Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
18 July 2012

Meeting time:
08:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

Policy: Llinos Dafydd / Legislation: Fay Buckle
Committee Clerk
029 2089 8403/8041
HSCCommittee@wales.gov.uk

Agenda

1. Introductions, apologies and substitutions

2. Consideration of recently published correspondence between Welsh Government officials and Professor Marcus Longley (08:30 - 10:00) (Pages 1 - 63)

HSC(4)-23-12 paper 1a : Information published on the Welsh Government disclosure log

HSC(4)-23-12 paper 1b : The Best Configuration of Hospital Services for Wales - A Review Of The Evidence (written by Professor Longley)

HSC(4)-23-12 paper 1c : Information from the Welsh NHS Confederation

08:30 - 09:15 - session 1
Professor Marcus Longley

09:15 - 10:00 - session 2
Lesley Griffiths AM, Minister for Health and Social Services
David Sissling, Director General, Health Social Services & Children, Welsh Government and Chief Executive, NHS Wales
Dr Chris Jones, Medical Director, NHS Wales and Deputy Chief Medical Officer, Welsh Government

3. Food Hygiene Rating (Wales) Bill: Stage 1 - Evidence session 4 (10:00 - 10:30)

Minister for Health and Social Services

Lesley Griffiths AM, Minister for Health and Social Services
Christopher Brereton – Head of Environmental Public Health Legislation, Welsh Government
Christopher Humphreys – Legal Services Department, Welsh Government

4. Food Hygiene Rating (Wales) Bill: Stage 1 – Evidence session 4 (10:30 – 11:30) (Pages 64 – 87)

Association of Convenience Stores
Shane Brennan – Public Affairs Director, Association of Convenience Stores
HSC(4)-23-12 paper 2

British Beer and Pub Association
Brigid Simmonds – Chief Executive, British Beer and Pub Association
HSC(4)-23-12 paper 3

British Hospitality Association
John Dyson – Food & Technical Affairs Adviser, British Hospitality Association
HSC(4)-23-12 paper 4

5. Papers to note (Pages 88 – 91)

Minutes of the meetings held on 28 June & 4 July

5a. Inquiry into Residential Care for Older People – Notes of reference group meetings held on 24 May & 12 June (Pages 92 – 104)
Note of reference group meeting 24 May
HSC(4)-23-12 paper 5

Note of reference group meeting 12 June
HSC(4)-23-12 paper 6

6. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business: (11:30)

7. Food Hygiene Rating (Wales) Bill: Key Issues (11:30 – 12:15)

8. Inquiry into Residential Care for Older People: Key Issues (12:15 – 13:00)

Health and Social Care Committee

HSC(4)-23-12 paper 1a

Consideration of recently published correspondence between Welsh Government officials and Professor Marcus Longley

Attached as an annex to this paper is the correspondence between Welsh Government officials and Professor Marcus Longley, which was recently published on the Welsh Government website.

Annex

Source – Welsh Government disclosure log

http://wales.gov.uk/publications/accessinfo/disclogs/dr2012/julsep/health1/dlhlth161/?skip=1&lang=en [accessed 12 July 2012]

Hlth161 Communications with Prof Marcus Longley regarding the Case for Change document

4 July 2012. You asked for copies of correspondence and records of discussions between Professor Marcus Longley, the NHS Confederation Wales and the Welsh Government regarding the Case for Change document over the last six months

4 July 2012

Dear

Thank you for your email of 29 May asking for the following information:

Details of discussions/correspondence between Professor Marcus Longley, the NHS Confederation Wales and the Welsh Government regarding the Case for Change document over the last six months.

We have identified information which falls within scope of your request. The relevant extracts are attached to this reply.

In responding to your request for information, I think it is important that we set out the context for the "Case for Change" document and the process for its production.' Together for Health – a Five Year Vision for the NHS in Wales' sets out the challenges facing the health service in Wales and the changes needed to ensure Wales has high quality services. Together for Health is clear that retaining the status quo is not an option. As part of their response to the challenge set in Together for Health, Health Board Chief Executives and the NHS Confederation commissioned the Wales Institute for Health and Social Care (WIHSC) to articulate a “National Case for Change” against the available evidence base.

The report produced by Professor Longley is owned by the Health Boards and the NHS Confederation, and its purpose is to articulate the reasons why Health Boards need to change services, and to help Health Boards in engaging with their communities about the future of hospital services in Wales. During its production, Welsh Government officials responded to requests for statistical and other information from Professor Longley and the Confederation. Given the importance and high level of public,

political and media interest in any proposed changes to NHS services, officials in Department of Health, Social Services and Children; the Minister for Health and Social Services and Welsh Government's Cabinet were, of course, updated on progress in developing the Case for Change and on the timing and plans for its publication. The Cabinet were informed of the content of the Professor Longley's report in a Cabinet paper which was made public on 27April 2012 and is available here (see spotlight). Throughout its production, the Welsh Government did not seek to influence or amend the content of the report, as that was entirely a matter for the NHS Confederation and for Professor Longley.

If you believe that I have not followed the relevant laws, or you are unhappy with this response, you may request an internal review by writing to:
Joanna Jordan
Director
Department for Health, Social Services and Children
Cathays Park
Cardiff
CF10 3NQ

When dealing with any concerns, we will follow the principles set out in the Welsh Government's Code of Practice on Complaints which is available on the Internet at www.wales.gov.uk or by post.

You also have the right to complain to the Information Commissioner. Normally, however, you should provide us with an opportunity to undertake an internal review before you complain to the Information Commissioner. The Information Commissioner can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 01625 545 745
Fax: 01625 524 510
Email: casework@ico.gsi.gov.uk

Also, if you think that there has been maladministration in dealing with your request then you may make a complaint to the Public Services Ombudsman for Wales who can be contacted at:
Public Services Ombudsman for Wales
Ffordd yr Hen Gae
Pencoed
Bridgend
CF35 5LJ

Yours sincerely,

Note of meeting with NHS Confederation held on Monday 23 January 2012 at Ty Hywel, Cardiff Bay.

Present:

Lesley Griffiths AM	Minister for Health and Social Services
Helen Birtwhistle	Director of Welsh NHS Confederation
Alice Attenborough	Welsh NHS Confederation Policy & Public Affairs Officer
Grant Duncan	Deputy Director, Medical Directorate
Jonathan Davies	Special Advisor
Dominic Worsey	Medical Directorate

Information redacted – not in scope

Engagement on "Together for Health" and update on University of Glamorgan Research

10. The Confederation and the University have been working to develop a suite of papers on the national case for change, which will support *Together For Health*. These will be finalised by the end of February, and an engagement plan is also being developed to highlight the work to key stakeholders. An AM centred event will be organised in Cardiff, and the Health Committee will also be kept fully abreast of developments.

Information Redacted - not in Scope

Dominic Worsey
24 January 2012

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 14 February 2012 08:16
To: Jones, Chris (DHSSC - Medical Directorate); Peter Bradley (Public Health Wales); 'John Watkins (Public Health Wales)'; Bowen, Richard (DHSSC - Directorate of Operations); 'Jeff.James@wales.nhs.uk'
Cc: 'Andrew Carruthers (Cardiff and Vale UHB - Service Planning)'; Ponton M (HESAS - WIHSC)
Subject: National Case for Change Safety and Quality paper final draft

Colleagues – please find attached the final draft of the Safety and Quality paper. **Very grateful for any comments, ideally by 20 February**. NB this paper does not contain the clinical outcomes data which you have helpfully been sending through – that will be in the 'overarching' paper.

To remind you… this is one of 4 papers (other drafts to follow in the next few days!):

- Overarching paper (inc summaries of other 3, clinical outcomes data, and 'the narrative')
- Quality and safety (attached)
- Workforce
- Access

Please give me a ring if that would be helpful.

Many thanks for your continuing help in this.

Marcus

Marcus Longley
Professor of Applied Health Policy and
Director, Welsh Institute for Health and Social Care
Lower Glyntaf Campus, University of Glamorgan, Pontypridd, CF37 1DL
Tel 01443 483070 Fax 01443 403070

http://wihsc.glam.ac.uk/

Subject	Service Change Group	Date	17/04/2012
Chair	David Sissling	Time	13:30
Location	Cathay's Park	Scribe	Leon Rees

Key Points Discussed		
	Topic	**Highlights**
	Case for Change Report	• Launch in early May • Media plan – important to create broader context so we do not unintentionally re-enforce a hospital focus.

Yr Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health, Social Services and Children
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Prof Marcus Longley
Welsh Institute for Health and Social Care
University of Glamorgan
Glyntaff Campus
Pontypridd
Wales
CF37 1DL

Our Ref : DS/LR

9 March 2012

Marcus

Just a quick note to thank you for your work on the Case for Change. I am aware that certain aspects are still subject to some revision, but overall it is looking good. I am sure it will help to change the tone and terms of the debate.

Regards

David Sissling

From: Bowen, Richard (DHSSC - Directorate of Operations)
Sent: 24 January 2012 09:20
To: 'Longley M J (HESAS - WIHSC)'
Subject: RE: Stats for 'statement for change'

As I said - just a start as I'm not sure what exactly you're after but let me know either way.
The McKinsey work is not at least 2.5 yrs old but we'll have a look through the key areas and get back to you.
There may be some nuggets worth flagging again.
R

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 24 January 2012 08:42
To: Bowen, Richard (DHSSC - Directorate of Operations)
Subject: RE: Stats for 'statement for change'

Richard – many thanks for this, just the job! Will go through now in detail, and get back to you as necessary.

It would also be helpful to have sight of the McKinsey stuff, where you think this is still current. Would that be possible?

In the meantime … I'd be very grateful for your comments on the attached, which is a (still incomplete) draft of the first of the papers we are producing. The aim is to produce a total of 4 papers:

- Quality and Safety (attached)
- Workforce (which I'll send through on Thursday)
- Access
- Over-arching paper, which summarises the above 3, and pulls together all the threads – this will be self-standing, but will direct readers to the above 3 if they want to follow up the evidence on any particular points.

They should summarise the key evidence, in an objective but accessible way, with a view to allowing the interested lay reader to draw their own conclusions on the key aspects of the argument for service re-configuration.

That's the aim… but do they succeed?! The drafts are still work in progress, but should be complete enough for you to get a sense of the whole.

I'd be very grateful for any comments, ideally by next Tuesday (31st) if possible.

Marcus

Director of WIHSC and Professor of Applied Health Policy

Tel. 01443 483070 http://wihsc.glam.ac.uk/ http://twitter.com/marcuslongley

From: Bowen, Richard (DHSSC - Directorate of Operations) [mailto:Richard.Bowen@Wales.GSI.Gov.UK]
Sent: 23 January 2012 18:33
To: Longley M J (HESAS - WIHSC)
Subject: FW: Stats for 'statement for change'

Marcus
Apologies for delay. Starter for 10.
Come back to me on some of this.
you can also have the latest CEO performance paper if any help - good bit on mortality for the first time e.g. weekend effect.
R

Information Redacted – out of scope

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 17 January 2012 20:52
To: Bowen, Richard (DHSSC - Directorate of Operations)
Subject: RE:

Thanks Richard.

(Confusingly, the health stats stuff is for a presentation to the Bevan Commission on Thursday on something else... but clearly all roads lead to your team!)

Marcus

Marcus Longley
Director of the Welsh Institute for Health and Social Care and Professor of Applied Health Policy
University of Glamorgan
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01443 483070
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From: Bowen, Richard (DHSSC - Directorate of Operations) [Richard.Bowen@Wales.GSI.Gov.UK]
Sent: 17 January 2012 19:54
To: Longley M J (HESAS - WIHSC)
Subject: RE:

Marcus
Just spoken to colleagues in Health Stats (Welsh Gov) and Terry Gill (my team centrally) who have also been asked to furnish you with the same information? We will link to see what

there is available on this and get back to you.
R
Richard Bowen
Director of Operations / Cyfarwyddwr Gweithrediadau
Directorate of Operations / Cyfarwyddiaeth Gweithrediadau
***Department for Health, Social Services and Children* / Cyfarwyddiaeth Gyffredinol lechyd & Gwasanaethau Cymdeithasoll**
Welsh Government / Llywodraeth Cynulliad Cymru
Tel/ Ffon: 029 2082 5850
Fax / Ffacs: 029 2082 3907
e-mail / e-bost: Richard.Bowen@wales.gsi.gov.uk

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 17 January 2012 10:41
To: Bowen, Richard (DHSSC - Directorate of Operations)
Subject:

Richard - many thanks for the helpful chat last week.

To confirm, we'd be most grateful to have sight of any material of which you're aware which bears on the workforce, safety and access dimensions of the case for change. We'll pick up material via parallel discussions with colleagues on stroke service, workforce (NLIAH), primary care and public health, but any other relevant evidence (the 'killer facts') would be really useful.

It would be good if we could receive any material by early next week, if possible.

I'm very happy to talk to colleagues if any of this need clarification.

Many thanks once again

From BlackBerry

Marcus Longley
Director, WIHSC and Professor of Applied Health Policy
01443 483070

Information Redacted – out of scope

From: Bowen, Richard (DHSSC - Directorate of Operations) <Richard.Bowen@Wales.GSI.Gov.UK>
To: Andrew Carruthers (Cardiff and Vale UHB - Service Planning); Harris, Abigail (DHSSC Strategy and Planning) <Abigail.Harris4@Wales.GSI.Gov.UK>; Helen Birtwhistle <helen.birtwhistle@welshconfed.org>; Gill, Terry (DHSSC - Directorate of Operations) <Terry.Gill@Wales.GSI.Gov.UK>
Cc: Jones, Chris (DHSSC - Medical Directorate) <Chris.Jones@Wales.GSI.Gov.UK>
Sent: Thu Mar 22 19:19:26 2012
Subject: RE: Case for Change

Thanks Andrew - will ask Terry to see what he can forward to Marcus.

Terry's presentation highlighted the need to be extremely careful when comparing the mortality data however the Regional comparison is extremely useful and gives the context of the argument. Bottom line does indicate the excess deaths debate but when to take all factors into account....

Terry - please can you link with Andrew C as appropriate.

Many thanks

Richard

Information Redacted – out of scope

From: Harris, Abigail (DHSSC Strategy and Planning) [mailto:Abigail.Harris4@Wales.GSI.Gov.UK]
Sent: 22 March 2012 17:06
To: Helen Birtwhistle; Andrew Carruthers (Cardiff and Vale UHB - Service Planning)
Cc: Jones, Chris (DHSSC - Medical Directorate); Hands, David (DHSSC - Corporate Services and Partnerships)
Subject: Case for Change

Helen,

I know you are expecting comments back in from the LHBs today on the Case for Change report. I know there has been concern in particular about the RAMI data - we had a presentation today from Terry Gill on mortality which highlighted more explicitly the differences between the Welsh and English data (the most signficance being the community hospital data which are included for Wales but not for England). There was a suggestion today that inclusion of regioal comparisons might be useful in however the mortality data are presented in the final version of the slides for next week and the report.

