for Health' is driven by an ambition for quality of care, the economic and financial situation will also be a significant context for this Programme. Services can only be sustainable if they are affordable.

Listening to Doctors, Midwives, Nurses and Therapists

The Programme Board decided that the South Wales Programme called for a new approach to working with the professional staff who deliver health care for patients in hospitals and communities across South Wales. A series of clinical conferences and summits were organised in May and June 2012 to initiate the Programme. These events brought people together to discuss how the advice, guidance and evidence matched with their direct experience of working to provide the best in health care for their patients.

We invited representatives of doctors, midwives, nurses and therapists from all the main hospitals together with representatives of General Practitioners. They were joined by representatives of Community Health Councils and senior staff from Health Boards. Over 300 people were involved in these events, many of them in two or three events. This has never been done on this scale before and we have appreciated the professional approach taken and the honesty of the discussions that took place. This approach has continued and clinical conferences were held in February and March 2013 and a broader stakeholder event in April 2013.

In order to fully explore the clinical issues within each specialty area, the Programme established Clinical Reference Groups (CRGs) led by a Medical Director of one of the participating Health Boards and comprising leading clinical professionals from across South Wales. The role of each CRG was to consider the clinical standards underpinning the services, the clinical outcomes that should be delivered, the most appropriate clinical model for delivery and the workforce required to deliver the new models of care. These CRGs operated outside but alongside the clinical conference arrangements and feed back to fellow clinicians and other stakeholders was provided through these major events.

The outcomes of the CRG recommendations and the work of the clinical summits and conferences suggested that in order to provide safe, sustainable services into the future, South Wales would need to concentrate the specialist elements of maternity, paediatric, neonate and emergency medicine services on 4 or 5 sites. The individual sites that might deliver these elements of service were not considered at this stage as the recommendations were based on clinical evidence and workforce considerations and not geography.

In addition to the organisational principles and processes, as above, the South Wales Programme Board engaged with staff, clinicians, the public and other key stakeholders to develop and agree a set of benefit criteria that would be adopted to consider the models of future service provision. These criteria were:

- Quality
- Safety
- Access
- Equity
- Sustainability
- Strategic fit

The collective views determined the overall weighting of the criteria and the benefit criteria were approved by each individual LHB Board prior to their application in developing and driving the options for consultation.

Engagement with stakeholders

The relationship with the Community Health Councils that support each of the LHBs involved in the Programme is very strong, with Directors of Planning, CHC Chief Officers and the Programme Director meeting regularly. CHC attendance, as observers, has also been encouraged and their perspective and "public" scrutiny throughout the work has been both very supportive but also appropriately challenging. It has been very important to all parties to recognise and maintain the independent role of the CHCs throughout the process.

Recognising the challenges faced by the the local Health Boards in South Wales the Programme Board embarked upon a major review of their services. This began with an extensive listening and engagement exercise "Matching the Best in the World" http://www.wales.nhs.uk/SWP/how-we-got-here

This was conducted between 26th September and 19th December 2012 and focused on six possible scenarios– three fixed points, University Hospital of Wales, Cardiff; Morriston Hospital, Swansea, and the planned Specialist and Critical Care Centre near Cwmbran, as well as one or two of the remaining hospitals – Prince Charles Hospital, Merthyr Tydfil; Royal Glamorgan Hospital, Llantrisant; and the Princess of Wales Hospital, Bridgend.

The overall aim of the listening and engagement process was to better inform the Health Boards by providing opportunities for staff, stakeholders and the public to express their ideas about the way that some specialist and emergency health services are provided.

In this context, the local Health Boards in South Wales jointly appointed Opinion Research Services (ORS) to design suitable questions and support them in managing and reporting the collection of views from the public and stakeholders.

In addition, the Local Health Boards conducted many meetings with the public, staff and other stakeholder groups to explain the background, listen to their views and understand their concerns.

The Health Boards also received a significant number of written responses as part of the listening and engagement process, and these were separately considered in addition to the questionnaire feedback.

The outcome of the engagement process highlighted:

- An **overwhelming majority supported** the characteristics identified by the Health Boards to make sure that health services are sustainable. The high level of agreement was consistent across the five health boards.
- An **absolute majority supported** the future pattern of hospital services that had been recommended; with specialist services and emergency care being concentrated in fewer centres so that better care can be provided. However, responses differed depending on location with many respondents showing concern about centralisation, and wanting care to be kept local, especially due to travel distance, time and cost implications.
- An **absolute majority supported** travelling to receive care from a specialist team rather than receiving treatment at a local hospital although responses again differed by area. Whereas some respondents agreed that in principle, travelling to receive quality, specialist services makes sense, others felt that in practice public transport, road networks and parking will need to be improved.

There was **less consensus** about whether some emergency care centres may be provided at fewer centres rather than ensuring that all centres provide a full range of services. There was little difference in responses by Health Board area. Further responses show that respondents were concerned about A&E closures and want emergency care to be kept local, as well as travel implications to be taken into account.

Further consideration of the original six scenarios was undertaken between January and April 2013 prior to formal consultation. This was informed by the outcomes of the engagement process and through further clinical and stakeholder conferences using the agreed benefit criteria. This culminated in ORS publishing this work in “Towards a Preferred Option” on behalf of the SWP Programme Board which described the further analysis undertaken. http://www.wales.nhs.uk/SWP/supporting-documents

The feedback from the engagement and the further work undertaken informed the development of four options for formal public consultation and a “best fit” option identified by the Programme Board. The recommendations from the Programme Board were approved for consultation by each of the Health Boards, and endorsed by WAST, on 22nd May 2013

Formal Public Consultation

The SWP has carefully followed the Welsh Government’s ‘Guidance for Engagement and Consultation on Changes on Health Services’ (March 2011) and the

Consultation Institute has provided guidance and monitored the Programme's compliance with this guidance.

Formal consultation commenced on 23rd May 2013 and closed on 19th July 2013. Prior to the publication of the consultation document the Programme leads undertook a briefing event with Assembly Members (AMs) with a short presentation and an open question and answer session. This completed a series of discussions with individual and groups of AMs throughout the process from engagement to consultation. This briefing was followed by a press and media briefing session in the same format prior to each Board approving the consultation framework and supporting documentation later that morning.

The consultation has taken a variety of forms to optimise the ability of the public and other interested parties to engage and contribute to the discussion around the future pattern of specialist hospital services. Three forms of consultation document were produced in Welsh and English – a full document, a summary version and an "Easy Read" version – the full document and summary version were also provided in a number of formats including Braille and talking books. http://www.wales.nhs.uk/SWP/consultation-documents.

The CHCs from across South Wales have again facilitated and chaired the public meetings and fifty individual, open public meetings were held throughout the South Wales area over the eight week period with 2,331 people attending. The attendance at public meetings varied between communities within the South Wales Programme area depending on how the public thought their local services would be impacted upon. In addition to the consultation documents, the process has been underpinned by detailed technical documents http://www.wales.nhs.uk/SWP/supporting-documents.

In addition to the open public meetings, focussed discussions were held with particular equality groups, e.g. Black and Ethnic Minority groups, people with a variety of disabilities, the young and the elderly, as well as other groups supported through the Councils for Voluntary Services across South Wales.

The extensive engagement process also included meetings with and presentations to Assembly Members and Members of Parliament as well as Local Authorities and their elected members, Local Service Boards and other fora.

The interest amongst staff has also been significant and discussion with staff groups, professional fora, Local Partnership Committees and Stakeholder Reference Groups has been a major feature of the South Wales Programme.

There has been an unprecedented response to the consultation with **59,726 responses** received via the open questionnaire (27,710), household survey (820), signed template letters (24,303), petitions (6,367 signatories) and individual submissions (526) from various organisations such as the Royal Colleges and the National Clinical Forum and from other professional groups.

The South Wales Programme Board has again commissioned ORS to undertake the analysis of the responses and collate the feedback received through the consultation period. In view of the level of response, the SWP Programme Board, with the support of the Community Health Councils, has agreed to extend the period of review by a month to ensure due consideration of the responses prior to decision making by the end of this calendar year.

The Programme has produced regular updates for the public and other stakeholders throughout the life of the programme and these will continue post consultation and review. http://www.wales.nhs.uk/SWP/press-releases-and-updates

Consideration of Equality Issues

The South Wales Programme Board is mindful of the statutory duty placed on each Health Board under the Wales Public Sector Equality Duty 2011 and, accordingly, an equality impact assessment is being undertaken on the Programme's proposals. The EIA evidence document was published on the South Wales Programme website at the launch of the consultation. During the consultation process a wide range of discussions were held with key interested groups and forums about the proposals. In addition, specifically targeted meetings and events took place to ensure the Health Boards gave full opportunity to equality and diversity groups to put their views forward on the options, identify any particular impacts due to their protected characteristic and to identify possible ways to minimise or remove these effects. The EIA evidence document will be reviewed and updated in light of the feedback from the consultation responses and will form an important element of the decision-making process by the Health Boards later in the year.

Independent Scrutiny and Advice

Wherever practical and possible the South Wales Programme Board has sought independent expert and professional advice on a range of work.

Consultation Institute
The SWP has worked closely with the Consultation Institute in relation to the engagement and consultation process. The Institute has provided expert guidance and advice on best practice to inform our approach and through conducting a compliance assessment to confirm that the approach adopted meets its stringent standards in terms of engagement and consultation. The SWP has been subject to key milestone reviews by the Institute and has successfully completed a mid-term review during the consultation period. The Programme has now successfully achieved compliance at stage 4 of a 6 stage process.

Cardiff University, School of Mathematics
Prior to beginning consultation, the SWP sought an independent review by the School of Mathematics at Cardiff University of the methodology used to assess the data as applied to the options for future services. Their report stated:

"Based on access to materials and information provided, we have a high level of confidence in the appropriateness of the underpinning modelling approach and validity of the results."

Swansea University – Centre for Health Information, Research and Evaluation
Following the engagement process and during the consultation the issue of public transport and its importance in supporting access to services was reinforced. The SWP commissioned Swansea University to undertake a mapping exercise of the current transport network across South Wales and map this against each of the options proposed within the public consultation. This was to identify the current challenges of the network and identify the potential gaps in the availability of public transport in each of the proposed options. The outcome of this research will be considered by the Programme Board prior to decision-making.

Opinion Research Services
The interpretation and presentation of the engagement findings and the response to the consultation responses has been undertaken by Opinion Research Services (ORS) on behalf of the SWP. ORS was founded in 1988 within Swansea University and after ten years it became a university spin-out while retaining its research-orientation. It is a highly regarded and regulated social research practice and is providing an independent analysis of the responses received.