I understand that Marcus has had all of the information that was presented today from Richard Bowen's team.

Helen, look forward to receiving the updated comms plan. David was chasing today for feedback from LHBs on their assessment of comms capacity and capability.

Abi

From: Harris, Abigail (DHSSC Strategy and Planning)
Sent: 22 March 2012 17:40
To: 'Helen Birtwhistle'; Jones, Chris (DHSSC - Medical Directorate); Andrew Carruthers (Cardiff and Vale UHB - Service Planning); Hands, David (DHSSC - Corporate Services and Partnerships); Sissling, David (Director General, Health, Social Services & Children)
Subject: RE: Case for Change - publication of independent WIHSC research

All,

I have just had a conversation with Helen - due to the work being done with the health boards to finalise the report, the closeness to recess, and the practicalities of organising at short notice, the briefing planned with AMs won't go ahead next week. Therefore suggest it takes place in early May once Easter recess is over and local elections are out of the way. The health boards have all seen the presentation so the key messages can be used in local engagement work.

The timetable below will therefore need to be updated to reflect the changes and all parties have more time to prepare.
Hope this is helpful.

Abi

From: Helen Birtwhistle [mailto:helen.birtwhistle@welshconfed.org]
Sent: 22 March 2012 17:19
To: Harris, Abigail (DHSSC Strategy and Planning); Jones, Chris (DHSSC - Medical Directorate); Andrew Carruthers (Cardiff and Vale UHB - Service Planning)
Cc: Hands, David (DHSSC - Corporate Services and Partnerships); Jane Green; Alice Attenborough; Sian Pugh
Subject: Case for Change - publication of independent WIHSC research
Importance: High

Prynhawn da, bawb.

Further to yesterday's Team Wales event and to our brief follow-up meeting, please find below my recommendations for the publication of Marcus Longley's evidence-based research, and a summary of our actions.

A key element of what we discussed yesterday was whether the briefing for AMs could and/or should go ahead next Wednesday (28 March 2012). While we agreed that the presentation that Marcus Longley gave yesterday at Team Wales would be appropriate and would start to get the debate opened up, the fact that we're now only three working days before the event is problematic. You may recall that only two out of sixty Assembly Members had said they would attend when we arranged the event for this week, 21st March, and that was when we gave them two weeks' notice. Ideally, we would have given them the new date when we postponed/cancelled initially. We have had no adverse reaction to the cancellation but run the risk now, at such a late stage, of rearranging at very short notice for the last week of term and then possibly cancelling again, which could prompt questions. Our intelligence from the workings of the Assembly tells us that AMs will not be impressed with the short notice. We also are not in possession yet of the Chairs' feedback, which may impact on Marcus' presentation.

I do, however, appreciate the alternative arguments, about having some outlet for the general tenor of the findings before the Easter Recess. It's a difficult balance but, because of the logistics, and developments this week, it could simply be too late now to go ahead. Having said that, I have put the following summary together on the basis that there could still be an event on 28 March. A possible alternative would be for us to offer the Wednesday 28th briefing slot to Mark Drakeford, whose office has been incredibly co-operative throughout this whole process. As Chair of the Health and Social Care Committee, it would be entirely appropriate to give him an early indication of the findings and to discuss next steps.

March 2012

Thursday 22nd: NHS Chairs submit their feedback to the draft research report to Helen Birtwhistle (HB), Welsh NHS Confederation (Confed), by close of play.

Thursday 22nd: Welsh Government informs Confed of decision on whether presentation to AMs can go ahead on 28 March (recommend that this takes form of Marcus Longley (ML) presentation to Team Wales)

Friday 23rd: (If AMs' briefing to go ahead) Confed confirms arrangements, issues invites etc

Friday 23rd: HB works with lead Chair, Chris Martin, to review the individual feedback and create a summary, which will be shared with Chairs and Chief Executives. This feedback can then be shared with ML.

Friday 23rd, prov. 3.30pm: HB meets ML(and others – Andrew Carruthers (AC), Jane Green (JG)) to hand over feedback and discuss.

Week beg, Monday 26th: ML reviews feedback and produces further draft/indicates extent of any additional work and probable timescale

Monday 26th: Confed finalises media holding position/key messages to be used in the event that research gets into public domain before formal publication.

Confed shares key messages etc with David Hands (DH) and liaises re handling

Confed alerts and informs Health Board and Trust comms teams about event, key messages, holding position etc

Tuesday 27th: Confed chases AM attendance for next day's breakfast event and briefs Mark Drakeford, AM, Chair of Health and Social Care Committee, who is sponsoring/chairing event

Wednesday 28th , 8-9am: ML delivers presentation on Case for Change. Also present AC, HB, JG. Introductory message is that this research is still to be finalised but wanted to share themes with AMs before Recess in order to stimulate and inform ongoing debate. No materials available to take away.

Ongoing: AC to lead on preparation of the NHS response to the independent research findings

AC to work with Confed team, who will prepare detailed media handling for publication of research

Confed to work with its members on ensuring key stakeholders etc are representative of local audiences

Confed to brief key NHS spokespeople (including clinical voice) on key messages and publication plan

Confed to prepare Communications toolkit and provide to NHS Comms teams

Monday 2 – Sunday 22 April inclusive: Assembly Recess

April 2012

Tuesday 17th: Update briefing at Chief Exec peer group meeting

Friday 20th: Confed convenes briefing meeting of all-Wales NHS Comms teams for full briefing

Dates to be confirmed: ML to advise on when Research report will be finalised and ready for publication

Allow one week for translation into Welsh

Report sent to Chief Execs and Confed

Confed to send report on behalf of the NHS in Wales to the Minister, Lesley Griffiths AM (unless delayed beyond this, recommend report is formally sent to Minister week beg. 23 or 30 April, for potential publication week beg. 7 May)

May 2012

?Tues 8th, :Weds 9th, Thurs 10th:

Publication of independent research, to take form of pre-briefings for media, development of story packages, proactive identification of interview opportunities etc. Communications to be led by Confed, in discussion with WG comms.
If AMs' pre-briefing has not taken place already (just before Recess) then incorporate briefing for AMs into publication handling plan (to coincide with or take place just before media embargo)

Dates to be confirmed: Series of stakeholder discussion events throughout Wales (using Universities as venues to reinforce that this is an independent report, setting the national context).

Ongoing: Media plan in place to maximise key issues raised in independent Report and in the response from NHS Wales.

I think this covers what we discussed yesterday and gives a robust planning outline to which we can all work. If I've missed anything, however, please don't hesitate to say.

Grateful if Abi could confirm the position re 28th March and the AMs' briefing. If it is to take place we will endeavour to re-make arrangements immediately.

Look forward to continuing to work with you all on this really interesting initiative.

Cofion gorau,

Helen

Helen Birtwhistle
Director Welsh NHS Confederation
Welsh NHS Confederation
Unit 3
Waterton Park
Bridgend
CF31 3PH

DDI: 01656 643800
Fax: 0844 7744299
www.welshconfed.org

From: Harris, Abigail (DHSSC Strategy and Planning)
Sent: 16 March 2012 14:12
To: 'Helen Birtwistle (helen.birtwhistle@welshconfed.org)'; Hands, David (DHSSC - Corporate Services and Partnerships); 'Andrew.carruthers2@wales.nhs.uk'
Subject: E-mail

Dear Helen, Andrew and David,

I thought it might be useful to catch up on the various conversations today about the Case of Change (CfC) publication planned for 28th.

I know, Helen, that you are working on the communications plans for this. It is recognised that there is nervousness about the state of preparedness to be on the front foot with the management of communication for the publication and the period building up to it and following it.

I have had a brief discussion with David. There is support for the CfC being launched on 28th if the comms plans are right and the Minister will want to be assured of this. We recognise the importance of keeping the momentum going over this critical period.

David is therefore looking for sight of the comms plan which sets out clearly the comms activity planned within local health boards and nationally - with an indication of who is fronting the activity. David has a series of meetings with the Minister (including one with the LHB and Trust Chairs) on Monday afternoon and so would like sight of the plans to inform those discussions.

This follows on from the broader discussions this week about the need to strengthen the planning and delivery of the communication support to the TfH process. As you confirmed this morning, Andrew, you have received the detailed engagement and communications plans from each organisation along with the overarching plans and you are pulling these together at the moment.

Hope this helps to clarify the position and the expectations.

Thanks Abi

Abigail Harris
Director of Strategy and Policy
Department of Health, Social Services and Children
Welsh Government
Cathays Park
Cardiff

Direct telephone line: 029 2082 6103
Abigail.Harris4@wales.gsi.gov.uk

Note of meeting with NHS Confederation held on Monday 23 January 2012 at Ty Hywel, Cardiff Bay.

Present:

Lesley Griffiths AM	Minister for Health and Social Services
Helen Birtwhistle	Director of Welsh NHS Confederation
Alice Attenborough	Welsh NHS Confederation Policy & Public Affairs Officer
Grant Duncan	Deputy Director, Medical Directorate
Jonathan Davies	Special Advisor
Dominic Worsey	Medical Directorate

Information redacted – not in scope

Engagement on "Together for Health" and update on University of Glamorgan Research

10. The Confederation and the University have been working to develop a suite of papers on the national case for change, which will support *Together For Health*. These will be finalised by the end of February, and an engagement plan is also being developed to highlight the work to key stakeholders. An AM centred event will be organised in Cardiff, and the Health Committee will also be kept fully abreast of developments.

Information Redacted - not in Scope

Dominic Worsey
24 January 2012

Subject	**Ministerial update meeting with NHS Confederation**	**Date**	**02/05/12**
Chair	**Minister for Health and Social Services**	**Time**	**10:00**
Location	**Minister's Office, Ty Hywel**	**Scribe**	**Dominic Worsey, Medical Directorate**
Attendees	**Helen Birtwhistle** — **Director of Welsh NHS Confederation** **Alice Attenborough** — **Welsh NHS Confederation Policy & Public Affairs Officer** **Jonathan Davies** — **Special Advisor** **Claire Habberfield** — **Workforce & OD** **Dominic Worsey** — **Medical Directorate**		
Apologies	**None**		

Information Redacted – Out of Scope

2.	Engagement on "Together for Health" and update on University of Glamorgan Research	• Professor Marcus Longley's Case for Change report will be published on 9 May. This will coincide with an event for AMs, being hosted by Mark Drakeford at the Senedd, when Professor Longley will present the findings of his study. • The Minister confirmed she had received a draft of the report, and had forwarded a copy to the First Minister's office. • It was acknowledged the report might contain some unpalatable messages about the current state of the Welsh NHS , but this is necessary if we are to be open and honest with the public. • Four roadshows were planned, starting during the week commencing 7 May, in Carmarthen, Aberystwyth, Llandudno and Cardiff. The target audience will be county councilors, CHCs, academics, charities and local action groups (such as Sosspan and aBer). • The Confed will also 'piggyback' onto other suitable events where possible, and a full action plan had been submitted to David Sissling's office.

Information Redacted – Out of Scope

Subject	**Ministerial update meeting with NHS Confederation**	**Date**	**23/01/12**
Chair	**Minister for Health and Social Services**	**Time**	**13:30**
Location	**Minister's Office, Ty Hywel**	**Scribe**	**Dominic Worsey, Medical Directorate**
Attendees	**Helen Birtwhistle** — **Director of Welsh NHS Confederation** **Alice Attenborough** — **Welsh NHS Confederation Policy & Public Affairs Officer** **Grant Duncan** — **Deputy Director, Medical Directorate** **Jonathan Davies** — **Special Advisor**		
Apologies	**None**		

Information Redacted – Out of scope

3.	Engagement on "Together for Health" and update on University of Glamorgan Research	• The Confederation and the University have been working to develop a suite of papers on the national case for change, which will support *Together For Health*. These will be finalised by the end of February, and an engagement plan is also being developed to highlight the work to key stakeholders. An AM centred event will be organised in Cardiff, and the Health Committee will also be kept fully abreast of developments.

Information Redacted – Out of scope

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 26 January 2012 16:07
To: Davis, Liz (DHSSC - Director for Workforce & OD)
Subject: NCfC Workforce Technical Document

Dear Liz

Following on from your recent discussion with Mike Ponton about the 'National Case for Change', I am attaching herewith as promised the latest draft of the workforce paper, and would be most grateful for your comments.

We are aiming to produce a total of 4 papers:

- Quality and Safety
- Workforce (attached)
- Access
- Over-arching paper, which summarises the above 3, and pulls together all the threads – this will be self-standing, but will direct readers to the above 3 if they want to follow up the evidence on any particular points.

They should summarise the key evidence, in an objective but accessible way, with a view to allowing the interested lay reader to draw their own conclusions on the key aspects of the argument for service re-configuration.

That's the aim… but does it succeed?! The draft is still work in progress, but should be complete enough for you to get a sense of the whole.

I'd be very grateful for any comments, ideally by early-ish next week if possible…

Please give me a ring if further clarification would be helpful

Kind regards

Marcus

Director of WIHSC and Professor of Applied Health Policy

Tel. 01443 483070 http://wihsc.glam.ac.uk/ http://twitter.com/marcuslongley

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 22 February 2012 13:51
To: Jones, Chris (DHSSC - Medical Directorate)
Subject: National Case for Change

Dear Chris WORKFORCE Final Draft .doc

I attach the latest draft of the Workforce Paper which is part of the suite of papers we are preparing for the forthcoming debate on the National Case for Change.

We have used material from the Deanery, NLIAH and other published papers, including the impact of medical workforce issues such as the European Working Time Directive, the shortage of junior/middle grades in some places and the possible changes in training. However, on reflection the evidence as presented does not seem to be as incisive as we might have hoped.

Is there any further evidence that you could provide to sharpen up the document and its impact in supporting the case for change.

If you are attending the Clinical Forum later, perhaps we could have a quick chat about this.

Regards
Marcus

Marcus Longley
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From: Jones, Chris (DHSSC - Medical Directorate)
Sent: 05 February 2012 17:14
To: 'Longley M J (HESAS - WIHSC)'; 'Andrew.Carruthers2@wales.nhs.uk'
Cc: Coley, Michelle (DHSSC - Medical Directorate); Eley, Carl R (DHSSC - Medical Directorate); Chainey, Shaun (DHSSC - Medical Directorate); White, Cathy (DHSSC - Medical Directorate); Hanson, Jane (DHSS - CPCHSD); Bowen, Richard (DHSSC - Directorate of Operations); Perks, Roger (DHSSC - Directorate of Operations); Duncan, Grant (DHSSC - Medical Directorate)
Subject: RE: Clinical Outcomes data

Hi Marcus,

Yes absolutely agree the National Clinical Audit data shows us exactly where we are on many important services. We have all this in WG, held by Carl Eley's branch, and we will share with you.

Cancer survival data are held by Cathy White via the National Cancer Team.

CHKS data is held in Richard Bowen's directorate (Roger Perks) and again we re happy to share anything we can that would help.

I am copying to relevant colleagues and hope to catch up with you shortly,

Best Wishes,

Chris

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 03 February 2012 11:11
To: Jones, Chris (DHSSC - Medical Directorate); Andrew.Carruthers2@wales.nhs.uk
Cc: Coley, Michelle (DHSSC - Medical Directorate)
Subject: Clinical Outcomes data
Importance: High

Chris/Andrew - we've been trying to track down data from the various audit-type sources to include in the National Case for Change papers - as we've discussed, a crucial piece in the jigsaw is the argument 'we cant stay as we are: just look at outcomes'. So far, so elusive! I've approached Peter Bradley and Richard Bowen, who have been most helpful with other data, but nothing of this sort.

I guess I'm thinking of cancer, cardiology, mental health...? The CHKS database, for example...?

Can you help? It would be a real shame not to include it...

(PS did you hear Bruce Keogh on the radio this morning, on the back of the recent stuff about weekend care - very good on the 'moral case' for change...)
Marcus

Marcus Longley
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From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 20 February 2012 17:35
To: andrew.goodall@wales.nhs.uk; mary.burrows@wales.nhs.uk; jan.williams7@wales.nhs.uk; allison.williams4@wales.nhs.uk; trevor.purt@wales.nhs.uk; andrew.cottom@wales.nhs.uk; Bob.hudson@wales.nhs.uk; simon.dean@wales.nhs.uk; elwyn.price-morris@wales.nhs.uk; paul.roberts@wales.nhs.uk
Cc: Davis, Liz (DHSSC - Director for Workforce & OD); Galton, Bernard (DG People Places and Corporate Services); Jones, Chris (DHSSC - Medical Directorate); peter.bradley@wales.nhs.uk; Bowen, Richard (DHSSC - Directorate of Operations); Jeff James (Cardiff and Vale UHB - Whitchuch Headquarters); andrew.carruthers@wales.nhs.uk; PAT & MICHAEL PONTON
Subject: SUBJECT National Case for Change in Service Configuration: Papers 2 and 3

Dear Colleague

Please find attached the final drafts of the 2nd and 3rd papers, on Workforce and Access issues. The overarching paper – which sets out 'the case for change' succinctly, in one place – will be prepared following your feedback on these.

As always, very grateful for any comments, ideally be the end of this week. Please do not distribute widely at this stage

Please give me a ring if you think that would be helpful.

Many thanks, as always

Marcus

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From: Jones, Chris (DHSSC - Medical Directorate)
Sent: 04 March 2012 17:31
To: 'Longley M J (HESAS - WIHSC)'
Cc: 'Andrew.Carruthers2@wales.nhs.uk'
Subject: RE: ABMU Changing for the Better - Results of Voting 29th Feb

Hi Marcus,

This is interesting and pretty clear as you describe. Encouraging overall.

Andrew will brief you on last Friday. Helpful meeting between MDs and planners. I think there was a general feeling that the CfC needs to be more positive if possible I.e. describing a persuasive vision of how things could be better. People seemed to think there was a gap where a blueprint in response could exist and Andrew is thinking about this.

There was an excellent presentation on the emergency response service covering the west of Scotland and a feeling that we need something similar in Wales. This is a positive new service that needs to go in.

I wonder also if we could provide a list of new services and technologies that must be delivered and examples of other systems producing better outcomes and experience than us.

I was pleased to have been able to meet Rachel on Friday. It was a great evening.

Best Wishes,

Chris

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 03 March 2012 17:01
To: Jones, Chris (DHSSC - Medical Directorate)
Cc: Andrew.Carruthers2@wales.nhs.uk
Subject: FW: ABMU Changing for the Better - Results of Voting 29th Feb

Chris - have a look at the attached. Quite interesting snapshot of leaders' opinions of case for change and its chances...

On Wednesday, we did some electronic voting with 170 leaders in ABMU, based on the Case for Change presentation. Andrew was there. Interesting results:

1. theyre positive about the need for change, especially re the workforce (slide 3), and
2. positive about the chnaces of success (slide 9)
3. think the biggest obstacles to be overcome are attitudes of the workforce, money and political will (in that order) (sldie 10)

Marcus

Marcus Longley

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Information Redacted – out of scope

Health and Social Care Committee

HSC(4)-23-12 paper 1b

Consideration of recently published correspondence between Welsh Government officials and Professor Marcus Longley

Attached as an annex to this paper is the summary of the report by Professor Marcus Longley, *The Best Configuration of Hospital Services for Wales: A Review of the Evidence.*

Also attached are links to the three documents -related to Access, Workforce and Quality & Safety - published to support the report:

- **Access** document - available here
- **Workforce** document – available here
- **Quality & Safety** document - available here

THE BEST CONFIGURATION OF HOSPITAL SERVICES FOR WALES:

A REVIEW OF THE EVIDENCE

SUMMARY

Professor Marcus Longley

Welsh Institute for Health and Social Care · University of Glamorgan

April 2012

ACKNOWLEDGEMENTS

This Summary is based on three more detailed reviews of the evidence on Quality and Safety, the Workforce and Access researched and written by my colleagues Mike Ponton and Katie Norton, with assistance from Amy Simpson and Susan Kimani. We are all most grateful to staff in Welsh Government, NHS Wales and the Wales Deanery who made available data on key aspects of this work, and to other colleagues with whom we discussed the evidence and who reviewed earlier drafts of the papers. The work was commissioned by Wales' Local Health Boards.

The author

Professor Marcus Longley MA (Oxon), MScEcon, PhD, FFPH, AHSM is Director of the Welsh Institute for Health and Social Care and Professor of Applied Health Policy at the University of Glamorgan. mlongley@glam.ac.uk http://wihsc.glam.ac.uk/

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SUMMARY

This paper reviews what the evidence suggests about the optimal number, size and distribution of hospital services in Wales. It is written for a non-specialist audience: Welsh citizens who want to make up their own minds about how their hospitals should be configured. Further information on three key parts of this debate – quality and safety, the workforce, and access – is contained in three accompanying papers.

This paper sets out to help the reader answer four questions:

Q: On Safety and Quality: **What's wrong with our current pattern of hospital services?**

A: There is an accumulating body of evidence which suggests that patients in Wales do not always get the best possible outcomes from their hospital care, and that in some key specialty areas – notably major trauma, general trauma and emergency care, stroke care, maternity and newborn care, and paediatrics – the way services are organised in Wales probably falls well short of what the evidence suggests is optimal.

Q: On the Workforce: **We've got more staff than ever before, so what's the problem?**

A: There are now acute pressures on medical staffing in paediatrics, emergency medicine, core surgical training and psychiatry, and more generally in some of the more remote parts of Wales. A 'perfect storm' has developed, with more doctors in our hospitals, but actually less availability in comparison with the demand for their services.

Q: On Access: **Is poorer access inevitable to ensure good safety and quality?**

A: Centralising services is almost bound to increase some people's travel times. However, there is a lot which can be done to mitigate the impact of the centralisation of some services. In particular, the risks associated with longer travel times could be substantially reduced, if pre-hospital emergency services were also re-configured.

Q: And putting the elements together: **What's the case for change?**

A: There is now a strong case for re-configuring some hospital services, in Wales as elsewhere in the UK. This has a positive aspect – patient outcomes could be improved – and a negative aspect – some services will collapse because of shortages of key staff, if changes are not made proactively. While these problems have been developing over time, the need for change is now urgent in some key specialties, as levels of medical staffing become acute.

It is in the nature of this evidence sometimes to be frustratingly vague, inconclusive, contradictory, or simply non-existent, and not always to point to a single answer. However, as this summary and the accompanying papers show, there is now convincing evidence that hospital services in Wales are not always configured optimally, and that patient care may suffer; and that some key staff groups, in some hospitals, are unsustainable, with the risk of imminent service collapse. Readers therefore have to weigh the evidence for themselves, taking into account the interpretations placed upon it, and applying their own common sense. Health policy decisions are usually like this - in part about value judgements - and striking an acceptable compromise between different objectives is something else that readers must do for themselves. Hence the need for a serious public debate about these issues. In some key respects, however, there is now a sufficient weight of evidence to give serious cause for concern about whether we really are getting the best possible care from the resources we currently invest.

'Here now is the opportunity to build a hospital service equal to any in the world and matched, I would think, by very few… the intention of the Government and of the Hospital Service [is] to rise to that opportunity… This Plan is nothing less than a plan for the modernisation of our hospital system… to make clear the sort and size of hospitals which we ought to have if we are to make the best use of the specialist techniques of our time, together with the general practitioner services and the domiciliary services.'

Lord Newton, introducing *The Hospital Plan for England and Wales* to the House of Lords in 1962

1. INTRODUCTION

I. PURPOSE OF THIS PAPER

People across Wales are about to be asked for their views on how their health services should be changed. This paper is designed to help people make up their own minds. It reviews the evidence on what constitutes 'the best' in hospital provision, and assesses the strength and implications of the evidence. The focus is on **what the evidence suggests about the optimal number, size and distribution of hospital services in Wales**. It is impartial, based solely on the evidence reviewed, and any judgements made on the basis of the evidence are explicit. It is written primarily for a lay audience: people who care about the future of their health services, and want to make up their own minds between the sometimes conflicting views presented through the media and elsewhere.

It does not consider *local* plans: it merely reviews what the evidence says *in general* about changes to the pattern of hospital services. It focuses primarily on acute hospitals, but makes the point that these hospitals are only one part of a complex network of services that make up NHS Wales, and they depend on the services around them. It also works on the basis that the evidence can *help* make a decision, but it *doesn't tell you what the answer is*. At the heart of these difficult issues lies a set of value judgements: people need to decide for themselves what matters most for them in healthcare, and what compromises they are prepared to accept.

This paper is based on three accompanying 'technical' documents which describe the evidence in more detail:

I. Quality and Safety
II. Workforce
III. Access

If the reader wants more information on any particular issue, it can be found in these technical documents.

II. SOME STRAIGHT ANSWERS TO SOME SIMPLE QUESTIONS

Much of the controversy which dogs any proposed reconfiguration of health services, anywhere in the UK, stems from proposals to change what hospitals provide, and particularly to 'take away' services from local hospitals. All too often, it would appear, the discussion is not informed by the evidence, and people are left puzzled (and even suspicious) about what is going on. In reviewing the evidence, we have been guided

by some simple – but profound - questions which people repeatedly ask about the future of their hospitals, and to which they sometimes struggle to get a convincing answer:

- On Safety and Quality: **What's wrong with our current pattern of hospital services?**
- On the Workforce: **We've got more staff than ever before, so what's the problem?**
- On Access: **Is poorer access inevitable to ensure good safety and quality?**

And putting the elements together: **What's the case for change?**

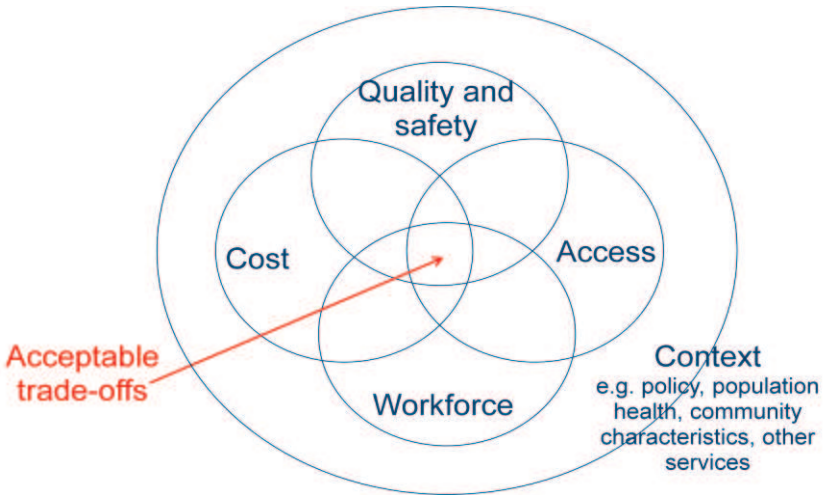
Another issue which frequently crops up in these discussions is about money: **Can we afford to improve the service?** The evidence on this is not reviewed here, but there is some discussion about what this question might mean.

2. THE CONTEXT

I. WORLD CLASS HOSPITALS DEPEND ON...

The Bevan Commission recommended to the Welsh Government that health care in Wales should be *'best suited to the needs of Wales and comparable with the best anywhere'*. In short: 'world class'. Definitions of what constitutes 'world class' in hospital care vary from place to place and observer to observer, but there is a measure of consensus around four sets of issues in particular that will determine overall success: the quality and safety of the care provided in the hospital; how accessible it is; whether the workforce is sufficient in quality, quantity and distribution; and whether the system is affordable. Each of these must be sustainable into the future. No system in the world has ever managed to achieve perfection in all of these domains, or ever could: 'world class' is about finding a set of trade-offs which is acceptable to citizens and professionals (Figure 1):

Figure 1: The determinants of world class hospital care



This paper is about acute hospital services, and the evidence reviewed here takes that narrow focus. But the contextual factors are vital to the success of the hospitals. They translate into a series of objectives,

common to most healthcare systems in the developed world, including Wales, and are already subject to a variety of other initiatives:

- Helping people and communities look after themselves better – to prevent ill health and keep people well
- Controlling the growing burden of chronic disease – to minimise the impact of long-term conditions, which already account for most healthcare in Wales
- More NHS capacity and coordination outside hospital – to shift the balance of resources towards the community
- Preventing unnecessary hospital admissions – to make sure that people are only admitted to hospital when this is really their best option
- Better coordination between all service providers – to provide effective team working across the complex range of services which people require
- Adopting world class efficiency measures – to continue the endless task of making the system work as efficiently as possible
- Following best clinical practice – to make sure that all services follow accepted good practice
- Avoiding delayed discharges – to ensure that people leave hospital to the most appropriate destination for them, without any delay
- Services designed for different communities – to make sure that services are properly configured and attuned to where they work
- Partnership between services and patients – to ensure that all patients are fully engaged in their own care, making decisions and receiving care which suits them
- Adequate resources – to ensure that services work efficiently and get the money and other resources they need.