NHS Wales Centre for Equality and Human Rights
The NHS Wales Centre for Equality and Human Rights is a strategic resource for NHS organisations that helps them to build capacity and capability to ensure they are able to meet their statutory equality and human rights requirements, and that they demonstrate they meet the diverse needs of patients and staff when planning and delivering health services,. The Centre has worked closely with the SWP to ensure that we are able to demonstrate we meet our obligations under the spirit and requirements of the legislation.

Gateway Review
A Gateway review of the process to date is being undertaken by an independent team at the end of September 2013 and the outcome of this review will be presented to the Senior Responsible Officer and the Programme Board in October.

Impact on Plans

During a number of consultation meetings, members of the public raised issues regarding the information used to determine the models presented for consultation e.g. patient flow models and the impact of supporting services such as transport and information services. This feedback has been used to inform some additional work currently underway around a revised flow analysis based on public views and "natural" flow, further analysis of the public transport network across South Wales and the need to be able to transfer patient information between health boards and other organisations safely. This will be considered by the Programme Team and Programme Board during October and will further contribute to the evidence for decision-making by the LHBs later this year.

Relationship with the Deanery and National Clinical Forum (NCF)

The Wales Deanery is a member of the Programme Board and is represented by the Dean or Vice-Dean at each meeting. In addition, deanery leads are members of the Clinical Reference Groups and provide advice in respect of training and education needs relating to the future clinical models and configurations. The deanery reconfiguration leads for paediatrics and obstetrics have also given focused presentations to the Chief Executive Officers, Medical Directors and planning leads on the future pattern of education and training in these specialty areas.

In relation to the National Clinical Forum, the SWP has made formal presentations to the NCF on 16th January 2013 following the engagement period and again on 23rd April and 15th May 2013 prior to launching the formal public consultation process. The NCF has confirmed support for the proposed changes to services within South Wales and has recognised the considerable leadership of clinicians in the development of the service models and subsequent options. Concerns have been raised by the forum in respect of potential impacts upon primary care services, the available workforce to deliver a five site model of specialist services and the need to develop new non-medical workforce model in all areas of the NHS.

Next Steps

The South Wales Programme consultation closed on 19th July 2013 and ORS is currently collating the responses to develop a comprehensive report for the South Wales Programme Board to consider in October 2013. Work continues to consider the revised patient flow analysis informed by comments from members of the public during the consultation phase. Another clinical conference will take place in October to report the initial outcome of the consultation to the clinical staff who have worked together to develop the service models and options that have been considered. Fortnightly meetings are continuing to be held with the Community Health Councils across South Wales prior to decision making by the end of this calendar year.

Written Evidence from the Wales Deanery for the Health and Social Care Committee

1. **What view the Deanery takes on staffing issues currently facing the NHS in Wales:**

It is perhaps important to put the role of the Wales Deanery ('the Deanery') into context before commenting on the questions as outlined in the correspondence with the Health and Social Care Committee. The purpose of the Deanery is to support, commission and quality assure education and training of trainees, General Practitioners, Dentists and Dental Care Professionals in Wales. This accounts for approximately 2700 doctors in training and 330 dental trainees in Wales.

The Deanery is accountable to the General Medical Council (GMC) and has to ensure that it meets its obligations for the welfare of its trainees and patients in Wales. There is now one set of standards for the entire postgraduate medical training pathway from the Foundation Programme up to the award of the Certificate of Completion of Training (CCT). The Document 'The Trainee Doctor,'[1] published in 2011, incorporates the standards that the GMC will hold postgraduate deaneries accountable for in accordance with the Medical Act 1983.

The Deanery provides evidence on a regular basis to the GMC that these standards are complied with, for example Annual Reports and Data Returns. In addition the GMC undertakes a Quality Assurance Inspection Visit to each deanery in the UK, the most recent in Wales being November 2011. The GMC also approves curricula and assessment systems, devised by the Specialty Royal Colleges, training programmes and posts.

As a result the Deanery is only in a position to comment on training grade recruitment issues for which we manage the process for NHS Wales. The Deanery cannot comment on staffing issues for non-training grades.

Following the collapse of the Medical Training Application Service (MTAS) in 2007, recruitment to Specialty Training positions continues to evolve. The process has been streamlined across the UK. For each specialty, trainees now apply to one entry portal and preference their region of choice. This process has significantly reduced the number of applications managed by each Deanery; however, this now provides a more realistic reflection of the number of applicants wishing to apply to Wales for a particular specialty or grade.

Throughout the UK there are difficulties in recruiting to certain specialties, namely, Paediatrics, Psychiatry, core and Higher Medical specialties and Emergency Medicine. Wales is not alone in having difficulties filling rotas within these specialties, however it should be noted that fill rates for Wales are significantly lower than those across England.

1. *General Medical Council (2011) The Trainee Doctor, GMC*

For example, across the UK 269 Emergency Medicine posts were advertised for August 2013 105 trainees accepted offers generating a fill rate of 39%[2]. Wales advertised 8 posts for 2013, only one of these posts was filled.

Recruitment gaps impact heavily upon rotas which then puts undue service pressures on the trainees, to the detriment of their educational experience. It is the Deanery's recommendation, based upon findings from the Temple Report[3], that training rotas should have 11 participants to prevent vulnerability from recruitment gaps, less than full time (LTFT) training, sickness absence, out of programme training opportunities and maternity leave. Participants can include trainees, non-training grades doctors and for example where appropriate advanced practitioners. This approach should provide Wales with sustainable training programmes for the future.

For most specialties trainees are placed across 15 Units in Wales where rotas consist of less than 11 participants. This therefore means that our trainees in these specialties are spread too thinly across too many hospitals.

In order to comply with the GMC standards in training and the requirements of the individual Specialty Curricula, trainees need to obtain the relevant patient exposure, seeing a breadth and depth of presentations and management of sick patients. This means that it is not possible to put trainees in every department in every hospital across Wales, as the training opportunities afforded to them during their comparatively short training period are insufficient to meet the curricula requirements. If trainees are unable to meet curriculum requirements they fail to progress to the next level of training, they are more likely to fail Royal College examinations and this in turn leads Wales to have an increasingly poor reputation for training which impacts upon our attractiveness for future recruitment rounds.

There is always a tension between service provision and education within the NHS and it is vitally important that we strike the correct balance between our trainees learning in the workplace and making a contribution to service provision, but fundamentally ensuring they get the best possible training. To ensure the future provision of high quality doctors delivering safe patient care in Wales, trainees need protected time for their education to enable them to achieve required Royal College examination success and a smooth progression through their training programme.

2. How staffing difficulties are best explained:

It is best to continue to focus on the difficulties we are having in the recruitment of junior doctors, in Wales in the first instance. The NHS in Wales has had an over-reliance on the presence of junior doctors for service provision, dating back many years. The European Working Time Directive in 2005 reduced the available hours that doctors could work to 56 per week and the only way that the service could manage this reduction was to increase the number of junior doctors. Unfortunately, in Wales there was a marked increase in the number of Senior House Officer (now called core training) posts across all Trusts in order to make the rotas compliant. This had a detrimental knock on effect to recruitment to higher specialty training in

[2] Health Education England – Specialty Training 2013 Recruitment Fill rates. July 2013.
[3] *Temple, J (2010). Time for Training. A review of the impact of EWTD on the quality of training*

Wales as it meant our competition ratios going from core training to higher training were out of sync with the rest of the UK.

When deciding upon what specialty and locality to apply to for Specialty training, applicants now have access to information from various sources. For applicants today, opportunities for career progression is an important factor. The more core posts there are compared to higher posts the less the likelihood that a trainee will progress from core to higher training. For example, in 2013 the applicant to post ratios for higher surgical specialties peaked at 17 applicants per post advertised. This information is known to trainees and can be tracked and is available on the web.

Successive years with vacancies have resulted in recruitment panels lowering the tolerance threshold resulting in a lower quality of appointees. These doctors have difficulty passing the Royal College examinations, league tables for which are published and available on the web UK-wide, and again this is a negative factor in applying to a locality with low pass rates. This is supported by evidence from the annual review of progress reviews of trainees. In 2012 the number of trainees requiring a formal extension to training as a result of failure to progress increased by 35% and the number of trainees withdrawn from training increased by 44%.

The immigration rules changed in 2007 which prevented a significant number of international medical graduates from coming into Wales. Wales had previously been well served by a large number of international medical graduates who principally were a great help in service provision and were not in training posts. In 2008 Wales received applications from 1466 international medical graduates; in 2012 the UK as a whole received applications from 1777. In turning this traditional source of doctors off, Wales found itself again over reliant on the presence of trainees for service provision.

There are other issues that do not make Wales an attractive a place to apply for work and training, one is notably the geography. Applicants are concerned when they move to Wales they might have to rotate over significant distances, in order to complete their training. While we, by and large, have no problem filling the hospitals along the M4 corridor, we have increasing difficulties with recruitment to both West and North Wales. We have sought to address this issue with North Wales by linking in with the Mersey Deanery to have rotations that no longer require the trainees to travel to South Wales to gain the necessary experiences to meet the curriculum requirements. We are therefore looking to maintain rotations across the North of Wales, but this will take some time to bed in.

There are other perceptions that trainees and indeed other staff have with regard to coming to Wales. One of which is a misunderstanding of the need to be able to speak Welsh, and indeed it has been reported that some people believe we have a different currency to the rest of the UK.

The medical employment pool is evolving. UK graduate numbers increased by 76% in the 10 years to 2006, of which two thirds were female. Currently 52% of all trainees in Wales are female. The demand for LTFT training, for either ill health or disability or as a result of carer responsibilities either for children or dependents, has risen from 87 in 2007 to 232 in 2013. There are currently 232 trainees working on a part-time basis with another 22 predicted to start by the end of 2013. This equates to approximately 8% of the trainees in Wales.

To date in 2013 106 trainees have taken maternity leave and 56% of these have returned to work on a part-time basis. During an average training programme trainees may take maternity leave more than once and may alternate between full and LTFT employment.

NHS Wales workforce data shows that the feminisation of the workforce has yet to fully impact upon the NHS and more women are yet to arrive in the middle grade years of service and training.

In terms of a marketing strategy, it is highly unlikely that the majority of people applying for jobs would have any real understanding of where Betsi Cadwaladr University Health Board or indeed Hywel Dda Health Board exactly are geographically. Both have excellent educational opportunities available and are beautiful settings to be located and live in for an excellent work life balance but the benefits of these locations have not been maximised.

It is import to highlight that recruitment and retention of General Practice (GP) trainees is an issue in Wales. This is at a time when GP provision is increasingly key to an integrated modern health service. Similar patterns exist whereby trainees' preferences do not include North or West Wales.