Achieving world class hospital services means achieving world class provision in all of these aspects, as well as the optimal configuration of hospital services themselves. In Wales, the achievement of the third objective – dramatically improving health and related services *outside* hospitals – is particularly important for the future of hospital services. It has been clear for some time that Wales has more hospital beds than England - 3.90 beds per 1,000 population in Wales compared with 2.64 beds per 1,000 population in England (December 2011). Progress in this area (set out in the Welsh Government's policy *Setting the Direction*) must proceed in lock-step with the development of hospital services if the latter are not to be left plugging gaps in community provision, and admitting people who should have been cared for in the community.

II. 50 YEARS OLD, BUT CONSTANTLY CHANGING

The current pattern of hospital services in England and Wales was established according to a blue print set out 50 years ago by the then Minister for Health, Enoch Powell MP in *The Hospital Plan for England and Wales*. Its aim seems remarkably modern: to create world class hospital care, by developing a coordinated system in and outside hospital, using the latest technology and the full range of staff skills and expertise. The words of Lord Newton, quoted at the start of this paper, could almost have been said by the Welsh Minister in the Senedd last week!

The Hospital Plan gave birth to a network of 'District General Hospitals' of 600-800 beds, designed to serve populations of 100,000 to 150,000. These key building blocks still exist in recognisable form across Wales 50 years later; but the care they provide has changed and adapted to meet changed circumstances:

For example...	*... which means*
Primary care identifies patients at risk and manages them proactively	Diabetic patients used to be admitted to hospital to start their insulin… now it's done in the community
Length of hospital stay is much shorter	Many operations are done as day cases
Technology allows specialist care closer to home	Large parts of cancer care and most mental health services are now in the community
Staff have developed new roles	Many services are now led by non-medical staff

Change in these and other areas must continue in conjunction with any changes to the configuration of hospitals services.

3. WORLD CLASS HOSPITALS

I. SAFETY AND QUALITY

The safety and quality of hospital services can be defined and assessed in a variety of ways. The evidence relating to two of the most important is considered here. Clinical outcomes are those objective measures of success which matter most to patients, such as avoidable death and disability. Service models describe the way parts of the service – for example, types of surgery, stroke care, child birth - are provided. Looking at both helps us to answer the question: **What's wrong with our current pattern of hospital services?**

Further information on the data summarised here can be found in the accompanying paper of Quality and Safety. The discussion here on safety and quality should also be read in conjunction with the next section, on Workforce, which explores whether shortage of particular groups of staff may in itself be a threat to quality and safety.

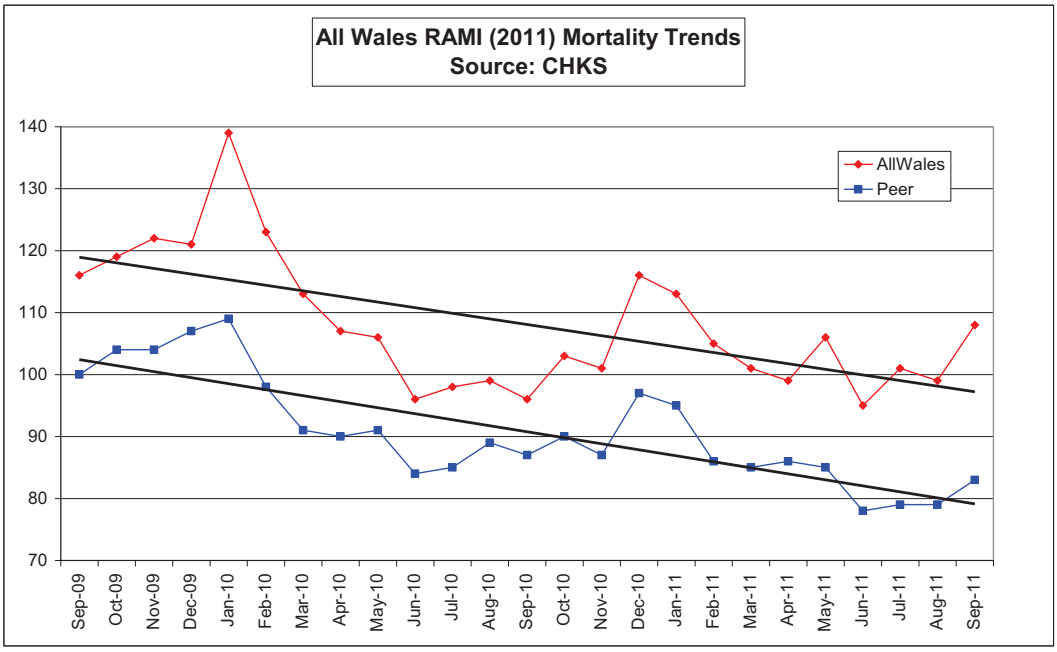
A. Clinical outcomes

Data on deaths in Welsh hospitals are used to construct a Risk Adjusted Mortality Index (RAMI). This attempts to adjust the 'crude' death rates for the differences between patients which are not the result of hospital care – for example, age, sex or severity of condition on admission. These are then compared with a broadly similar group of English hospitals, to see if there is any difference in the outcomes which might be the result of the hospital care itself. Like any statistical technique, the process of risk adjustment is not perfect, and it is possible that at least some of the difference observed is the result of extraneous factors such as differences in the types of hospital compared, or the local availability of hospice care. So the data

presented here should be used with caution. The data also mask variation between the different English regions.

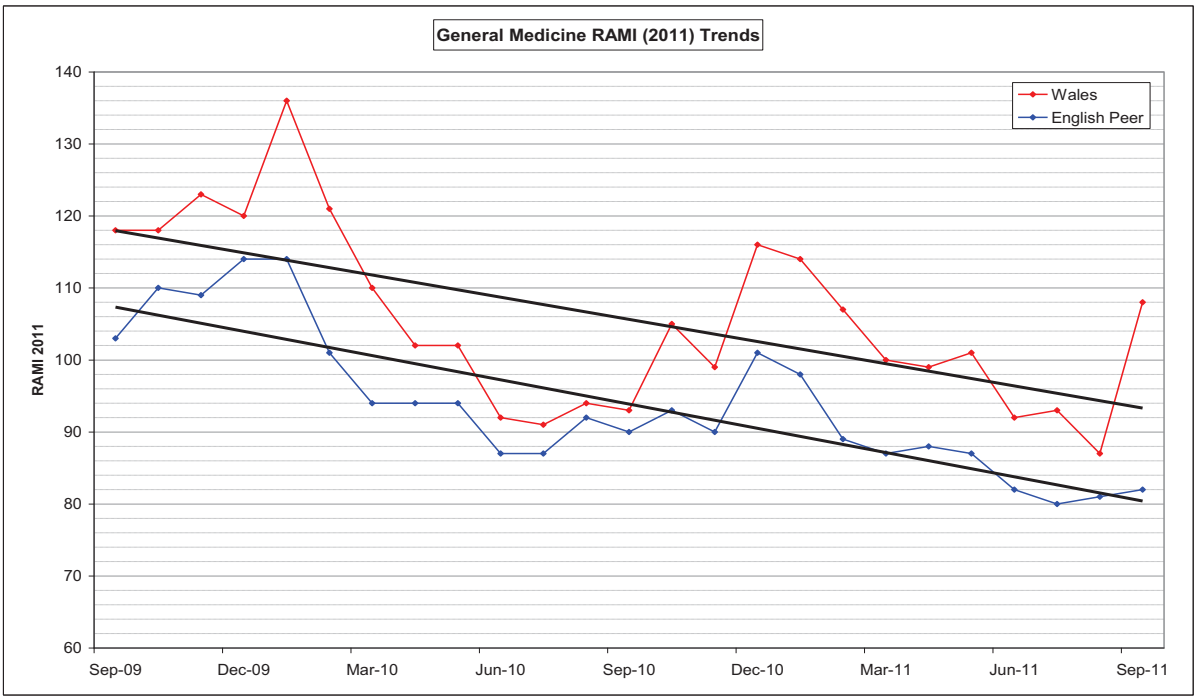
Figure 2 shows the overall comparison between Welsh and English hospitals, with a remarkably similar (improving) pattern between the two countries, but a consistently poorer performance from Wales:

Figure 2: Risk adjusted mortality trends 2009-11, Wales and England



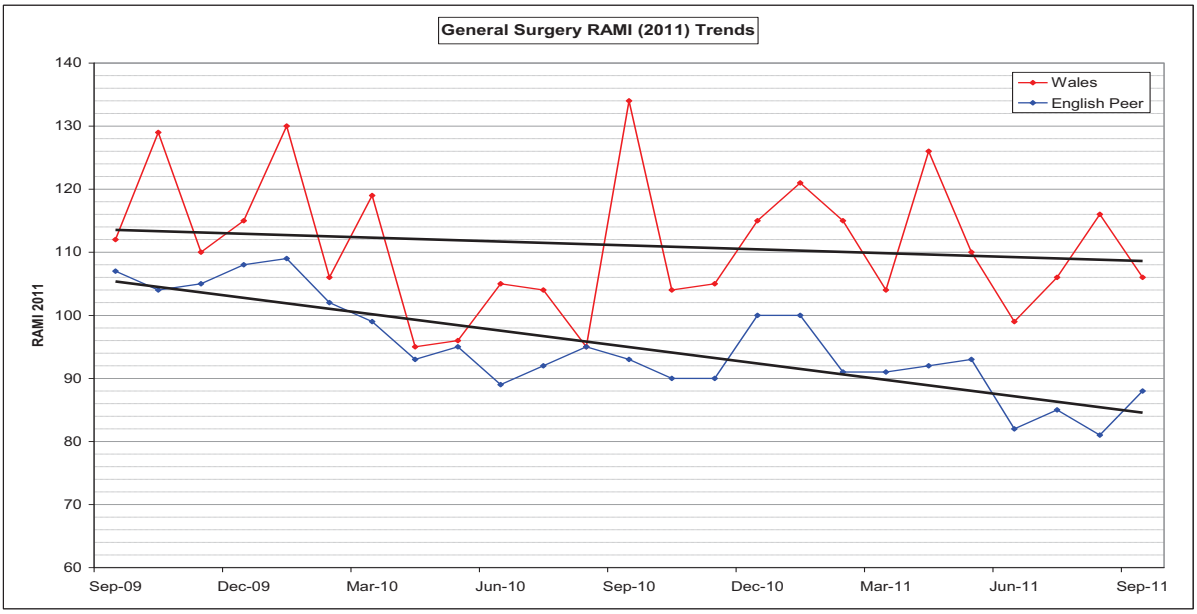
Looking more closely at some of the bigger specialties within this overall picture, general medicine appears to follow a similar pattern (Figure 3):

Figure 3: General Medicine risk adjusted mortality trends, 2009-11, Wales and England



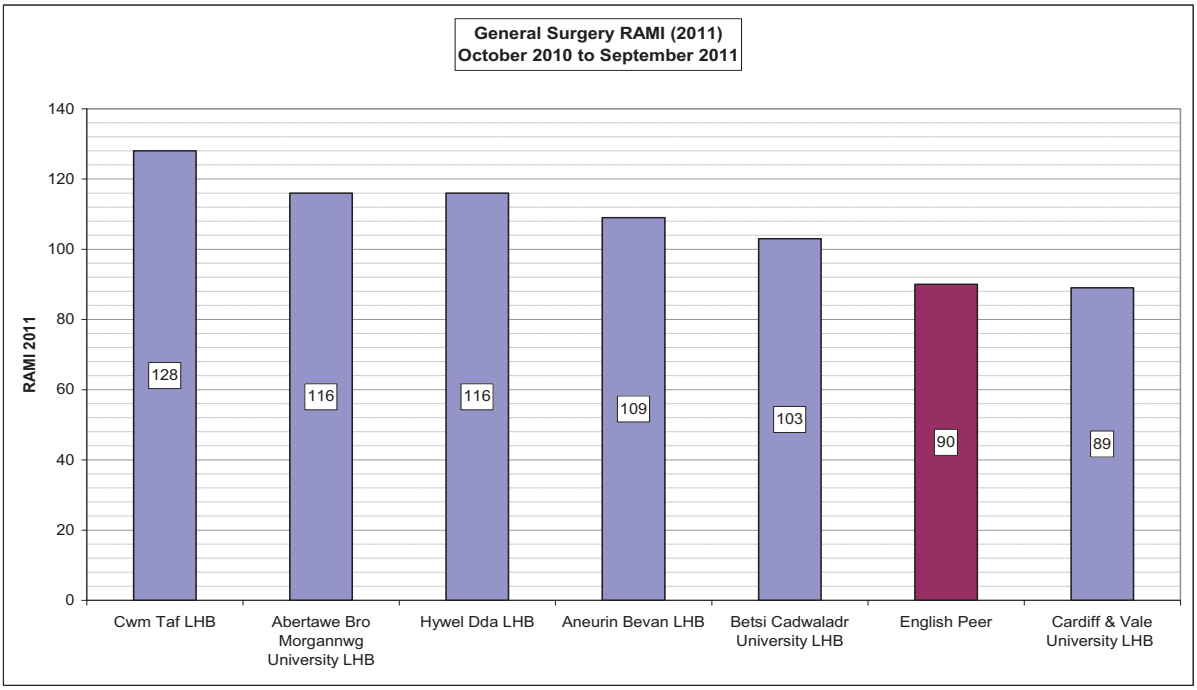
In general surgery, the difference between England and Wales appears to be widening (Figure 4):

Figure 4: General Surgery risk adjusted mortality trends, 2009-11, Wales and England



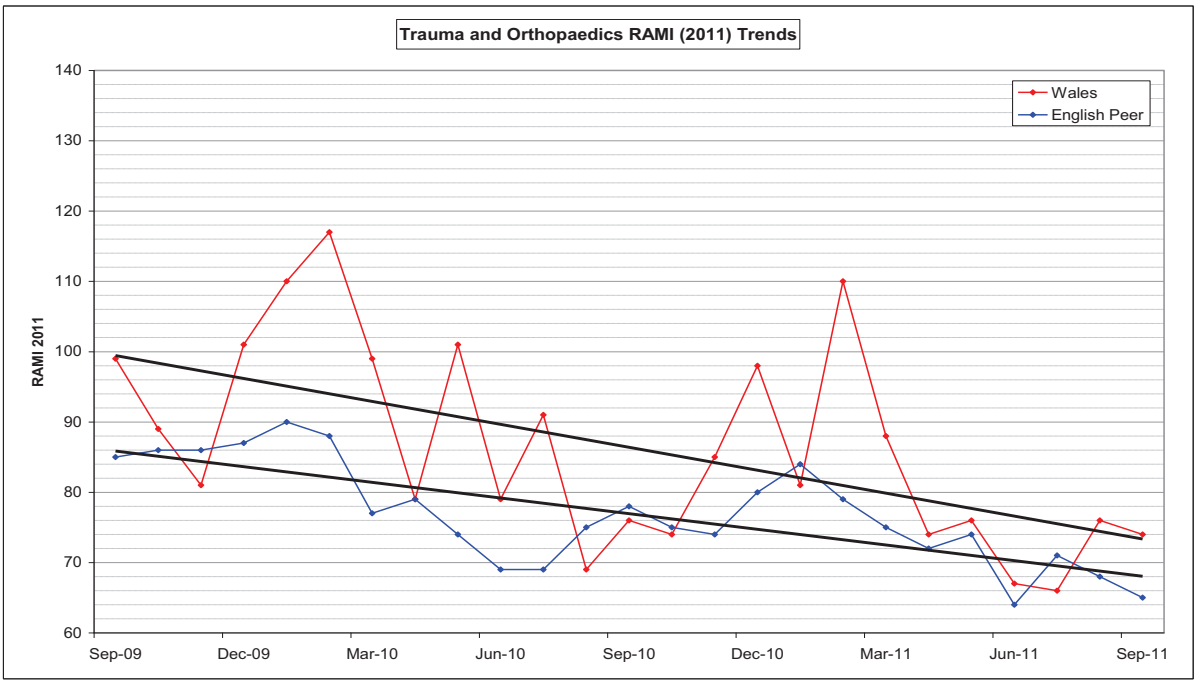
with substantial apparent variation between the different Welsh Health Boards (Figure 5):

Figure 5: Risk Adjusted Mortality, General Surgery, Welsh Health Boards and England, 2010/11



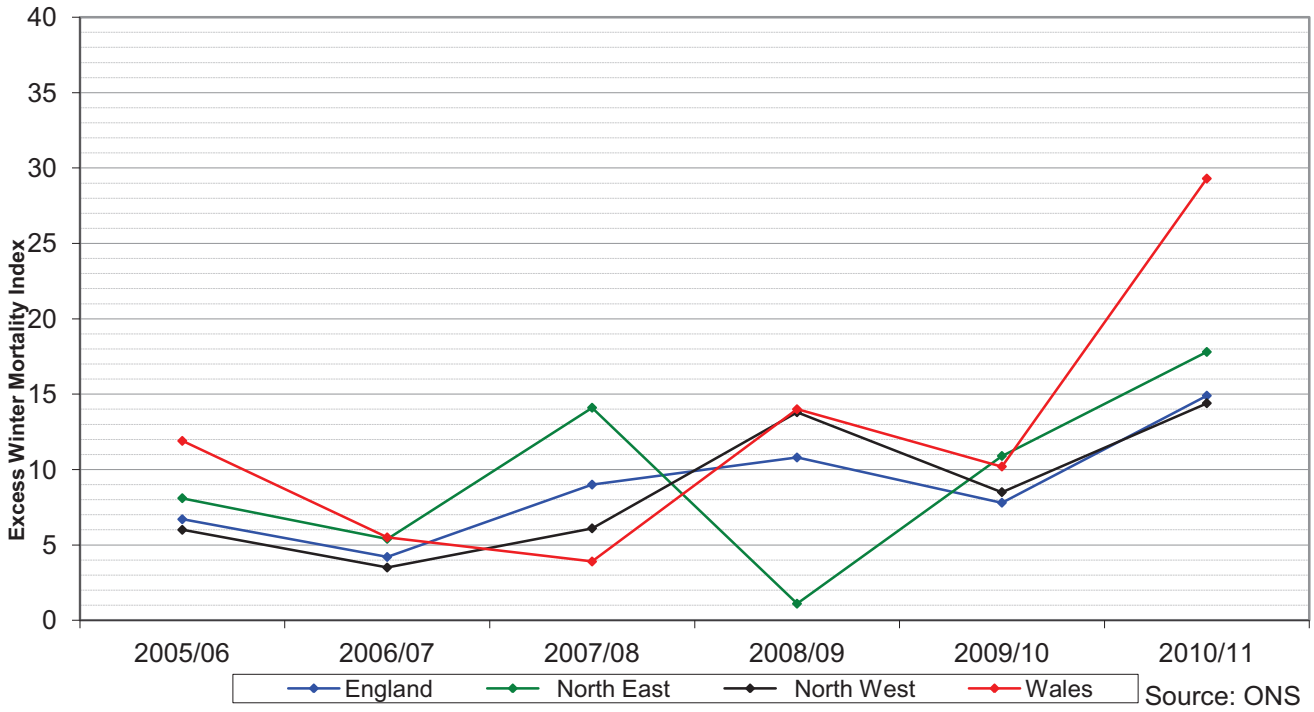
In trauma and orthopaedics, the gap between the two countries appears to be narrowing (Figure 6). However, Wales seems to have difficulty maintaining safe standards when there are seasonal peaks in demand:

Figure 6: Trauma and Orthopaedics risk adjusted mortality trends, 2009-11, Wales and England



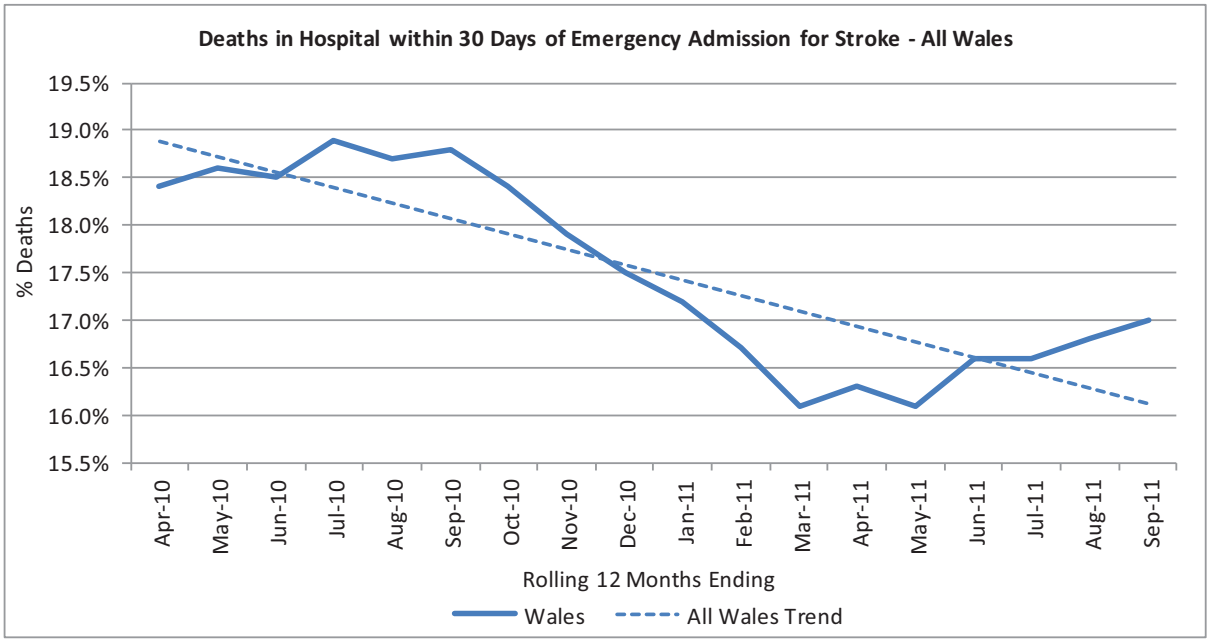
This is also reflected in the calculation of the 'excess winter mortality index', which shows Wales often performing less well than comparable regions in England (Figure 7):

Figure 7: Excess winter mortality index, ages 0-64, by region, 2005/6 to 2010/11



In stroke care, there has been a clear improvement in outcomes since a seminal audit by the Royal College of Physicians (Figure 8):

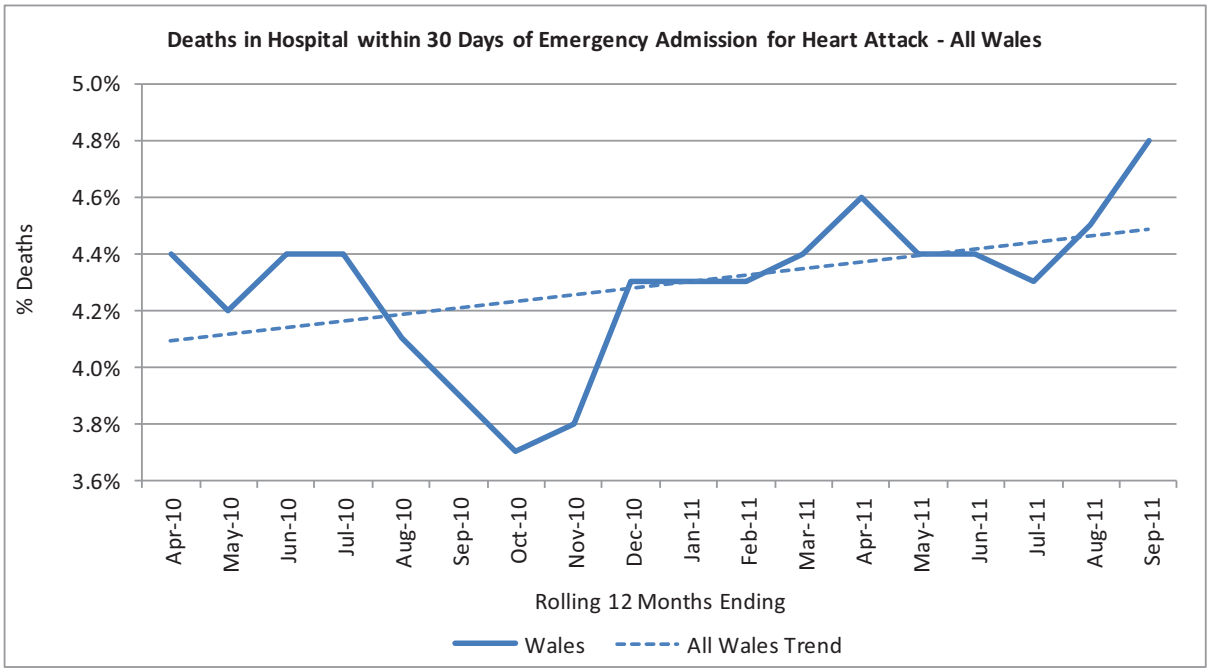
Figure 8: Deaths in hospital within 30 days of emergency admission for Stroke, Wales, 2010-11



However, the data for December 2011 show a wide variation in performance between hospitals in the compliance with agreed standards for the vital first day of post-stroke care. These range from over 95% compliance in four of the fifteen hospitals providing stroke care in Wales, to under 50% compliance in two hospitals.

Deaths after emergency admission for heart attack in Wales appear to be increasing (Figure 9):

Figure 9: Deaths in hospital within 30 days of emergency admission for heart attack, Wales, 2010-11



Another form of outcomes data is based on auditing individual departments, and comparing what they achieve with comparable units elsewhere. One of the biggest of these is the Trauma Audit Research

Network (TARN) database which provides detailed information on performance and outcomes for Accident and Emergency (A&E) departments. Unfortunately, only six of the 13 Accident and Emergency Departments in Wales have provided data to inform the TARN Database. Figure 10 provides a summary of the measure of unexpected survivors or deaths between 2008 and 2011, where 0 suggests average performance, and a positive number better than average. These data are generally good, but unfortunately no data are available for more than half the Welsh units:

Figure 10: Comparative outcomes of A&E Departments, Wales, 2008-11

Local Health Board	Hospital	Rate of survival
Cardiff and Vale	University Hospital of Wales	2.9 Additional survivors/100 patients
Betsi Cadwaladr	Glan Clwyd	0.2 additional survivors/100
	Wrexham Maelor	1.6 additional survivors/100
	Ysbyty Gwynedd	2.7 additional survivors/100
Abertawe Bro Morgannwg	Morriston	1.7 additional survivors/100
	Princess of Wales	0.7 more deaths/100
Aneuran Bevan	Nevill Hall	No data
	Royal Gwent	
Cwm Taf	Royal Glamorgan	
	Prince Charles	
Hywel Dda	Bronglais	
	West Wales General	
	Withybush	

Another dimension which has received a lot of attention in both England and Wales recently is the impact of the day of the week on which patients are admitted. In both countries, there is now worrying evidence that patients admitted at the weekend – and especially on Sundays – are more likely to die than those admitted Monday to Friday (Figure 11):

Figure 11: Deaths in hospital by day of admission, Wales, 2010-11

Table 3: Mortality Rate Excluding Paediatrics, Obstetrics and Midwifery by Day of Admission and Hospital

Admitting Hospital	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Hazard Ratio
Bronglais General Hospital	4.99%	5.59%	4.41%	7.86%	6.53%	6.72%	4.15%	1.89
Ysbyty Glan Clwyd	6.13%	6.10%	6.26%	5.87%	5.30%	6.03%	6.39%	1.21
West Wales General Hospital	5.63%	5.15%	5.67%	4.92%	5.75%	6.94%	6.00%	1.41
Morriston Hospital	4.62%	5.13%	5.41%	4.93%	5.93%	5.23%	6.00%	1.30
Nevill Hall Hospital	4.76%	4.51%	4.32%	5.15%	5.73%	5.00%	6.86%	1.59
Prince Charles Hospital	5.50%	4.69%	4.97%	4.58%	5.36%	5.24%	6.48%	1.42
Princess of Wales Hospital	7.60%	7.06%	6.82%	8.06%	7.18%	8.41%	8.06%	1.23
The Royal Glamorgan Hospital	6.00%	6.32%	5.94%	6.75%	5.41%	7.21%	7.68%	1.42
Royal Gwent Hospital	3.97%	4.50%	4.82%	4.85%	4.36%	5.56%	5.65%	1.42
University Hospital of Wales	5.56%	5.56%	5.21%	5.55%	6.13%	5.02%	5.90%	1.22
Withybush General Hospital	5.63%	5.88%	5.19%	6.66%	5.56%	7.25%	6.63%	1.40
Wrexham Maelor Hospital	4.71%	5.28%	5.15%	5.53%	5.37%	5.86%	6.01%	1.28
Ysbyty Gwynedd	6.44%	5.59%	5.29%	4.79%	4.86%	4.97%	4.80%	1.34
Total	**5.35%**	**5.36%**	**5.32%**	**5.54%**	**5.49%**	**5.90%**	**6.22%**	**1.17**