3. How staffing difficulties in Wales are best addressed:

The most important aspect for attracting and retaining trainee doctors to Wales is to improve the training experience for them when they are in the country. This means less reliance on their presence for service provision and agreed educational contracts with their employing authorities, as opposed to their current contract which is more predicated on service provision. Trainees require protected time for education in the working week to attend theatre or outpatient clinics and take study leave.

The role of educational supervisors needs to be professionalised. This can be achieved by the Educational Supervisor agreement that the Deanery is implementing across all of the Health Boards. It sets out an agreement between educational supervisors, Health Boards/Trusts and the Deanery, defining roles and responsibilities for the provision of educational supervision. Inclusion of educational supervision within the appraisal process, with educational supervisors committed to improving their skills through continuous professional development in the role will lead to improved educational experiences for trainees.

The Deanery also believes that training should be undertaken on fewer sites to enable a critical mass of trainees. This will ensure that trainees get sufficient clinical experience, that their rotas for out of hours are robust with a minimum of a 1 in 11 out of hours commitment and that they will get protected time during the working day for education, attendance at out-patient clinics and exposure to theatre time within the craft specialties. This we believe will improve their experience, improve the examination pass rates and improve patient care.

To date the Deanery has introduced a number of initiatives to aid recruitment and retention across Wales. In some specialties the Deanery has reduced the number of

fixed term positions. These unattractive posts have been converted to long-term sustainable posts offering the security that trainees require.

The Deanery has developed the Wales Clinical Academic Track providing a unique 8 year programme with equal focus on clinical and academic training. This is a much sought after programme attracting and retaining high calibre trainees in Wales.

In certain specialties we have initiated and piloted additional years to provide opportunities for doctors to consolidate their training experience and better equip them for competition into higher training.

The Deanery has also undertaken to reduce the number of core training posts in specialties with particularly high competition ratios to bring them more into line with opportunities into higher training. These posts have been either converted to higher training within that specialty or the funding utilised to develop posts in new emerging specialties such as Pre-Hospital Emergency Medicine, Intensive Care Medicine, Stroke Medicine and the development of the Clinical Leadership Fellow programme which will support career progression and lifelong learning for aspiring medical and dental leaders. The Deanery believes that investment in these specialties will show Wales in a positive light with regard to the rest of the UK. .

Other initiatives include the All Wales Foundation Programme iDoc Project which provides trainee doctors with a Smartphone device to enable access to accurate medical information to aid clinical information delivery and just-in-time learning.

In 2009 the Deanery launched the Best Educational Supervisor and Trainer (BEST) Awards aimed at ensuring excellence in medical training through the development and support of high quality educational and clinical supervisors throughout Wales. These annual awards have gone from strength to strength and are a model followed by other deaneries across the UK.

The All Wales Health Information and Library Extension Service (AWHILES) which is unique to Wales provides all training grade doctors and dentists with access to high quality postgraduate facilities and educational support so that they can achieve their potential in service provision to the NHS in Wales.

The Deanery recognises that the very many positive aspects of training in Wales should be highlighted to potential applicants. The Deanery actively promotes ‘Training in Wales’ at various medical careers fairs across the country. The Deanery recognises, however, more work is needed to emphasize the excellent and highly regarded research facilities, excellent trainers and excellent teaching and training facilities available across Wales.

In 2012 the Professional Support Unit of the Deanery, whose work supports the development of doctors and dentists, were runners up in the Healthcare People Management Association (HPMA) Excellence Awards under the category: Healthcare Performance award for best coaching and personal development strategy. The Professional Support Unit was commended on being the first Deanery submission in the UK for HPMA awards.

The Deanery continues to publicise as best it can the quality of training in Wales and in 2012 won the Medical Women’s Federation Award for being the most Family Friendly Deanery in the UK. This is the second year in a row that we have been the

outright winner of that award and is a reflection of our commitment to provide not only the best possible training for trainees here in Wales, but also a positive work-life balance in order to promote the retention of doctors who come to Wales.

The Deanery works in close collaboration with Medical and Clinical Schools across Wales. With Cardiff University School of Medicine the Deanery is playing a leading role on the harmonisation of the final year of undergraduate medicine with the first year of Foundation. The aim of this initiative is to ensure that on graduation newly qualified doctors are fit for purpose for their role in the NHS and are competent and confident clinically.

4. To what extent current proposed service reconfiguration is driven by the need to respond to staffing challenges?

The Deanery has worked closely with all the Health Boards with regard to their service reconfiguration plans. The Deanery's own training reconfiguration plans started on the 1st March 2010 and pre-dated the service reconfiguration issues that we are now facing. The rationale behind training reconfiguration has already been outlined with regard to fewer sites, sustainable rotas, protected teaching time and less reliance on the trainees for service provision.

Clearly with the number of doctors in training they still do make a substantive contribution to service delivery. The key for Wales is to get the balance right which is a difficulty throughout the UK. Although the Deanery has highlighted the need to undertake training on fewer sites, we have never directed any of the Health Boards as to which sites we think training should take place as it is up to the service to decide the exact configuration of service provision for Wales.

The Deanery's involvement with the Health Boards and the current plans that we have seen (we have continuous engagement meetings scheduled with each of the Health Boards in Wales, we have representation on the South Wales Programme Board and the National Clinical Forum) do suggest that there will be a great benefit to patient care and delivery of care with service reconfiguration. The Deanery believes this will have a positive effect on training, recruitment and retention of doctors who we hope to retain within Wales as the workforce of the future, delivering the highest possible quality of care for our patients.

While we realise the Health Boards are working to a certain timeframe, we do believe that training reconfiguration in some specialties is likely to occur ahead of the timescale being set for service reconfiguration. This is particularly pertinent in Paediatrics, Emergency Medicine and Psychiatry, where there are currently insufficient training doctors to either comply with all rotas or indeed ensure they get the best possible training at the best possible sites across Wales.
We are committed to working with the Health Boards, particularly when their service reconfiguration plans are predicated on the presence of trainees, to ensure that the trainees have access to the best possible teaching and training and that we deliver the best possible care for patients.

We are very grateful for the opportunity to present our plans and ideas around the training needs of doctors and dentists in Wales and the positive impact that these can have on the present and future service delivery to ensure the best possible standards of care for our patients.

5. To what extent current service reconfiguration plans meet the staffing challenge.

The preferred option as described in the South Wales Programme Board consultation exercise does in general terms map to the proposed reconfiguration of training within the South Wales area. In essence, a smaller number of training units where trainee doctors can be consolidated and provide a 24/7 on call service will allow sustainable and safe rotas, however we must stress that trainees alone cannot be relied upon to provide out of hours cover for all of these units and an increase in non-training grades will be required. In addition these rotas will allow trainees to gain access to academic and teaching experiences which will improve their general perception of their learning within NHS Wales. By enabling trainees to attend educational opportunities this will help in their preparation for Royal College exams, which is a key indicator of performance.

The Deanery has regular formal discussions with Health Boards where the proposal to move to a 'hub' and 'spoke' model for training, where trainees undertake the majority of their work and out of hours duties in the 'hub' hospital and 9-5 daytime, elective or clinic-based work that meets curriculum requirements will take place in the 'spoke' hospital, is being explored. The Wales Deanery has made it very clear from the beginning of service reconfiguration that we would not stipulate or name any particular hospitals that would be the 24/7 hub or the spoke. This decision is for Health Boards. We have made it clear that a smaller number of training units does not preclude any Health Board making a decision to develop or maintain current clinical services but that this has to be on the basis of there not necessarily being trainee doctors available on a 24/7 basis to provide those services. The Deanery has made it clear to all Health Boards that we support a hub and spoke model whereby the hospitals within the spoke arrangement can provide educational experience on a daytime basis as long as that maps to the curriculum requirements of the trainees.

The South Wales Programme should be mindful of potential changes to the structure of postgraduate medical education and training and the impact this may have upon service delivery, more specifically, The Shape of Training Review led by Professor David Greenaway which aims to report in the Autumn of this year. Early indications have included the need for more generalist care doctors skilled to deliver in local and community settings and provide acute and non-acute care.
The Wales Deanery has representation on the Sponsoring Board and Expert Advisory Group for this review and we will update the South Wales Programme Board on the conclusions and potential impact once these have been finalised.

Wales Deanery
September 2013

HEALTH AND SOCIAL CARE COMMITTEE CONSIDERATION OF LHB SERVICE RECONFIGURATION PLANS

THE ROLE OF THE NATIONAL CLINICAL FORUM IN THE REFORM PROCESS

EVIDENCE SUBMISSION BY THE NATIONAL CLINICAL FORUM

1. Introduction and Background

This paper updates the previous evidence submission to the Health and Social Care Committee on the 25th January 2013.

The National Clinical Forum (NCF) was established at the request of the NHS Wales Chief Executives in November 2011 to provide expertise, advice and challenge to service change plans developed by NHS organisations that would impact on populations in Wales. Initially it was established to run for one year from November 2011 to November 2012. In September 2012, due to the on-going service change planning processes, the NHS Wales Chief Executives asked the Forum to continue for a further year.

The NCF has its own formal Terms of Reference, which were reviewed in February 2013. **The revised Terms of Reference are attached as Appendix 1.**

The NCF is made up of healthcare professionals from across Wales who are experts within their own field and are generally part of the national advisory structure. Professor Mike Harmer was appointed as an independent Chair of the Forum for two days per month and in this role is responsible for both chairing the meetings and coordinating the views of the Forum in responding to LHB plans. To support the Chair, Dr Mike Tidely was appointed Vice-Chair in February 2013.

Whilst the majority of members of the NCF work within NHS Wales, the Forum itself is autonomous of both Welsh Government and Local Health Boards and Trusts. This enables the Forum to provide impartial advice based upon expert knowledge to assist LHBs in scrutinising and developing plans to deliver safe, high quality, effective and sustainable clinical services. Where individual members are commenting on plans developed by their employer organisations, interests are declared and due diligence applied.

The NCF costs the NHS £12,000 per year to run, which consists mainly of expenses for members attending the meetings.

2. Governance Arrangements

The Chair of the Forum reports to the LHB Chief Executive (the 'lead Chief Executive') who chairs the LHB Chief Executive peer group and therefore represents the LHBs in Wales.

The official views and opinion of the NCF are only communicated by the Chair or Vice-Chair, or through the National Director, Together for Health, at the request of the Chair.