Notes:- Data relates to discharges between September 2010 and August 2011 inclusive

Source: NWIS

Data is for emergency admissions only

Data relates to patients with all admitting treatment specialty excluding 'Paediatrics', 'Obstetrics' and 'Midwifery'

'The Royal Glamorgan Hospital' includes deaths for 'Mental Health Services at Royal Glamorgan Hospital'

'Ysbyty Gwynedd' includes deaths for 'Ysbyty Gwynedd (psychiatric)'

The day of the week with the highest mortality rate for each hospital is highlightd in dark grey and the day with the lowest rate in light blue

The Hazard Ratio is calculated as the ratio of the mortality rate on the day with the highest rate to the mortality rate on the day with the lowest rate

The pattern varies between specialties, but few ensure consistent care across the week. The variations in some specialties are even more pronounced than the overall picture – take, for example, the mortality associated with patients admitted with fractured neck of femur based on day of patient admissions (Figure 12):

Figure 12 Deaths associated with patients admitted with fractured neck of femur based on day of patient admission, Wales, September 2010-October 2011

Mortality Rate	Sun	Mon	Tue	Wed	Thu	Fri	Sat	All	Hazard Ratio*
Betsi Cadwaladr	6.0%	6.6%	5.9%	4.0%	7.9%	8.3%	4.9%	6.2%	2.1
Hywel Dda	2.4%	4.3%	4.4%	6.1%	5.9%	8.5%	5.7%	5.4%	3.6
Abertawe Bro Morgannwg	13.4%	4.0%	13.6%	6.2%	10.4%	10.9%	7.5%	9.2%	3.4
Cardiff & Vale	14.9%	15.1%	9.1%	6.4%	5.5%	13.5%	7.8%	10.3%	2.7
Cwm Taf	5.7%	8.0%	9.4%	4.1%	8.8%	3.2%	13.2%	7.7%	4.1
Aneurin Bevan	7.9%	9.0%	3.8%	10.1%	4.3%	6.7%	9.0%	7.2%	2.6
Powys	0.0%	20.0%	3.7%	3.6%	4.0%	0.0%	0.0%	4.5%	
All Wales	8.0%	7.7%	7.0%	6.0%	7.2%	8.6%	7.5%	7.4%	1.4

Note: Mortality rates should be viewed in conjunction with the number of deaths/admissions to understand the impact of the volumes

Denotes highest mortality rate day

Denotes lowest mortality rate day

* Hazard Ratio compares worst day mortality with best - eg patients in Cwm Taf are over 4 times as likely to die on a Saturday compared to a Friday

All of these data are beset by a variety of definitional and quality issues, and all should be treated with caution. However, they suggest grounds for concern about clinical outcomes in some key specialties, and according to the day of admission.

We turn now to the evidence which links service models to clinical outcomes.

B. Service models

While outcome data are valuable as a way of highlighting problems, they do not necessarily show the causes of those problems, and it is open to interpretation how far these figures are influenced by hospital configuration (as opposed to the other factors reviewed in Section 3.I.C below). An alternative approach is to look at how services are actually configured and delivered now, and ask the question: do the service models in Welsh hospitals follow the evidence about best practice?

The most obvious message from the evidence on service models is that it is impossible to generalise across all the different specialties of modern healthcare: the issues are often different, so each needs to be considered individually.

The second, and slightly more frustrating conclusion, is that we quite often do not have sufficient evidence to be sure about the optimal configuration. Carrying out research in this area – establishing a convincing link between the way services are provided and outcomes – is really difficult, mainly because there are so many elements that go into a service model, and so many other factors which may influence outcomes. There is a range of evidence, from multiple, large-scale randomised controlled trials (the strongest evidence), where researchers have tried to allow for all the variables, through to a consensus of expert

opinion based on evidence which in itself would be inconclusive. The former is as near to 'proof' as we are likely to get, but rare; the latter is much more common and certainly valuable, but experts are not always right, and their opinions should be treated with caution. In the middle there is a growing body of studies which look for statistical associations between models and outcomes, with some attempt to control for confounding variables.

There is another *caveat*: a lack of evidence of harm is not evidence of a lack of harm. In other words, because we cannot 'prove' that a model is harmful, that does not mean that we should assume it's safe. More research is always needed!

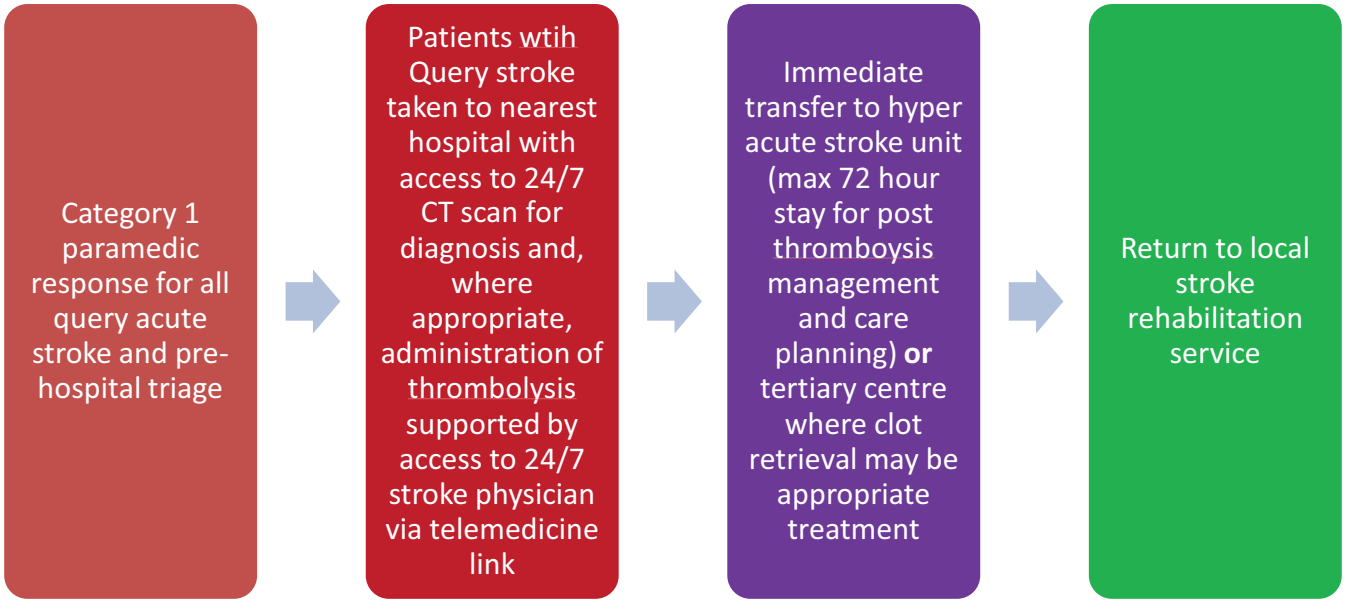
On the basis of the available evidence, however, there are several specialties where we can be reasonably sure that we know how services should be configured:

1. **Major Trauma Services** (i.e. multiple injuries involving different tissues and organs systems that are, or have the potential to be, life threatening). There is evidence of significant outcome benefits for patients with major trauma when treated in a dedicated major trauma centre. In a typical year around 1000 patients in Wales have major trauma:
    - Regionalisation of care to specialist trauma centres reduces mortality by 25% and length of stay by 4 days
    - High volume trauma centres reduce death from major injury by up to 50%
    - Time from injury to definitive surgery is the primary determinant of outcome in major trauma (not time to arrival in the nearest emergency department)
    - Major trauma patients managed initially in local hospitals are 1.5 to 5 times more likely to die than patients transported directly to trauma centres
    - One centre might typically serve a population of 3-4 million

2. **General Trauma and Emergency Care –** there is evidence for some patients (such as patients with ruptured abdominal aortic aneurysms) of outcomes improving as unit size increases, but it is not statistically significant. Services that meet clinical standards and consistently follow recommended pathways make the most difference, whatever the size of the unit. There is increasing evidence that outcomes are better when there are more senior doctors on site 24/7 and this is becoming increasingly difficult to achieve in smaller units:
    - Outcomes better where senior doctor cover is available 24/7
    - Some (weak) evidence that, for certain procedures (e.g. ruptured abdominal aortic aneurism), outcomes improve with unit size
    - Compliance with clinical standards and pathways more important than scale (smaller hospitals often show better compliance)
    - Time to treatment can be reduced through mobile provision in some cases

3. **Stroke Care** - The evidence suggests that patients who are admitted to a 'hyper-acute stroke unit' that is compliant with standards for acute stroke care are likely to have better outcomes. It is important to ensure prompt access to a neurosurgical centre for the very small number of patients assessed as being suitable for clot retrieval. The ideal configuration would ensure the following (Figure 13):

Figure 13 Stroke pathway



4. **Maternity and Newborn Care Services –** There is no evidence of a consistent relationship between outcomes and size of unit and as such no clear conclusions can be established from published research. For women who have been assessed as low risk, midwifery units appear to be safe for the baby and offer benefits for the mother, and for women having a second or subsequent child the same is true for homebirths. Professional advice in the form of Royal College of Obstetricians and Gynaecologists Guidelines suggests that units offering obstetric care should meet minimum numbers of dedicated hours of consultant presence on obstetric wards each week. Meeting this standard is likely to lead to fewer obstetric units in Wales, given the numbers of obstetricians practising in Wales.

5. **Paediatric Services-** There is no evidence of a consistent relationship between outcomes and size of unit, and as such no clear conclusions can be established from the published research. Professional guidance in the form of Royal College of Paediatrics and Child Health Standards recommends that small paediatric units admitting fewer than 1800 children each year should not continue to exist, unless they are geographically isolated. Meeting this standard is likely to lead to fewer inpatient paediatric units in Wales though it is less clear what it means for paediatric services in hospitals without an inpatient paediatric unit.

For other specialties, the link between size of unit/volume of patients and quality of care is less clear. For example, in the case of the surgical specialties, there is good evidence linking patient outcomes and *individual surgeon* volume, rather than *hospital* volume. The Royal College of Surgeons of England 2006 Reconfiguration Working Party concluded that for much of general surgery, these volumes could be achieved by clinical networking rather than concentration on single hospital sites.

In other cases, centralisation is associated with dramatic improvements in outcomes. In North Wales, for example, certain specialised stomach operations (oesophagectomy and gastrectomy) were previously

carried out in four District General Hospitals, but were centralised on one, five years ago, with substantial improvements for oesophagectomy:

- four-year survival figures now show in-hospital mortality at 3% compared with a UK average of 4.5%
- re-operation rates are now running at 6% compared with a UK average of 10%

and for gastrectomy:

- in-hospital mortality was 5% compared with a UK average of 6%
- re-operation rates are now 1% compared with a UK average of 7%.

Patients' families are offered hotel accommodation if they have travelled long distances, especially in the few days post-surgery.

The picture is further complicated, however, by the issue of inter-dependencies between some of the specialties. The original 1962 conception of the District General Hospital sought to achieve a cluster of mutually-dependent specialties in one place. In the subsequent 50 years, the detail of this has changed, but the principle remains. For example, in the case of emergency care, there is now a generally-accepted minimum set of acute services required on site to provide a safe emergency service department (Figure 14):

Figure 14 Services required to support an emergency department

Supported On-Site By 24 Hour Access to:
Acute Medicine
Level Two Critical Care
Non-Interventional Coronary Care Unit
Essential Services Laboratory (biochemistry, haematology, blood transfusion, microbiology, infection control and mortuary services)
Diagnostic Radiology (X-ray, ultrasound and CT Scan)
Supported by 24 Hour Local Multi-Hospital Network Access (not necessarily on-site) to:
Emergency Surgery
Trauma & Orthopaedics
Paediatrics
Obstetrics & Gynaecology
Mental Health
Supervised Surgery
Interventional Radiology

It may be the case, therefore, that some specialties have to change or re-locate, not because their own model of care is inadequate, but simply to follow other specialties which depend upon them.

C. Other determinants of quality and safety

The discussion so far has focused on the possible relationship between volume and quality/safety of care, because this has proved to be one of the most contentious elements in any health service reconfiguration across the UK. But there are many other determinants of quality and safety in hospital services which are at least as strongly evidence-based.

Within the hospitals themselves, we know for example that the following are important:

- Levels, qualification, training and utilisation of staff – a lot of work has been done on nurse staffing, for example
- Resources available for key elements of the system
- Adherence to guidelines and evidence-based care pathways
- Application of research evidence

and the quality and safety of care in hospitals is directly affected by what happens outside, for example:

- The quantity, quality and organisation of primary and community services
- The resources available to the local community to care for its own health and wellbeing.

Many of these factors are unrelated to hospital size; others can be correlated with hospital size, sometimes inversely. In short, hospital configuration may be a necessary element in ensuring quality and safety; it is never sufficient in itself.

D. Conclusions

Despite all the necessary *caveats* about the evidence, it is clear that:

- Patients in Welsh hospitals cannot yet be confident that their outcomes will always be 'comparable with the best anywhere', as the Bevan Commission suggested should be the case
- Some key parts of the hospital service are not configured as they should be

The NHS will need to consider how many hospitals of different sorts it can support if it is to ensure that outcomes for patients will be the best possible, in every hospital, at all times during the week.

II. THE WORKFORCE

This section reviews the current levels of staffing of key elements of the Welsh hospital service, both now and in the foreseeable future, to see whether they pose any threat to the quality and safety of services. In the process, the aim is to help answer the question: **We have more staff than ever before, so what's the problem?** The focus is primarily on medical staff, because that is where it is claimed the biggest problems lie, but some of the key issues affecting other staff in the hospital sector are also briefly reviewed. Further information is contained in the accompanying paper on The Workforce.

A. Medical staffing: the perfect storm

When one considers the level of medical staffing in Welsh hospitals, there is an immediate paradox: we have more hospital doctors than ever before (in the last ten years, the numbers of hospital doctors in Wales have increased by 49% (+1,807 whole time equivalents), including an increase of 66% in consultants (+836)), and yet there is much talk about acute shortages in key areas. How can both be true?

The answer lies in the 'perfect storm' of reducing availability and increasing demand:

- Reduction in available medical input: while total numbers have increased, the amount of clinical time provided by each doctor has reduced as the impact of the following has taken effect:
    - the European Working Times Directive: between 2007 and 2011, the number of doctors in training in Wales increased from 2748 to 2810, but the number of hours worked per week fell from 134,206 to 126,651) ; and
    - changes to the consultant contract: in 2004, consultants typically worked a total of 11.5 sessions per week, of which 9.3 were clinical; in 2010 this had reduced to 10.4, of which 7.9 were clinical.

  This is further compounded by the fact that
    - doctors in training (especially women) are increasingly opting to work fewer hours to create a more acceptable work/life balance: currently 7.5% (203) of doctors in training are working less than full time.
- Increases in the minimum requirements for doctors:
    - As a result of the changes outlined above, there has been a revision of the number of consultants needed to staff rotas: in large specialties, such as trauma and orthopaedics and general surgery, 8 consultants are now required to provide a viable rota.
    - The evidence cited in the previous section about the harmful effect of inadequate senior staff cover 24/7 has further increased the need for senior staff.
- Recruitment problems in certain specialties, often on a UK-wide basis, compounded sometimes by unattractive training patterns (e.g. where junior doctors feel they don't receive adequate supervision), and by a fluctuating supply of overseas doctors.
- A longer-term trend towards greater sub-specialisation - at one time, surgeons would be expected to carry out a variety of different operations on different parts of the body - to treat all sorts of conditions. Over time, however, a number of distinct specialities have evolved. For example, there are currently none surgical specialities: Cardiothoracic; Neurosurgery; Oral and Maxillofacial; Otolaryngology (ENT); Paediatric Surgery; Plastic Surgery; Trauma and Orthopaedics (T&O); Urology; General Surgery. In General Surgery, there are several 'Areas of Special Interest', including Upper Gastrointestinal; Colorectal; Vascular; Breast and Oncoplastic; Transplantation; Endocrine. This pattern is mirrored in medicine. This all tends to make smaller hospitals less attractive for many aspirant consultants, and to increase the overall demand for consultants.

The impact of these concurrent changes can be seen in recruitment difficulties across Wales. Figure 15 shows those specialties where several Local Health Boards are experiencing severe difficulties with recruitment. These are not the short delays which can often accompany bureaucratic appointment processes: they are persistent problems, where departments are left trying to cover gaps with temporary staff, and often experiencing acute, stressful – and sometimes risky – staff shortages:

Figure 15: Medical staff recruitment problems by Specialty, Wales

Specialty	No. HBs with recruitment difficulties	National shortage?
A&E	6	Yes
Paediatrics	6	Yes
Mental Health/CAMHS	6	Yes
Clinical Radiology	4	No
Medicine/Geriatrics*	4	?
Anaesthetics	3	Yes
Microbiology	3	Yes
Obs and Gynae	3	Yes

*Source: LHB workforce plans 2010/11 *Sub-specialties unclear*

There is also a financial impact of these shortages. Costs for agency medical staff, for example, are high and rising in Wales (Figure 16):

Figure 16 Agency analysis at Month 6 2011/12

	2010/11 Full Year	2011/12 to September
ABMU	£3.282 m	£2.023 m
Aneurin Bevan	£2.031 m	£1.027 m
Betsi Cadwaladr	£13.351 m	£7.083 m
Cardiff & Vale	£2.67 m	£1.296 m
Cwm Taf	£3.977 m	£2.085 m
Hywel Dda	£5.275 m	£3.357 m
Powys	£0.217 m	£0.062 m
Public Health	£0.017 m	£0 m
Velindre	£0.146 m	£0.003 m
Welsh Ambulance	£0 m	£0 m
Total	**£30.966 million**	**£16.936 million**
Projected to year end		£33.872 million

B. Specialities under pressure

Set against this general background of the 'perfect storm', some specialties and training areas are particularly hard hit, together with some of the more remote parts of Wales. Tensions can arise between the needs of the NHS for doctors in training to keep services viable, and the obligations of the Postgraduate Deanery, General Medical Council, Royal Colleges and others to ensure adequate levels of training and appropriate experience and career progression. In a UK-wide market for recruitment, trainees' own wishes can also be a powerful lever for change. The following four areas illustrate where the pressures are at their greatest in Wales:

1. **Paediatrics –** Recruitment in Paediatrics has been low for the last 2-3 years, and there is no expectation either in Wales or the UK that this situation will be resolved in the short to medium term. As Figure 15 shows, all Welsh Health Boards are experiencing persistent recruitment difficulties in this specialty. This poses particular problems as there are too many paediatric inpatient units, and therefore too many medical staff rotas, for the numbers of available doctors. Several rotas cannot now be staffed in a compliant way and this is the immediate problem being faced in three of the health boards. In the latest recruitment round there were 11 acceptances for 20 vacancies. The GMC survey shows that the workload for Paediatric trainees in Wales is amongst the highest in the UK, and Wales has the lowest and second lowest examples in the UK of Working Time Directive compliance. All of this has led the Royal College of Paediatrics & Child Health in Wales to conclude that *'the current paediatric inpatient service provision in Wales is unsustainable with the full implementation of the Working Time Directive in 2009. Wales has too many paediatric inpatient units with too many middle grade rotas. There is an urgent need to decrease the number of inpatient paediatric units and significantly increase the number of Consultants in Wales.'*

2. **Emergency medicine** is a problem across the UK. The GMC are currently undertaking a review of the cover in Emergency Medicine in all departments across the UK. There are particular concerns around the supervision of Foundation Doctors overnight in A&E departments. The Deanery has sought to minimise this in Wales, but there is a need for an urgent review of where training is actually placed as it is spread too thinly across too many departments. All Welsh Health Boards are experiencing recruitment difficulties in this speciality (Figure 15). The GMC survey shows the workload in A&E in Wales to be the highest in the UK. This does not help recruitment. Wales is towards the bottom half in Working Time Directive compliance. This year there is half the number of middle-grade doctors in the appointments process and we have appointed to only 11 out of 20 vacancies.

3. **Core surgical Training** in Wales has been a long-standing problem. In contrast to paediatrics, there is an oversupply of Core Surgical Trainees who have no hope of progressing through to higher training because there are not enough consultant posts for them. This has a knock-on effect to recruitment into these posts, but the service seems to be reliant on their presence. The examination results are poor in Core Surgical Training and competition ratios going forward into higher training are amongst the highest in the UK. The GMC survey shows Wales as the worst in the UK for overall satisfaction and one of the lowest for adequate experience. The Deanery are reducing the number of Core Surgical Trainees over the next two years with the aim of bringing down competition ratios, improving the quality of the applications and reducing the number of sites that the Core Trainees will be available to work at. However, the Deanery is not reducing the higher training numbers so Wales will be producing the same number of qualified surgeons.

4. **Psychiatry** training is another UK wide issue with reduced numbers across the UK; this is particularly acute in Wales. Again, with this specialty there are too many sites with Junior Doctors unsupervised out of hours. The Deanery will be reviewing these in the coming months and removing Junior Doctors from out-of-hours cover. This will by definition affect service delivery, but is in line with the GMC requirements. The GMC survey of trainees showed low overall satisfaction, with some reporting inadequate experience and poor educational supervision.

Failure to resolve these problems will lead to gaps in staffing, which may in turn threaten the safety and quality of the service, and its sustainability.

Outside hospitals, the situation with GPs is also posing difficulties. Many GPs in Wales are likely to retire over the next few years, and recruitment for GP training posts is already proving problematic in some parts of Wales (an area where Wales has previously been strong). This will also pose a challenge for hospital services, where the aim is to transfer some services to the community.

C. Non-medical staff

The focus so far has been on medical staff, because this is where the pressures are most acute, in some cases threatening the continuity of care over the next few months. But safe and high quality care equally depends upon all the other staff – nurses, midwives, allied healthcare professionals, healthcare scientists, and others - and they too face a series of challenges and opportunities.

The NHS has been busy creating new roles for many of these staff groups. Some patients are now being prescribed medication by nurses and pharmacists, for example, and they are attending minor injuries departments where nurses provide all the care. There are advanced practitioners in most of the healthcare professions, working at very high levels of specialised care and taking responsibility for the whole service provided. As elements of services are increasingly transferred from hospitals to the community, hospital staff are acquiring new levels of skill and providing new models of care.

Local managers are also looking carefully at the most appropriate mix of skills in clinical teams. As a result, staff are taking on responsibilities which used to belong to others: nurses substituting for doctors, support staff for registered professionals of various disciplines, and staff providing a wider range of services for their patients to reduce the numbers of professionals with which each patient has to interact. Such changes have the potential not only to provide high quality care, highly valued by patients, but also to mitigate the shortage of doctors – for example in minor injuries units.

The healthcare workforce generally is ageing, and this will soon start to present challenges in particular areas. Some more specialised areas of provision are experiencing recruitment difficulties, and competition for staff is growing from overseas countries who themselves have recruitment difficulties.

Most of these changes have implications for the education and training of non-medical staff, and the commissioning of this educational input has to keep pace with the changes. The numbers recruited for pre-registration education have fluctuated significantly over the past decades, making consistent workforce planning difficult. A considerable proportion of all professional education is done after initial qualification, and delivering such continuing professional development requires close cooperation between the NHS and the Universities – to release staff for new roles while they are still under pressure in their current role, and to anticipate what new skills are going to be required.

The proposed changes to hospital re-configuration will depend upon this continuing process of adaptation and development in the non-medical workforce, and a coordinated approach to education, service provision and quality assurance.

D. Conclusions

Some parts of the Welsh hospital service now face an acute shortage of medical staff. This stems from longer-term changes in work patterns which are common across the UK, exacerbated in some specialties in Wales by the fact scarce medical resources are being stretched across many hospitals. This may also mean that staff are not available everywhere to ensure consistently high quality care for 24 hours a day, 7 days a week. Recruitment of additional staff may help in some areas, but given the fact that similar pressures are now facing hospitals across the UK, this is unlikely to resolve the issue. New staff roles and service models may also alleviate the issue, but the problem is now urgent, as doctors in training are likely to be removed from some hospital departments in 2012. Other challenges face the wider NHS workforce, including the dependence on staff likely to retire in the next decade, and the need to match training to the service's future requirements.

III. ACCESS

There has been a lot of talk about the need to centralise some of the more specialised aspects of hospital care to fewer - and therefore for many people more remote – hospitals. So far in this paper we have looked at the strength of the evidence for this, from both a safety/quality aspect, and from the point of view of workforce pressures. This section looks at what we mean by 'access', at the possible risks that come from services being further away, and at what can be done to reduce the impact on patients of more remote services. It helps to answer the third of our questions: **Is poorer access inevitable to ensure good safety and quality?** Further information is contained in the accompanying paper on Access.

A. What do we mean by 'access'?

At first sight, this might seem a pedantic question: surely we simply mean how *easy* and *quick* it is to get the *care we need*, when we need it? It does mean this, but as always, the devil lies in the detail. For example:

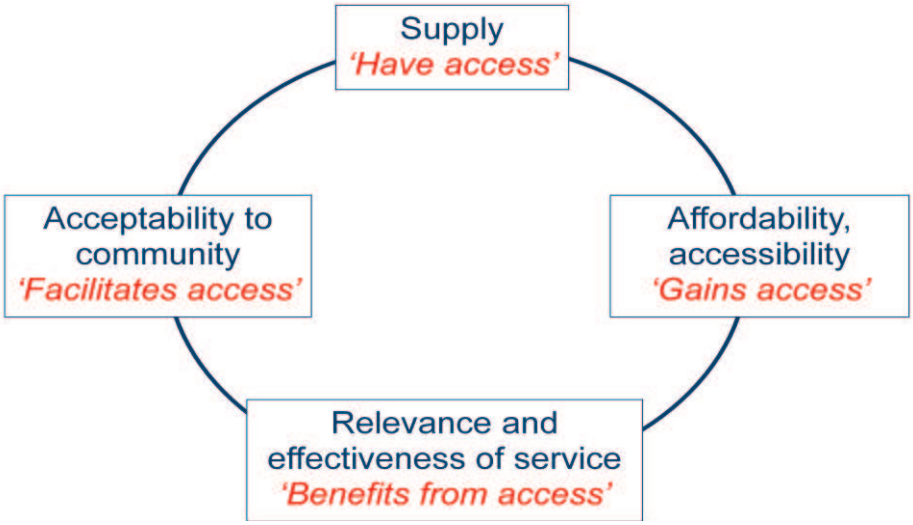
- **Ease** of access means different things in different circumstances: people might expect different access for a one-off visit to a hospital specialist, as opposed to repeated monthly visits over several years;
- **Quick** access also depends on circumstances: it is increasingly possible to take immediate emergency care to people, rather than having to take them to hospital.

And most importantly,

- The **care we need** is a critical dimension – immediate access to poor care is of little use to anyone.

We know that people expect different levels of access, depending on their level of need and the nature of their condition. So services need to ensure access in this graduated way, which is about much more than simply where services are located ('having access' in Figure 17):

Figure 17: Dimensions of access



B. Does longer travel time mean poorer outcomes?

The location of services – and therefore travel time - is nevertheless important, and for people with life-threatening conditions it can literally be a matter of life and death. Some studies have shown a link between travel times and impaired outcomes, for example in child birth, severe respiratory problems, and asthma; others have failed to find any link. In some cases the problem is the distance to GP services (leading to delayed diagnosis) rather than hospitals; in others it is the remoteness of hospital services themselves.

In all cases, however, the issue is the time taken to *access appropriate care*. In many cases, because of the way services are currently configured, this is the same as time to hospital. But this is often because pre-hospital care is not well developed, and the only option is to rush people to hospital. In other countries, services are in place to take care to people, rather than take them to care, often using an advanced network of mobile treatment facilities, by both road (advanced mobile clinical facilities) and air (helicopter and plane).

In Scotland, for example, in most of the country – including most of the remote areas - people with life-threatening emergencies can be reached within 45 minutes in all but the most extreme weather conditions, and provided with world class stabilisation and transfer to hospital as necessary. Relying solely on conventional ambulance services would produce much longer times, and poorer outcomes. Applying the same model to Wales might suggest maximum access times of no more than 20-30 minutes across the country.

In short, it is the **time to the start of appropriate treatment that matters**, rather than the time to hospital. Increasingly, these are not the same thing.

C. What can be done to reduce the impact of more remote services?

As we have seen, there is much more to accessibility than simply travel time. The NHS can reduce the impact of physically remote services in many ways.

First, technology can help. We are just beginning to see the potential of technology in four areas:

- Supporting self care – e.g. home telemonitoring for people with long term conditions, easier access to information on self care
- Supporting the delivery of safer care – e.g. electronic health records enabling the communication of patient data between professionals
- Enabling delivery of services more locally – e.g. virtual healthcare teams, consisting of healthcare professionals who collaborate and share patient information digitally
- Supporting efficiency – e.g. solutions for appointment scheduling, patient data management, mobile working

Second, there is a substantial body of evidence showing different ways of reducing the need for hospital services. These include ensuring continuity of primary care, providing hospital-at-home services, assertive case management in mental health, early senior review in A&E, multi-disciplinary interventions and telemonitoring in heart failure, better integration of primary and secondary care, structured discharge planning, and personalised health care programmes.