The official views and opinion of the NCF will be communicated in writing to the relevant LHB or LHB's. In order to facilitate the Forum assessing all plans it is asked to consider against the same criteria, the NCF has established a set of Evaluation Criteria. These Evaluation Criteria will be used to formally assess all plans that are put forward by LHB's for formal Public Consultation. **The Evaluation Criteria are attached as Appendix 2.**

At any time, via the lead Chief Executive, LHBs or the NHS Wales Chief Executive's can request a progress update or an overview commentary from the NCF.

Any costs and expenses incurred by the NCF are split equally between the LHB's.

All publically available documents of the NCF can be found on the National Clinical Forum website.

3. The Role Of The NCF In The Reform Process

As part of change management plans within and across LHBs, the NCF is a key stakeholder in the engagement and consultation process and has the unique ability to provide impartial clinical advice to Boards.

When it was established in 2011, this was a new arrangement in Wales and, as such, the NCF's working has continued to evolve as the process has progressed within the scope of its Terms of Reference. One of the benefits of the Forum is that it can provide advice and scrutiny of the changes being proposed by NHS organisations and it is also able to provide challenge and commentary on any issues that may be yet to be fully considered by the LHB(s).

The NCF has effectively established an on-going relationship with all LHBs and Trusts through the service planning process, and is there to be used as frequently as those organisations feel it is necessary to obtain expertise, advice and guidance on their emerging plans. As a minimum it has been agreed by the LHBs with the NCF, that they will attend a meeting with the NCF at the pre-engagement and pre-consultation stages of the process. These meetings and subsequent correspondence are held in

confidence with the LHB's, although the LHB's can choose to release that correspondence at a later stage in the reconfiguration process. The NCF provides its formal public response to the LHB consultation process as any other stakeholder would do during the formal consultation period.

The NCF is purely advisory in function, and has no right or power of veto over any of the proposals or plans it considers.

In providing feedback to LHBs, it has been determined by the NCF that it will do so in two distinct parts:

1. Formally respond to those issues that the LHB is engaging and/or consulting upon including advising on any critical dependencies that the Forum considers have been omitted from the process;
2. Formally advise when it feels necessary and appropriate, under separate cover, on those issues the Forum considers the LHB must also address but which are not yet part of any on-going engagement and consultation.

The NCF has determined that when required these two distinct parts will be issued separately, but simultaneously. It is important that these responses are given equal importance but are issued separately so that they do not cut across any formal consultation processes.

The NCF uses its meetings with the respective LHB's, and any other information that the LHB submits to it to develop its views and opinions on proposed plans. During those meetings, members of the Forum have the opportunity to question LHB's as to their thinking, rationale and evidence behind advancing any given proposal.

The NCF's Evaluation Criteria are used to help formulate the formal responses. Each member of the NCF is asked to respond on each plan using the criteria as a template for assessment. This ensures consistency of approach to the evaluation by all, and ensures the Chair can co-ordinate the response to a standard format. This is usually done outside of the meetings and submitted to the Chair due to the considered comments members wish to make. This process will be commenced after a broad discussion on the proposals, both with and without the presence of the presenting LHB at a scheduled NCF meeting. Members are provided the opportunity to comment on the drafts of the co-ordinated response prior to formal submission, as it is very much an iterative process.

4. Lifespan Of The National Clinical Forum

As stated previously, the NCF was initially established by the NHS Wales Chief Executives, for one year from November 2011 until November 2012. This was extended to November 2013 by the NHS Wales Chief Executives due to the on-going service change planning, engagement and consultation processes happening across Wales.

Over the coming months, the NHS Wales Chief Executives will again consider the future lifespan of the NCF, and any role it might have, in providing LHB's and Trusts with impartial expert clinical advice beyond November 2013.

The NCF believes it is adding value to the current service change planning process, and could see how such a role might be of benefit in the longer term. Feedback to it from within the NHS is that it has added value to the service reconfiguration process, in the challenge and advice it has provided. In the future, the NCF believes that in addition to the advice and support role during the planning process, an independent clinical body could have a valuable role to play in the implementation of agreed plans.

APPENDIX 1

NATIONAL CLINICAL FORUM

Terms of Reference and Operating Arrangements

Introduction

All NHS Organisations are developing service plans to improve quality, responsiveness and accessibility of care across Wales. These plans will develop new sustainable models of care that integrate the NHS in Wales as a whole system, encompassing primary, community, secondary and specialist care services. The focus is on locally - based services wherever possible maximising the opportunities highlighted in *Setting the Direction*, with access to high quality specialist services when needed, through a network of specialist centres and centres of excellence.

This may involve some significant change to the current pattern of healthcare delivery in Wales. Although it is for the Local Health Boards and Trusts (LHBs) to plan, lead and implement any service changes required, there is a need for them to be supported nationally. This will ensure a consistent approach to service standards and models of care across Wales.

Purpose

The National Clinical Forum (NCF), hereafter referred to as "the Forum" will be an advisory task and finish group. **The NCF therefore has no decision making powers or right of Veto over any proposals/plans it considers**. Its role will be to advise LHBs if as a result of their service change plans, standards and policy requirements will be met, improved outcomes can be achieved and patients will be better served.

The Forum will consider if proposals for service change:

- are appropriately influenced by relevant evidence and best practice;
- provide a basis for sustainable delivery of services; and
- combine to create a realistic and ambitious way forward for healthcare in Wales.

In undertaking this role, the Forum may also be asked to consider any external/international expert advice the LHBs may decide to commission to support their plans.

Its role does not include consideration of professional terms and conditions of service.

Scope and Duties

The Forum will, in respect of its provision of advice to LHBs:

- offer advice and feedback to LHBs on an individual organisation, regional or all-Wales basis on any aspect of all service change plans that will impact across Health Board Boundaries or have impacts for Wales as a whole;
- Offer advice and feedback to LHBs on any local service change plans they request the Forum to review;
- Offer advice to LHBs on the development and content of the national narrative describing the clinical case for change.
- Offer advice to LHBs on the adoption of best practice service models and innovative practice across Wales, inclusive of best practice in training and education across all professions;

The Forum may provide advice to the LHBs:

- at Chief Executive Officer Group meetings, through the attendance of the Forum's Chair or a nominated representative;
- in written advice; and
- in any other form agreed with the LHBs.

The Forum may determine if it requires to be supported by any subgroups or additional sources of specialist advice to assist it in the conduct of its work, and may itself, determine any such arrangements.

Membership

Membership of the Forum will comprise healthcare professionals from within NHS Wales, but will be independent of individual organisations. Any member of the Forum should not therefore be an executive or independent member of any LHB/Trust. Its membership will be drawn from a wide range of multi-disciplinary clinical specialists.

Chair
The Forum will be Chaired by an independent Chair from Wales identified by the NHS Wales Chief Executives, and a Vice Chair will be identified to provide support to the duties of the Chair.

Vice Chair
The Vice Chair will be chosen by the Chair from the existing Forum members with the agreement of the Forum members.

Members

The following clinical groups will be represented:

- Public Health
- Ambulance Services

- Members drawn from WMC NSAG, representing the following specialties:
    - child health
    - women's health
    - mental health
    - medicine
    - surgery
    - anaesthesia / critical care
    - general practice
- NJPAC, Welsh Scientific Advisory Committee
- NJPAC, Welsh Therapies Advisory Committee
- NJPAC, Welsh Nursing and Midwifery Committee
- NJPAC, Welsh Pharmaceutical Committee
- Welsh Dental Committee
- General Practitioner (nominated by BMA)
- Nurse (nominated by RCN)
- Heads of Midwifery Advisory Group
- Postgraduate Dean
- Academy of Medical Royal Colleges in Wales
- The Rural Health Plan Implementation Group
- The Institute of Rural Health

Members will be invited to nominate a named deputy in the event that they are unavailable for a forum meeting.

Secretariat

As determined by the National Director, *Together for Health*.

In attendance

- National Director, *Together for Health*
- The Medical Director, NHS Wales, Nurse Director, NHS Wales and Director of Therapies and Health Sciences, NHS Wales may be in attendance as observers. The Forum may also determine that other Welsh Government officials or LHB/Trust staff be in attendance.
- The Forum Chair may also request the attendance, from time to time, of Board members or LHB/Trust staff, subject to the agreement of the relevant Chief Executive.
- The Forum Chair may, from time to time, invite external/international experts to aid discussion and review of specific service change issues.

Terms and Length of Office

Appointments to the Forum will be made through the National Director, *Together for Health* on behalf of the LHB Chief Executives. Members will either be invited on to the Forum in their role as Chair of an All Wales Professional Group/Committee, or as a nomination from such a group, committee or stakeholder organisation. The Forum is a task and finish group

which is anticipating needing to meet for a minimum of one year. The need for the continued role of the group will be reviewed regularly. In the interests of consistency in discussion and review of plans/information, Members will serve for the duration of the Forums' work, even if during the life of the Forum, they cease to be Chair of the Group or Committee that led to the original invitation. In this situation the Chair will have the option to invite the new Chair of that Committee to the Forum, if it is felt that the Committee concerned is no longer appropriately represented.

The appointed Chair and Vice - Chair of the Forum will hold those positions for the life of the Forum.

Members Responsibilities and Accountability

The Chair is responsible for the effective operation of the Forum:

- chairing meetings;
- ensuring all business is conducted in accordance with its agreed operating arrangements;
- developing positive and professional relationships amongst the Forum's membership and between the Forum and LHB/Trust Chief Executives and any other relevant groups;
- ensuring that any formal feedback to LHB's and notes of meetings accurately record the decisions taken and where appropriate, the views of individual members.

The Chair and Vice-Chair will cover for their colleague in their absence for any reason. If for some unforeseen reason, neither the Chair or Vice Chair can attend the meeting, but sufficient members are present to make the meeting quorate, then an attending member will be nominated by those present to chair the meeting.

Members – all members shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for any advice agreed by the Forum. All members are accountable to the Forum Chair for their performance as group members and to their nominating body or group for the way in which they represent the views of their body or group at the Forum.

The role of the Forum will necessarily mean that Members will, from time to time, receive highly sensitive and confidential information about health services across Wales from LHB's. The highly confidential nature of this information must be respected.

Resignation and removal of members

A member of the Forum may resign office at any time during the period of appointment by giving notice in writing to the Forum Chair.

If the Forum Chair and the nominating body or group, considers that:

- it is not in the interests of the health service that a person should continue to hold office as a member; or
- it is not conducive to the effective operation of the Forum. (This could include an attendance rate considered to be poor by the Chair, or evidence that confidential information has been shared outside of the Forum without explicit permission to do so).

it shall terminate the membership of that person by giving notice in writing to the person and the relevant nominating body or group.

A nominating body or group may request the removal of a member appointed to the Forum to represent their interests by writing to the Chair setting out an explanation and full reasons for removal.

Handling Conflicts of Interest

All members should declare any personal or business interest which may or may be perceived (by a reasonable member of the public) to influence their judgement. A register of interests will be established, kept up to date, and be open to the public. A declaration of any interest should also be made at any Forum if it relates specifically to a particular issue under consideration, for recording in the notes of the meeting.

Relationship with LHBs Chief Executives

The Forum's main link with the LHBs Chief Executives is through the Chair.

The Chair and Lead Chief Executive shall determine the arrangements for any joint meetings between the LHBs and the Forum, should it be required.

The lead Chief Executive shall put in place arrangements to meet with the Forum Chair as required to discuss the Forum's activities and operation.

Relationship with Local Healthcare Professionals Fora

The Forum Chair and Vice Chair will liaise with local Fora as he/she deems appropriate. It is expected that the Local Healthcare Professionals Fora would be an integral part of any local "continuous engagement" during the development of service change proposals, as per the National Guidance on Engagement and Formal Public Consultation. Therefore, the Forum would not anticipate being asked to consider plans that hadn't yet been advised upon locally by the Local Healthcare Professionals Fora.

The Forum may delay review of any LHB Service Change Plans, until it has received assurance that the Local Fora have been consulted, and their advice taken into account.

Support to the Forum

The National Director, *Together for Health*, will ensure that the Forum is

properly equipped to carry out its role by:

- ensuring the provision of governance advice and support to the Forum Chair and Vice Chair on the conduct of its business and its relationship with the LHBs and others;
- ensuring the provision of secretariat support for Forum meetings;
- ensuring that the Forum receives the information it needs on a timely basis; and
- facilitating effective reporting to the LHBs Chief Executives.

Forum meetings

At least the Chair or Vice - Chair plus 6 members must be present to ensure the quorum of the Forum.

Meetings should be held no less than monthly and otherwise as the Chair deems necessary. The requirement to meet and frequency of meetings will be reviewed on a regular basis.

To facilitate attendance, Video Conferencing Facilities will be made available at all meetings.

The LHBs commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others which advise it. Meeting dates, agendas and minutes should therefore be publically available unless there are any specific, valid reasons for not doing so.

Following each Meeting, the Chair or Vice Chair will produce a report summarising the items taken, discussions held and any advice being provided to the Health Boards. This will be available to the Public, and Members may use it to brief their respective committees.

Withdrawal of those in attendance

The Forum may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussions of particular matters.

8th February 2013.

Appendix 2

National Clinical Forum

Evaluation of Service Reconfiguration Plans

Introduction

The National Clinical Forum (NCF) was established at the request of the Local Health Boards (LHBs) to provide an independent group to evaluate the clinical aspects of the various reconfiguration plans. In considering the proposals put forward by the various LHBs, the NCF has attempted to view them in the light of the brief given to them by Welsh Government through a number of criteria.

The criteria are not intended to be totally inclusive of the many factors that may influence service delivery plans, but are based around the clinical delivery potential of such plans.

The Forum appreciates that the individual LHBs may face issues over public and political acceptance of plans but feels that its role is to concentrate on the clinical feasibility and sustainability of the service plan proposed.

The responses given from the NCF to the LHBs prior to and during the public consultation period will be based upon the application of the evaluation criteria outlined below. These evaluation criteria will be made available to the LHBs and any other interested parties prior to the completion of the consultation process.

Criteria for the Evaluation of Service Reconfiguration Plans

The key underpinning of the evaluation is based on the following components of the proposals:–

- Are the aims and objectives set out in the plan SMART (specific, measurable, achievable, realistic, and timely)?
- Do they specify what you want to achieve?
- Will it be possible to measure whether or not the objectives are being met?
- Is the plan going to be able to achieve these objectives? Are they attainable?
- Can they be realistically achieved with the resources you have available? Do they show value for money/ cost effectiveness?
- When should the objectives be met? Has timescale been set out?

Evaluation Criteria

Questions are set out to test the robustness and practicality of the Plans

Access and Integration of Services

- Is the Plan based on population needs with particular emphasis on addressing any known inequalities of provision?

- Does the plan show evidence-based practice as the main underpinning component of the revised care proposals, including where appropriate National guidance?

- Is there evidence that structures are/will be be in place to facilitate and develop integration between specialist, general and community services for all aspects of healthcare?

- Will the proposed service configurations provide timely and appropriate access to care?

- Is there an appreciation in the plan that primarily clinical need rather than the current estate configuration (service rather than hospital site) should be the founding basis?

- Has the plan been submitted to a process of 'rural-proofing' using a suitable tool such as that developed by the Institute of Rural Health?

- Has sufficient consideration been shown for distance and travel time from point of care and the transport implications for both routine and emergency care? This is particularly important for those Boards with a large rural population.

- Is the plan 'patient-centred' taking into account the 'patient journey' and the impact on relatives, especially for children?

- Does the plan include consideration of local public transport infrastructure?

- Is there evidence of appropriate collaboration with adjoining LHBs and other statutory bodies to consider fully the best care pathway for patients?

- Does the plan demonstrate evidence of working with other relevant services such as Local Authorities, Social Services and the Third Sector?

- Are Plans for increasing the community care of patients based on sound logistic and financial considerations?

- Is there evidence of pilot work or sharing of good practice for solutions in these areas?

- Is there clear and realistic evidence that there is sufficient capacity, both in terms of staff and ability to allow such change?

- Where appropriate, are the role of 'telemedicine' and other IT support mechanisms included?

Workforce

There must be evidence of a cohesive workforce plan.

- Is the workforce planning consistent with UK National and WG policies?

- Is it sustainable e.g. does it consider the availability of trainee staff in the future? Failure to address this matter may lead to training recognition being withdrawn centrally by Colleges, deanery and training committees with serious consequences.

- Are training plans aligned to National regulations and requirements of professional bodies (Royal Colleges, etc)?

- Does the plan take account that the positioning of trainees, in all fields of healthcare, is based on the experience available to the trainee in a particular setting rather than the service requirement? This must be taken into account in any plans. This might also include 'context experience' to ensure a broad breadth of experience.

- Is the provision of services by non-trainee, non-consultant clinicians considered in the light of the suitability and availability of the proposed workforce?

- Where appropriate, does the plan meet the training needs of existing staff in new developments and changing configuration? In particular, moving services to the community will impact upon the training needs of primary care professionals?

- Has consideration been given to the potential for extended roles for health professionals in the provision of care and have the training implications for such been given due consideration along with the necessary shift of resources?

- Is the timescale of such developments laid out and are they feasible?

Quality and Safety

Safety in patient care must be the priority in plan development.

- Is there clear evidence of patient involvement and consultation in the development of plans?

- Is there evidence of how the principles of 'Dignity in Care' underpin the strategy?

- Are all areas of care provision based upon accepted standards provided by appropriate bodies e.g. Statutory Professional Organisations, Royal Colleges, other professional bodies, advisory boards, etc?

- Is there sufficient assurance that services will be delivered in facilities that provide appropriate environments and support to ensure safety of patients and staff?

- Has sufficient emphasis been placed on the potential impact on configuration of integrating services, as appropriate?

- Does the plan maximise the potential for prevention and admission avoidance?

- Linked with the workforce plan, have governance issues relating to changing and enhanced staff roles, and working with joint agencies been considered.

Buildings and Facilities

- Has consideration been given to the appropriateness and sustainability of current estate and facilities to provide both current and projected care modalities?

- Is the strategy for the future of community hospitals clearly set out and to a timeline?

Compatibility across Wales

- How do the proposals for a specific LHB fit within an overall structure for NHS Wales its partner services?

Health and Social Care Committee

Meeting Venue:	Committee Room 1 – Senedd
Meeting date:	Wednesday, 25 September 2013
Meeting time:	09:30 – 11:09

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_25_09_2013&t=0&l=en

Concise Minutes:

Assembly Members:	David Rees (Chair) Leighton Andrews Rebecca Evans William Graham Elin Jones Darren Millar Lynne Neagle Gwyn R Price Lindsay Whittle Kirsty Williams
Witnesses:	Sarah Rochira, Older People's Commissioner for Wales
Committee Staff:	Llinos Madeley (Clerk) Sarah Sargent (Deputy Clerk) Stephen Boyce (Researcher)

TRANSCRIPT
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 No apologies were received.

2 Scrutiny of the Older People's Commissioner for Wales' Annual Report

2.1 The Older People's Commissioner for Wales responded to questions from committee members.

3 Papers to note

3.1 The Committee noted the minutes of the previous meeting.

3.1 Letter from the Petitions Committee: Equal Rights for Tube-fed Youngsters

3a.1 The Committee noted the letter from the Chair of the Petitions Committee; the Chair will respond, noting the correspondence.

3.2 Letter from the Petitions Committee: Ambulance Services in Monmouth

3b.1 The Committee noted the letter from the Chair of the Petitions Committee; the Chair will respond, noting the correspondence.

3.3 Letter from the Minister for Health and Social Services: Follow-up from the general ministerial scrutiny session, July 2013

3c.1 The Committee noted the letter from the Minister for Health and Social Services.

3.4 Letter from the Minister for Health and Social Services: Measles outbreak 2013

3d.1 The Committee noted the letter from the Minister for Health and Social Services.

3d.2 The Committee agreed to write to the Minister for Health and Social Services to ask:

- what impact the reduction of £1.9million to the health protection and immunisation budget, as reported by the Wales Audit Office's Health Finances 2012-13 and beyond [page 16], has had; and
- where provision of funding to deal with the recent measles outbreak was sourced, and whether the saving of £1.9million stood at the year end.

3.5 Letter from the Minister for Health and Social Services: Response to the Committee's Inquiry into the measles outbreak 2013

3e.1 The Committee noted the letter from the Minister for Health and Social Services.

3.6 Forward Work Programme

3f.1 The Committee noted the forward work programme for the forthcoming autumn term.

4 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

4.1 The motion was agreed.

5 Discussion on the Forward Work Programme

5.1 The Committee discussed options and proposals for its post-Christmas forward work programme.

6 Access to medical technologies in Wales

6.1 The Committee discussed it's approach to the inquiry into access to medical technologies and agreed to seek to appoint an expert adviser, and agreed the draft role description for that adviser.

7 Legislative Consent Memorandum: Care Bill

7.1 The Committee discussed the revised Legislative Consent Memorandum for the Care Bill.

7.2 The Committee agreed to write to the Deputy Minister for Social Services to seek clarification as to why the Care Bill does not appear to include any reciprocal requirement on local authorities in Scotland to meet the care and support needs of adults placed there by Welsh local authorities.

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref LF/GT/0897/13

David Rees AM
Chair of the Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

25 September 2013

Dear David,

I am writing to place on record my thanks for the Committee's detailed and thoughtful scrutiny of the Social Services and Well-Being (Wales) Bill which I have read with great interest. You will have seen from your evidence gathering, the extensive interests that those working in social care have and you will have appreciated their commitment to and their passion for what they do. I was delighted that you took evidence from such a wide range of stakeholders and I am sure that doing this greatly assisted your understanding of how important this legislation is and what this Government wishes to achieve with it.

I understand that my Private Office has been in touch to arrange a meeting to discuss the report further ahead of the plenary debate on 8 October but ahead of this I wanted to share with the Committee my responses to a number of the recommendations made for which I am minded to table amendments. These are as follows:

- Independent Advocacy, which I made a written statement on and for which you indicate your support (Recommendation 28);
- placing a duty on local authorities to promote Direct Payments (Recommendations 31 and 32);
- changing the legislative procedure to super-affirmative in relation to any decision to merge children's and adults regional safeguarding boards in section 117 of the Bill (Recommendation 37);
- adding reference to the probation service as a statutory Safeguarding Board Partner (Recommendation 39) in so far as is possible within the legislative competence of the National Assembly;
- provisions to strengthen arrangements for co-operation and partnership working (Recommendation 50); and
- the inclusion of 'aids and adaptations' within section 20(2) (Recommendation 59).

As you will be aware, there were some further calls for amendments, such as the delegation of assessment (Recommendation 10). In these cases, whilst we support the intention of the recommendations on analysis, we have concluded that provision is adequate to achieve the intentions set out by the Committee

I would also like to take this opportunity to share with you a table which sets out a summary of the categories of amendments I am proposing to table on behalf of the Government during Stage 2. I

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Gwenda.Thomas@wales.gsi.gov.uk

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wanted to do this ahead of the process formally starting in October so you had as much time as possible to consider the potential impact of these changes.

I hope you will agree that both the amendments above and those included in the table attached are a clear representation of my commitment to listening to the Committee and to stakeholders.

I am copying this letter and table of my responses to your recommendations to the Chair of the Constitutional and Legislative Affairs Committee.

Yours sincerely

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

Proposed Stage 2 Government Amendments

Topic	Amendments relate to…	Proposed Change / Purpose	Effect	Reason	Estimated number of drafting amendments	Tabling Tranche	Bill Part
1	**ASSESSMENT & ELIGIBILITY LF/GT/0442/13**	**Assessment**: To amend Section 10, 12 and 15 in order to require that an assessment includes an assessment of whether, and if so, to what extent other factors could contribute to meeting any needs identified; Amend Sections 10, 12 and 15 in order to require a local authority to assess whether the provision of preventative services or information, advice or assistance could contribute to meeting a person's needs or desired outcomes. Amend Sections 10 and 12 in relation to the persons who are required to be involved in the assessment. Amend Sections 10, 12 and 15 to ensure consistency across the Sections; consistency with the language used in Sections 26, 27 and 29; and to change references to 'consult' to 'involve'. **Eligibility**: Amend Section 19 to remove the power for Local Authorities to set their own (lower) eligibility level. Also amend Section 19 to include a regulation making power to specify eligible needs, including describing those needs by reference to the effect that those needs have, and the person's circumstances. Amend Sections 22 and 24 so that the duty to meet needs does not apply to needs that are being met by a carer. **Eligibility and Preventative Services**: Amend Section 19 to include an additional requirement on Local Authorities, following their determination of whether a person's needs meet the eligibility criteria. That requirement will be to consider whether the person would benefit from the provision of services under Sections 6 or 8 of the Bill. This requirement would apply, regardless of the determination of eligibility.	The intended effect of these amendments is to strengthen the connections between assessment; eligibility; preventative services; and information, advice and assistance. The changes will require Local Authorities to take into account a wider range of factors when considering if a person has eligible needs; and will ensure that the person being assessed has other options, even if the Local Authority has determined that they do not meet the eligibility criteria for care and support. The amendments will also ensure consistency with section 15, which already makes provision for the persons who are required to be involved in relation to the assessment of the needs of a carer.	Following extensive work with the Social Services Improvement Agency (SSIA) and stakeholders, and the publication of their report: Access to Care and Well-being; in addition to working closely with the Department of Health on the development of their framework for the Care Bill; the Deputy Minister agreed to amend the Bill in order to meet the principles of the SSIA report, and to achieve the flexibility required to deliver the new core services for assessment and eligibility in Wales.	29	**1**	**3 and 4**
2	**Section 117 of MHA (1983)** LF/MD/0476/13	To amend Section 37 to remove subsection (5).	The effect of this amendment is the removal of a regulation making power in relation to the interface between direct payments under the Bill and after-care services provided under Section 117 of the Mental Health Act 1983.	Technical amendments for consistency.	1	**1**	**4**
3	**FOSTER TO ADOPT LF/GT/0425/13**	To amend section 65 in a way that would enable looked after children to be placed with 'matched' prospective adopters at an earlier stage in the adoption process.	It is intended that these amendments would remove the necessity for prospective adopters to undergo the lengthy assessment process for Local Authority foster parent registration. This would reduce the delay in the placement of children in such cases, thereby ensuring earlier placement with their adoptive parent(s) (under a fostering placement) and avoid the need for changes of placement for the child. Those relevant prospective adopters would also receive the same entitlements as regular approved foster carers, including support and any appropriate fees.	We have proposed these amendments in an attempt to tackle the issue of delay without the potential risk of adverse effects on the child or prospective adopters. This is also something that was raised by Stakeholders and the Children and Young People's Committee during Scrutiny as something they wished to see within the Bill.	19	**3**	**6**

4.1	**CARE LEAVER ENTITLEMENTS - PART 1**	Section 88 - Young people entitled to support – to amend the Categories of young person entitled to support and assistance from 5 to 6. The amendment effectively splits the “former relevant children” definition into two separate Categories as opposed to a single Category:- Category 3, former relevant children who has passed the age of 18 and for whom the LA is providing support and assistance (previously 23CA of the Children Act 1989); and Category 4, former relevant children who have ceased contact with the local authority but before reaching the age of 25 wish to re-engage with the local authority and seek support and assistance to pursue a programme of education or training (previously 23CA of the Children Act 1989). Section 88(6) which prescribes the circumstances whereby the duties for Category 3 and 4 young people cease, is deleted and is re-stated in Sections 94C and 94D. Section 89 - Keeping in touch amends duties to “keep in touch” to reflect the revised Categories of children from 5 to 6; limits the duty to “keep in touch” with Category 3 young people to the provisions of 94C; amends existing Children Act 1989 references from “assistance” to “advice and other support” to provide greater consistency of language with the Bill; Section 90 – Personal Advisors: Pathway assessment and Plans: amends existing Children Act 1989 references from “assistance” to “advice and other support” to provide greater consistency of language with the Bill and limits the duty to keep the pathway plan of Category 3 and 4 young people under review to the provisions of 94C and 94D. Section 91 - Pathway assessment and Plans: amends existing Children Act 1989 references from “assistance” to “advice and other support” to provide greater consistency of language with the Bill.	The intended effect of these amendments is to preserve the entitlements currently under the Children Act 1989 for each of the current categories of care leavers – “eligible child”, “relevant child”, “former relevant child”, “(young persons entitled to) further assistance to pursue education or training” and “persons qualifying for advice and assistance”. These have been translated within the Bill into Category 1 - 6 young persons.	The reason for the amendments proposed follows further analysis of the consolidation of entitlements for care leavers under the Children Act 1989 into the Bill, has identified a number of issues where the preservation of entitlement has not been fully achieved. These amendments are required in order to achieve that preservation. LF/GT/0495/12 identified that there would likely be a requirement for amnedments to the Children's provisions to ensure compatability with extant children's legislation.	78	**4**	**6**
4.2	**CARE LEAVER ENTITLEMENTS - PART 2**	Section 92 - Support for Category 2 young people - Desirable “stylistic” amendment to subsection (1). Section 93 - Support for Category 3 young people - • desirable “sylistic” amendments to subsections (1), (4), (7) and (8); • clarifies that “support” under this section extends to the contribution it makes to individuals’ well-being, and education and training; • limits the duty to provide support to Category 3 and 4 young people under review to the provisions of 94C; • clarifies that duties to pay relevant to young people pursuing higher education is additional to duties under this section; and • section 936) is deleted but restated as section 94B. Section 93A - Support for Category 4 young people - Inserts provisions to re-state existing Children Act entitlements resulting from revised definition of Category 4 young people. Section 94 - Support for Category 5 and former Category 5 young people - desirable “sylistic” amendments to subsections (1), (4) and (5) andprovides that a LA may disregard interruptions in education or training; Section 94A - Support for Category 6 and former Category 6 young • Inserts provisions to re-state existing Children Act entitlements resulting from revised definition of Categories of young people. Section 94B – Supplementary provision about support for young people in further or higher education • Re-states Welsh Ministers regulation making power to define “full-time”, “further education”, “higher education” and “vacation” for the purposes of this Part (previously section 93(6).	See Part 1 above	See Part 1 above	\	**4**	**6**
4.3	**CARE LEAVER ENTITLEMENTS - PART 3**	Section 94C - Cessation of certain duties in relation to Category 3 young persons • Inserts provisions to re-state existing Children Act entitlements resulting from revised definition of Categories of young people including provision for local authorities to dis-regard interruptions to programmes of education or training. Section 94D - Cessation of certain duties in relation to Category 4 young persons • Inserts provisions to re-state existing Children Act entitlements resulting from revised definition of Categories of young people including provision for local authorities to dis-regard interruptions to programmes of education or training. Section 95 - Charging: amends existing Children Act 1989 references from “accommodation maintenance and support” to “support” to provide greater consistency of language with the Bill. Section 96 Information: amends existing Children Act 1989 references from “accommodation maintenance and support” to “support” to provide greater consistency of language with the Bill. Section 157 – Representations relating to former looked after children etc: Inserts provisions to re-state existing Children Act entitlements resulting from revised definition of Categories of young people. Policy has asked Counsel to consider renumbering the highlighted provisions, to immediately follow the provisions specifying “Support for Category 3 and 4 young people” (which are currently s93 and 93A respectively.)	See Part 1 above	See Part 1 above	\	**4**	**6**
5	**VISITS - Looked after and Accommodated Children** DC/GT/0396/13	Amend Subsection 81(1) to insert a regulation making power after 81(1)(b). The new subsection - 81(1)(c) - will allow Welsh Ministers to specify in regulations other categories of children for which the duty under Section 81 would apply.	The amendment will allow Welsh Ministers to prescribe in regulations additional categories of children to whom the duty should apply. These children, whilst not current or former LAC, may be considered vulnerable, or may otherwise benefit from a visit and assessment on entering the secure estate; and subsequently in preparation for their release and re-integration into the community. It is intended that this will assist with reducing re-offending; whilst also, in conjunction with Regulations under subsection (4), help to clarify the balance of responsibilities of all agencies engaged with such children, such as the secure estate in which the child has been placed, the broader Local Authority, LHBs and Youth Offending Teams.	Section 81 of the Bill, as currently drafted does not provide the power to prescribe those circumstances in which the duty extends. The proposed amendment, therefore, is required in order to ensure that specific groups of children, such as those on remand, are appropriately supported by the Local Authority through the duty under S.81.	1	**3**	**6**

6	**SAFEGUARDING - Duty to report Children at Risk** LF/GT/0427/13	Amend S.108 to extend the duty to report children at risk to 'relevant partners' of Local Authorities. Amend S.106 (duty to report adults at risk) to align the wording of the two duties and provisions at 106 and 108. Amend section 145 to align with the revised definition of 'relevant partner'.	The intended effect of these amendments is to align the duty to report children at risk with the duty to report adults at risk; and to align the revised definition of 'relevant' partner' throughout the Bill, so far as is possible.	The reason for these amendments is to align the duty to report children at risk at S.108, with the duty to report adults at risk at S.106.	5	**1**	**7**
7	**ADVOCACY** LF/GT/0433/13	To extend provision for statutory advocacy and meet the Deputy Minister's intention to provide: For a regulation making power to place duties on Local Authorities to make advocacy available in prescribed circumstances to prescribed persons; A duty to require Local Authorities to promote and inform people of their right to advocacy; A duty to require registered care home providers to inform people about the availability of advocacy services by the Local Authority; and A power to charge for the provision of those advocacy services.	The intended effect is to give the Welsh Ministers power to require Local Authorities to arrange for advocacy services to be made available to certain persons with need for care and support, to ensure that those persons are aware of their right to those advocacy services and to enable Local Authorities to charge for those services.	These amendments are being pursued following significant feedback and evidence submitted from stakeholders and opposition parties during stage 1 scrutiny . This will provide an enabling power to ensure that Local Authorities provide advocacy for some people who may have complex needs and do not have the capability or the wider support network to advocate on their behalf in decisions about their care. This will strengthen the 'voice and control' element of the Bill.	5	**1**	**10**
8	**Definition of Third Sector (Promoting Social Enterprise)** LF/GT/0508/13	To amend the wording of Subsection 7(1)(d) to clarify that 'promoting the availability of care and support and preventative services from third sector organisations' can encompass, but not exclusively, social enterprises and co-operative organisations.	It is intended that the re-wording of this Section will clarify that social enterprises and co-operatives come within the term 'third sector organisations'.	This amendment is being pursued following feedback and evidence submitted from stakeholders throughout the Scrutiny process.	1	**4**	**2**
9	**REGISTERS (Terminology used)** GT/0372/13	To amend the wording of Section 9 and the corresponding reference in Section 1 to remove references to 'blind' and 'deaf' and replace with 'sight-impaired' and 'hearing-impaired'.	The proposed amendments will bring the Bill in line with modern language, whilst further reflecting the broad range and levels of hearing and sight loss.	These amendments are being pursued following feedback and evidence submitted from stakeholders throughout the Scrutiny process.	5	**1**	**2**
10	**Safeguarding, Co-operation and Guidance**	1. Amend subsection (4) of Section 25 of the Children Act 2004 to include, as a relevant partner, any other Local Authority with which the authority agrees it would be appropriate to co-operate under this Section. 2. Amend Section 144 of the Bill to remove subsections (6) and (8). 3. Include a new guidance power in the Bill, to enable Welsh Ministers to issue guidance to Local Authorities and 'relevant partners' in the context of safeguarding and co-operation.	1. The intended effect of 1 is that the arrangements for co-operation and the relevant partners in relation to those arrangements for both adults and children are aligned. 2. The intended effect of 2 in the case of 144(8) is to retain the provision within subsection 25(9) of the Children Act 2004, in order that Secretary of State consent is required in order to issue guidance under this Section. In the case of 144(6), it will no longer insert the provision to enable local authorities and their relevant partners to share information for the purposes of co-operation to improve well-being. 3. The intended effect of 3 is to enable Welsh Ministers to issue statutory guidance to all relevant partners in relation to safeguarding and co-operation.	1. The reason for 1 is to align the co-operation arrangements for both adults and children. 2. The reason for 2 and the removal of subsections (6) and (8) of Section 144 of the Bill is an issue of competence. Consent has not been provided by the Secretary of State for this provision – which is required as it, in the case of 144(8), removes a pre-commencement power from a Minister of the Crown; and in the case of 144(6) confers a function on a Minister of the Crown. Therefore these subsections need to be removed in order to keep the Bill within competence. 3. The reason for 3 and the new guidance power is that on further reflection of the introduced Bill, it was felt that it did not adequately meet the policy needs required in relation to the ability of the Welsh Government to issue statutory guidance to all relevant partners listed in Section 143; and its impact on safeguarding and co-operation.	4	**1**	**9**
11	**Changes to procedures for Regulations** LF/GT/0548/13	Amend the Bill in order to effect a change in procedure for the following regulation making powers: Negative to Affirmative for Sections – 3(6); 7(3); 9(3); 23(1); 26(1); 27(1); 105(9); 112(4) Affirmative to Super-Affirmative for Section 117 To apply a Negative procedure to Section 25 of the Children Act 2004, by amending Section 66 of that Act. The regulation making power will be inserted into Section 25 of the 2004 Act following commencement of Section 144 of the Bill. To amend Section 85 to remove subsection (2), which states that the Lord Chancellor requires the consent of Welsh Ministers in order to make regulations under this Section. To amend section 77 to clarify that directions can be varied or revoked by later directions.	The effect of these amendments is that all of the regulation making powers contained within the Sections and subsections referenced will be subject to revised levels of procedure; and that the direction-making power in section 77 will be clarified.	The reason for these amendments follows requests and recommendations by the Health and Social Care; and Constitutional and Legislative Affairs Committees to reconsider the procedures for these powers during their scrutiny of the Bill during Stage 1 proceedings; and their subsequent Stage 1 reports. HSC Recommendation 37; and CLAC Recommendations 3, 5, 9, 10 and 13 refer. In relation to Section 85 (Referred cases – family procedures) - This is a technical matter which was discussed with Whitehall counterparts during discussions regarding consent in other areas of the Bill. Welsh Government and Whitehall officials agreed that it would be inappropriate to provide that the Lord Chancellor's regulation making power under this section be subject to Welsh Ministers' consent. The amendment to section 77 is being made to ensure that there is clarity throughout the Bill as to the ability to vary or revoke codes.	13	**2**	**11**

12	**Provider Failure (Market Management)** LF/GT/0387/13 & LF/GT/0524/13	To include provisions to place temporary duties on Local Authorities in Wales to meet the needs of an adult/carer; or help the adult/carer to meet those needs; which immediately prior to business failure, were being met by the failed business, where the business is an establishment or agency registered under Part II of the Care Standards Act 2000. To provide a power for the Local Authority on which the temporary duty is placed, to recover costs from the Local Authority in which the person is ordinarily resident, or, where the person is funding their own care, a power to impose a charge upon that person. To place duties on other Local Authorities and Local Health Boards to co-operate with the Local Authority on which the temporary duty is placed.	It is intended that the proposed amendments will ensure continuity of care for adults in receipt of residential care or domiciliary care, where a provider in the Local Authority's area has ceased to provide that care due to business failure. Details were set out in LF/GT/0287/13 and LF/GT/0524/13.	The main reason for including these provisions is to protect those people that would be affected should another provider fail, such as those affected by the recent issues with Southern Cross and Castle Beck. The Department of Health in England have sought to protect against these issues in Clauses 47-49 of their Care Bill, in addition to some amendments that are currently being planned. Those provisions, however, place duties on Local Authorities in Wales to arrange emergency care for those people that have been placed with a provider located in a Welsh Local Authority area, by a Local Authority in England, Scotland or Northern Ireland, where that provider ceases operation due to business failure. Failure to include the proposed provisions within our Bill would create an inequity of protection between those adults that have been placed by a Local Authority in Wales, and those that have been placed by a Local Authority in England, even though the provider may be based in a Welsh Local Authority area. The legal provision by which Local Authorities have assisted adults in these circumstances previously, was contained in a power under Section 47(5) of the NHS and Community Care Act 1990. Section 47 of that Act will be repealed by the Social Services and Well-being Bill, with the effect of Section 47(5) having been replicated in Section 22 of our Bill. This, however, is not considered to be sufficient in these circumstances, as it is a power and not a duty to meet needs. There is no current requirement for a Local Authority to meet needs in these circumstances; and no clear distinction of duty.	3	**2**	**11**
13	**Exception for provision of health services**	Amend subsections (1) and (2) of Section 31 of the Bill to add reference to "a health enactment" which is then defined in subsection (10) and which adopts a four nation approach, referring to (a) the National Health Service (Wales) Act 2006, (b) the National Health Service Act 2006, (c) the National Health to the National Health Service (Scotland) Act 2006, (d) the Health and Personal Social Services (Northern Ireland) Order 1972 and (e) the Health and Social Care (Reform) Act (Northern Ireland) 2009;.	The effect is that the scope of a local authority's power or duty to provide care and support, or its power to secure preventative services, does not extend to services or facilities which are required to be provided under the NHS whether this is under an NHS enactment applying not just to Wales or England, but also to Scotland or Northern Ireland.	The adoption of the four nation approach, which will allow persons to be placed in Wales by local authorities or health bodies in England, Scotland and Northern Ireland requires the augmentation of the healthcare exception in section 31 of the Bill to include reference to the health legislation in the other home nations to avoid the risk of over-lapping duties arising.	8	**4**	**4**
14	**Research**	To amend the Bill to include provisions equivalent to the provisions in the Children Act 1989 for Welsh Ministers, local authorities and local health boards to conduct or assist in research relating to their functions under the Bill and to transmit information relating to their functions under the Bill to Welsh Ministers.	To ensure that Welsh Ministers, local authorities and local health boards are able to conduct, commission or assist in the conduct of research in relation to matters connected with functions under the Bill; and that local authorities and local health boards are able to transmit information about the performance of their functions to Welsh Ministers. Key examples include the shared duty to assess the need for care and support etc of their population (under section 6) as well as their duties of co-operation and partnership (under Part 9).	Technical amendment to ensure current ability in relation to research are preserved.	3	**4**	**11**
15	**Non- Consequential Repeals**	**Expenses of Council Officers** – The proposal is to place a new provision within the Bill that would dis-apply S.49 of NAA '48 in relation to Local Authorities in Wales.	**Expenses of Council Officers** – The effect of this amendment is the dis-application of S.49 of NAA '48 in relation to Local Authorities in Wales.	The decision for the dis-application in relation to Wales, in this instance, has been taken to improve the coherence of the legal framework in relation to social services in Wales – one of the key objectives of the Bill. The disapplication of s.49 NAA is not consequential on any provision in the Bill, and so cannot be addressed by means of regulations under section 167 of the Bill.	2	**4**	**M**
16	**PUBLIC SERVICE OMBUDSMAN WALES** LF/GT/0024/13	Section 34Y forms part of what will become Part 2B of the Public Services Ombudsman for Wales (PSO(W)) Act 2005, upon commencement of Section 160 of the Social Services and Well-being (Wales) Bill/Act. The current provision provides a power to a Minister of the Crown to prohibit the Public Services Ombudsman for Wales from disclosing documents or information which may be prejudicial to the safety of the State or contrary to public interest. Subsection (3) of 34Y limits that power to only such information that is in relation to an investigation under what is currently Part 2 of the PSO(W) Act. This amendment will remove subsection (3) from Section 34Y of Schedule 3.	It is intended that this proposed amendment will widen the powers of a Minister of the Crown under Section 34Y to include the ability to prohibit the disclosure of such information that is in connection with investigations under the new, broadened powers of the Public Services Ombudsman for Wales, for which the Bill legislates.	The reason for this amendment arises from a previous competence issue. Consent from the Secretary of State was required due to a conferral of new functions on a Minister of the Crown, as a result of the widened powers of the PSOW brought about by the Bill. As consent was not provided prior to introduction, subsection (3) was added to the proposed new section 34Y of the PSO(W) Act 2005 in order to bring the Bill into competence. This amendment seeks to return this section of the Bill to that that was originally intended, prior to introduction. N.B. The Secretary of State for Wales has agreed in principle to provide consent for the conferral of new functions in this instance; and noted that formal clearance will be provided by the UK Government after the summer recess.	1	**4**	**10**
17	**Ordinary Residence**	Amend section 163(1) to clarify that its purpose is to make provision about the ordinary residence of adults living in accommodation of a specified type in Wales and insert new provision to deal with situations where an adult lives in such accommodation for consecutive periods. Amend section 163(2) to make provision about the ordinary residence of persons provided with accommodation under the health enactments of any of the four nations. Amend section 163(4) so as to disregard any periods spent in accommodation provided by or on behalf of a local authority in England when determining a child's ordinary residence.	The effect of the amendment to Section 163(1) is to ensure there is no overlap between the Bill and Schedule 1 of the Care Bill when determining an adult's ordinary residence. The effect of the amendment to section 163(2) is to ensure a consistent approach when determining the ordinary residence of persons provided with accommodation under the four nations' health enactments. The amendment to the current subsection (4) in relation to children will ensure parity with the current legislative provision (within section 105 of the Children Act 1989).	These amendments are being made in part as a consequence of the provisions in Schedule 1 of the Care Bill and mirror provisions in Sections 22 and 31 of the Care Bill. Others will ensure that the is continuity in the way in which the place of a child's ordinary residence is determined which will ensure that the Bill will operate in tandem with the Children Act 1989.	9	**4**	**4**

18	**Part 3 Children Act 1989, Miscellaneous**	1. To amend the Bill to ensure there is comprehensive equivalence in the definitions between the Bill and those provisions of the 1989 Act that are not being repealed / dis-applied in relation to Wales. 2. Amend section 67 to provide that a care and support plan prepared under section 67 can be used as the plan for the purposes of section 31A of the 1989 Act. 3. To amend the reference in section 79(4) to section 60. 4. To amend sections 98(5), 99(3) and 100(3) to require local authorities to consider whether their continuing duties or functions under the Children Act 1989 in relation to children duties should be exercised. 5. To amend the reference in section 59(3) to section 60(1).	1. The overriding policy aim remains to maintain the rights and entitlements currently available within the 1989 Act within the context of the Social Services & Well-being Bill and for ensuring that our Bill dovetails with those provisions of the 1989 Act that are not being repealed / dis-applied in relation to Wales. 2. The policy requirement is that local authorities should not be required to prepare multiple plans. Relevant information contained within the Care and support plan prepared under section 67 of the Bill will be capable of extraction in order to formulate the care plan provided to the Court under section 31A of the 1989 Act. 3. To provide appropriate cross reference. 4. The overriding policy aim remains to maintain the rights and entitlements currently available within the 1989 Act within the context of the Social Services & Well-being Bill. 5. To provide appropriate cross reference.	1. There is insufficient congruence with parallel interpretation section of the Children Act 1989. 2. Part 4 of the Children Act 1989 creates duties for local authorities in relation to care plans for children in public law family proceedings. Despite the different purposes for which care plans for children are prepared under the 1989 Act adn this Bill, this provision will avoid unnecessary duplication of effort. 3. Technical. Inappropriate cross reference. 4. Sections 98 and 99 are derived from sections 85 and 86 of the Children Act 1989. As currently drafted, the duty to assess is too narrowly drawn. 5. Technical. Inappropriate cross reference.	25	**3**	**6**
19	**Direct Payments**	1. To amend Section 37 to include new subsections that state any regulations made under Sections 34, 35 or 36 must require local authorities to take specified steps to enable relevant persons to make informed choices about Direct Payments. A 'relevant person' in this context is anyone whose consent must be obtained as set out under Sections 34, 35 and 36. 2. To make miscellaneous minor technical changes.	1. The effect of these amendments is that any regulations under Sections 34, 35 and 36 must place a duty on local authorities to ensure that they enable relevant persons to make informed choices about Direct Payments. 2. To clarify the intended meaning.	1. This was a request made under Recommendation 31 in the Health and Social Care Committee's Stage 1 report. 2. Technical	6	**2**	4
20	**Safeguarding - Board Partners**	Amend Section 111 to include the Probation Service as a partner in the context of Safeguarding Boards, insofar as is possible within the legislative competence.	The effect of this amendment is that any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 will be included as a partner in relation to Safeguarding Boards.	This was a request made under Recommendation 39 in the Health and Social Care Committee's Stage 1 report.	1	**2**	7
21	**Co-operation and Partnership**	Amend Section 147 to clarify the elements that any Regulations made under 147(1) **must** make provision for; and what those Regulations **may** make provision for. Amend Section 150 to place a duty on Welsh Ministers to issue guidance in relation to any partnership arrangements made under regulations under Section 147.	The effect of these amendments is a strengthening of co-operation and partnership arrangements under the Bill, in that any Regulations made in relation to partnership arrangements under 147(1), must make provision that specifies the local authorities and Local Health Boards that are to take part in partnership arrangements; the form of and the responsibility for the operation and management of those arrangements; the sharing of information; and the guidance that must be issued by Welsh Ministers in relation to those arrangements.	This was a request made under Recommendation 50 in the Health and Social Care Committee's Stage 1 report.	6	**2**	9
22	**Aids & Adaptations**	To amend Section 20 to include 'aids and adaptations' in the list under subsection (2).	The effect of this amendment is that aids and adaptations will be included as an example of what may be provided or arranged to meet needs under Sections 21-29.	This was a request made under Recommendation 59 in the Health and Social Care Committee's Stage 1 report.	1	**2**	4
23	**S.12**	To amend the Bill to clarify that the references to 'a child looked after by a local authority' within subsections 12(7), 23(4) and 24(4); (which disapply the duties and power under Sections 12, 23 and 24 in relation to those children); are taken to mean a child who is 'looked after' by a local authority in either Wales, England, Scotland, or Northern Ireland.	The effect of these amendments will be that the duty to assess the needs of a child for care and support under Section 12; the duty to meet care and support needs of a child under Section 23; and the power to meet care and support needs of a child under Section 24; are disapplied in relation to any child who is 'looked after' by a local authority in any of the countries referenced.	As currently drafted, the duties and power under these sections of the Bill do not apply where children are looked after by a local authority in Wales; but do apply where children are looked after by a local authority outside of Wales, but who have been placed within the area of a Welsh local authority – effectively discriminating against children who are looked after by Welsh local authorities. These amendments seek to rectify that issue.	TBC	**4**	3
24	**S.23**				TBC	**4**	4
25	**S.24**				TBC	**4**	4
26	**S.54 Technical**	To amend Subsection (1) of Section 54 to remove the word 'under', and replace with the term 'by virtue of' before the word 'Section' in both (1)(a) and (1)(b).	N/A - Technical amendment.	The reason for this amendment is to achieve consistency in drafting throughout the Bill.	1	**4**	5
27	**Consequential & Transitional provision**	To amend 167(1) to provide greater clarity in relation to the power it provides. It will be re-worded so as to read: "If the Welsh Ministers consider it necessary or expedient for the purposes of giving full effect to any provision of this Act or in consequence of any such provision, they may by regulations make-"	This amendment will ensure clarity in relation to the Welsh Ministers' powers to make regulations in order to put in place transitional or consequential provisions.	The reason for this amendment is to ensure clarity in relation to the Welsh Ministers' powers to make regulations in order to put in place transitional or consequential provisions.	1	**4**	11
28	**S.154 Welsh change**	To amend Section 154 of the Welsh text of the Bill to clarify the difference between 'support' and 'assistance'.	The effect of this amendment will be the clarification of the difference between 'support' and 'assistance' in the Welsh version of the Bill.	This amendment is a correction to the Welsh text only, there is no change required to the corresponding English text.	7	**4**	10
29	**Safeguarding - Technical**	Amend Sections 106 and 108 to remove the word 'including', and replace with the word 'or'.	N/A - Technical amendment.	The reason for this amendment is to achieve consistency in drafting throughout the Bill.	2	**4**	7
30	**Enactment Amendments**	Amend section 166 to widen the definition of 'enactment' to include legislation from Scotland and Northern Ireland, in addition to Wales and England. Amend sections 117, 153(7) and 167 to limit the definition of 'enactment' for those provisions to only legislation from Wales and England.	The effect of these amendment is that where a provision in the Bill relates to an enactment, this will include legislation from all 4 nations, rather than Wales and England only; except for sections 117, 153(7) and 167, where that definition will be limited.	The reason for these amendments is that the definition of 'enactment', as currently set out in Section 166 of the Billl, places unneccesary and unintended limitations on our legislation. These amendments seek to rectify that issue. There are also links to the way in which Cross Border issues are being dealt with.	TBC	**4**	V

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