Third, the sort of development in pre-hospital emergency care described above reduces the need for admission in some cases.

Finally, the issue with the greatest impact for most patients is the adequacy of non-emergency transport to and from hospital, both for patients and (in the case of in-patients) their visitors. There is a variety of measures, including better communication, efficiency of provision and targeting of NHS-commissioned transport which can improve services, and which were recently highlighted in the Griffiths Review. Beyond this, there have been many efforts to improve public transport and car parking, sometimes with success. Offering relatives hotel accommodation when they have travelled far (as in the North Wales example cited earlier) can mitigate some of the effects of remoteness.

D. Conclusions

Easy and timely access to care is important, to save lives, and to minimise the inconvenience for patients and their visitors, especially for those without easy access to a car. New technologies and ways of working can reduce the impact of remote hospital services – by improved emergency and non-emergency transport, and by greater use of tele-care. In emergencies, the crucial issue is often the time to receiving care, which is increasingly not the same thing as time to hospital. For non-emergency care, much has been

done – and more could be done – to take care out of hospitals, but substantial numbers of people will still need to travel, and for them, access can be difficult.

IV. COST

The financial pressures facing the NHS have been well rehearsed. They come in two forms: the long-term impact of rising expectations and an ageing population, with serious chronic disease problems; and the short-term budgetary constraints of the next few years. On the former, the Office for Budget Responsibility estimates that, simply because of the consequences of an ageing population, the NHS will need to increase its share of gross domestic product from 8.0% in 2009/10 to 10.2% in 2039/40 to stand still. We have an increasingly obese population, and in Wales it was estimated that the cost to the NHS of obesity and alcohol was £140m in 2008/9. In addition to these demand factors, there are cost pressures on the supply side: the increasing cost of new medicines, and the cost of employing staff are two major examples. In the short term, the fiscal consequences of the banking crisis are now being felt by NHS Wales. The Wales Audit Office estimates that there will be a funding gap (i.e. the difference between what NHS Wales would need to stand still, and what it will actually receive) of between £252m and £445m by 2013/14.

The scale of both the short-and long-term funding pressures is probably unprecedented in the history of the NHS. Not only will the NHS have to improve its efficiency by making its current services work better, it will also have to substantially change those services if they are to be sustainable. Is hospital re-configuration, therefore, about saving money?

The evidence on the cost impact of hospital re-configuration is not conclusive: sometimes it saves money, sometimes it is cost neutral, and sometimes it increases cost. The picture is often confused by the unpredicted cost implications of change, and by other coincident service changes. Because of this complexity, this paper does not attempt to consider this issue in Wales. However, it is unlikely that any service re-configuration will lead to a net *increase* in costs – unlike earlier service changes – because of the financial pressures mentioned above.

In general, the demographic and fiscal pressures re-emphasise the importance of tackling the determinants of world class healthcare set out in section 2.I above, including helping people to look after themselves better, and shifting care from hospitals and treatment, to community and prevention. In answer to our original question, **Can we afford to improve the service?** the answer is conditional: we can't afford it, if improvement means much more money. On the other hand, there are enough obvious inefficiencies in the current service to give some grounds for optimism. We await the detailed costings.

4. CONCLUSIONS

This paper set out to attempt some straight answers to some simple questions. On the basis of the evidence here – which is a summarised version of the evidence contained in the three accompanying papers – what can we conclude?

On Safety and Quality, the question was: **What's wrong with our current pattern of hospital services?** The answer is that in several respects key respects, our outcomes seem to be poorer than elsewhere. The reasons for this performance vary, and are not always clear. On the other hand, we can be reasonably sure that several of our service models (notably in major trauma, general emergency care, aspects of stroke care, some specialised surgery) are clearly well short of world class, and it would be reasonable to conclude that people are therefore suffering unnecessary disability and even death as a result.

On the Workforce, the question was: **We have more staff than ever before, so what is the problem?** The answer is that we have reached a precarious position with several key medical staff groups, and it is now possible to predict that services will have to be closed in an unplanned fashion in the near future if action is not taken immediately. We do not have sufficient senior staff where they are needed to ensure high quality care for all, and services which cannot recruit key staff are placed under considerable strain, and higher levels of risk. This situation has developed over time because we now demand more of our doctors, in particular, while their available clinical time is reducing and becoming increasingly specialised. Doctors in training are a key part of the service, but for some, their training is inadequate, and cannot continue. Many of these problems are common across the UK, and services everywhere have to respond in a similar fashion.

On Access, the question was: **Is poorer access inevitable to ensure good safety and quality?** The answer is that, in some cases, yes it is inevitable. But in most cases, there is a lot which can be done to reduce this problem – reducing the need for hospital care, using new technologies, improving non-emergency transport and access, and by improving the capacity of pre-hospital emergency care. The net effect of all these measures could be to improve access to the highest quality emergency care, and to confine the problems of remote hospitals to small numbers of people requiring highly specialised care, and to the most acute part of their 'pathway'.

And putting the elements together: **What's the case for change?** The case is really quite strong, in Wales as elsewhere in the UK, that some acute hospital services should now be reconfigured. There are both positive and negative aspects to this. On the positive side, Wales' hospitals could provide better care in some key respects, reducing the risk of unnecessary disability and even death. More negatively, the pressure on the availability of key medical staff in a small number of specialties is now so great that the collapse of some services is likely. The impact of re-configuration can often be mitigated, and there is also the potential of increasing access to emergency care for people across Wales, even in the most remote communities.

Through this review of the evidence, two themes recur. First, the evidence is seldom so unequivocal that the answer is immediately clear. It therefore requires interpretation and application to particular circumstances, and needs to be set in the context of the complex inter-dependencies which are typical of modern healthcare, both in hospital and outside. Second, health policy is usually about working out acceptable compromises between competing objectives – quality and safety, accessibility, cost.

Hence this paper – an attempt to present the non-specialist reader with a summary of what the evidence does support, so that he or she may make up their own mind.

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Health and Social Care Committee

HSC(4)-23-12 paper 1c

Consideration of recently published correspondence between Welsh Government officials and Professor Marcus Longley – Information from the Welsh NHS Confederation

16 July 2012

National Assembly for Wales Health and Social Care Committee
Submission of information from the Welsh NHS Confederation

The Welsh NHS Confederation represents the seven Local Health Boards and three NHS Trusts that make up the NHS in Wales. We are a membership organisation, with charitable status.

In November 2011, The Minister for Health and Social Services published 'Together for Health,' the Welsh Government's five-year vision for the NHS in Wales. Later that month, the Welsh NHS Confederation held its annual conference, on the theme of 'Transformational Change – what does it take.'

Throughout the course of this fourth National Assembly, since it came into being in May 2011, the Confederation has been unequivocal in its core message; that the NHS must change if it is to provide high-quality and safe services and if the people of Wales are to have the improved health and healthcare services they deserve.

Together with our members, we have always recognised that there are difficult and potentially unpopular decisions ahead. Indeed we have already seen vehement public opposition when Health Boards have outlined potential options – even before plans have been drawn up.

We also recognised that the NHS in Wales has a responsibility to explain what it needs to do and why, at the same time as demonstrating the remarkable improvements already made by shifting some services from hospitals into local communities and even people's own homes.

It is of vital importance that the public has access to clear and independent information. The overarching purpose of commissioning information from the Welsh Institute for Health and Social Care (WIHSC) was to have the existing evidence collected in one place in an attempt to promote discussions and to inform the debate. The research presented an overall picture of why the NHS in Wales needs to change.

In summary:

- The research was commissioned from WIHSC by the seven Health Board Chief Executives in NHS Wales.
- The National Director for Together for Health liaised with WIHSC on behalf of the Chief Executives to facilitate access to information, and to monitor delivery of the research.
- The National Director for Together for Health was appointed to co-ordinate activity across NHS Wales. The Director is based at Cardiff and Vale University Health Board.
- Following discussions between the Chief Executives at their regular Peer Group meetings (facilitated by the Welsh NHS Confederation), the Confederation circulated (on 21 December 2011) a proposed scoping paper for the research (prepared by WIHSC) to the Chief Executives for their feedback by 6 January 2012. (Attachment 1).
- Following that feedback, work commenced at a cost of £29,000. The invoice from WIHSC was paid by Cardiff and Vale University Health Board (host Board for the National Director) on behalf of the other Health Boards.
- The first twenty copies of the final printed summary document were ready for collection by the Welsh NHS Confederation on 23 April. Bulk printing for the engagement and communications activity was ordered on 25 April.
- The research report(s) 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence' was presented at a briefing for Assembly Members in Ty Hywel on Wednesday 9 May 2012. This was followed by a media briefing and a number of stakeholder meetings throughout Wales, in the following days and weeks.
- The publication of the final report, the response to it from the NHS in Wales and associated communications activity was co-ordinated by the Welsh NHS Confederation.

Conclusion

The report 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence' was commissioned by the NHS in Wales (specifically the Health Board Chief Executives through the National Director of Together for Health) to provide an independent overview of what the clinical evidence says about the best configuration for hospital services in Wales. Local Health Boards felt it was important that the public have ready access to clear and independent information to help them examine forthcoming service plans.

As Health Boards prepare to publish detailed options for healthcare services throughout Wales, it is even more important that information is readily available to the public as well as patients, their families and carers, and staff. This WIHSC piece of work, and its publication, represented a real and genuine attempt by Health Boards to inform a range of audiences and invite them to become involved in the debate.

At the Welsh NHS Confederation, we are deeply disappointed that the focus appears to have shifted from that important debate. The stark fact is that the NHS in Wales

has to change – something that is widely acknowledged in all quarters. The more authentic and well-informed the debate is about change, the better it will be for the future of healthcare services, and for the people of Wales.

From: Tegan Williams
Sent: 21 December 2011 15:21
To: All NHS Chief Executives
Subject: National case for Change

Prynhawn da, bawb.

Further to the Chief Executives' Peer Group meeting on Monday, I am pleased to forward to you the summary from Marcus Longley of the Welsh Institute for Health and Social Care on the proposed work around the national case for change. This sets out potential key headings – workforce, safety and access – on which the study will focus. The WIHSC team would be grateful for your comments by 6 January please (we can collate through the Welsh NHS Confederation here) as the timescale is quite tight.

In addition, to highlight the research, we are currently working on a programme of engagement with AMs/MPs which we expect to include a series of regional roundtable stakeholder events, a specific event for Assembly Members in Cardiff and 1-2-1 briefings with Opposition spokespeople and special advisers.

We look forward to receiving your feedback.

Cofion gorau – a Nadolig Llawen!

Helen

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THE NATIONAL CASE FOR CHANGE:
PROPOSED SCOPE OF DISCUSSION PAPERS AND ENGAGEMENT PROCESS

'Services best suited to Wales, but comparable with the best anywhere'.

1. Introduction

Two elements are proposed for this programme of work: a suite of discussion papers; and an engagement process (organised and facilitated by the Welsh NHS Confederation and WIHSC) to explore the material discussed in the papers, and other issues of interest. The purpose is to help provoke and inform a dispassionate and evidence-based discussion of the key issues relating to the national case for change, amongst both NHS staff and also external stakeholders (other statutory sector organisations, third sector, and interested 'lay' people, including elected representatives, media etc.). In this way, attention will be focused on principles and evidence, rather than the future of particular local elements of service provision. The discussion papers will provide a impartial and independent synthesis of the most important evidence relating to the key issues on which the national case for change hinges, and the engagement events will offer people an independently-facilitated, honest and structured opportunity to understand and challenge the evidence and arguments.

While the development of primary and community care services is an essential part of the future vision for the NHS and its strategies, the focus of this paper is primarily concerned with the changes affecting the future hospital infrastructure in Wales.

2. The Synthesis Framework

The framework used for the synthesis will bring together:

a) The range of the clinical and diagnostic services and the overall related proposals and implications that are central to the case for change
b) The key issues that are agreed as fundamental to the case for change: the workforce, quality and safety, access and sustainability
c) The context in which service change will be designed: current Welsh Government vision, strategy, policy and the health care standards that are a core requirement in the management and delivery of health care and relevant to the key issues that are the focus of this discussion paper.
d) The evidence with which to support the national case for change and on which to base the discussion within this paper including: current service and associated data, literature, best practice and service reviews, Inspector and Regulator Reports.

3. Scope of the discussion papers

Four discussion papers are proposed, to address the following:

Overview Paper

Using the framework set out above, this first paper will provide an overview of all the issues which are driving change, and briefly rehearse the main evidence. It will be accompanied by three other papers which will each explore one key issue in more depth:

The Workforce

Getting the right people with the right skills and competences in the right place at the right time:

- Consider current numbers (in post, vacancies, recruitment), longer-term trends, future projections.
- Overall review of the factors relevant to ensuring that the professional staff groups have the skills they need to work in a complex, changing NHS: team working, flexible working, streamlined workforce planning and development, maximizing the contribution of all staff to patient care, education and training, developing new and more flexible careers, developing the workforce to meet future demands.
- Review of the particular issues relating to the recruitment, training, deployment and retention of the medical workforce.
- Conclusions for discussion.

Safety

Will – we must want to improve; Ideas – we must know what to try; and Execution – we must know how to change. (Berwick, 2003 and Nolan, 2007).

- The clinical case for change: critical mass, range and depth of cover, clinical integration, scale of risk, etc.
- Clinical evidence base and Wales' overall performance.
- Conformance with clinical, professional and service standards.
- Evidence of best practice.
- Evidence of benefits/disbenefits of service change and rationalization.
- Conclusions for discussion

Access

Getting people to services or services to people.

- Access to secondary care including emergency, unscheduled and elective care including tertiary care and cross border services.
- Waiting times.
- Outreach - where and how services can be brought closer to local people when it is safe to do so.
- Use of new technology e-health, telemedicine and telecare - bringing services and information closer to people.
- Emergency and non-emergency transport.
- Conclusions for discussion.

Issues of Sustainability will be considered in each of the papers.

Professor Marcus Longley, Director, and Michael Ponton, Senior Fellow
Welsh Institute for Health and Social Care, University of Glamrogan

Food Hygiene Rating (Wales) Bill
Evidence from the Association of Convenience Stores

1. ACS (the Association of Convenience Stores) welcomes the opportunity to provide evidence to the Committee. ACS represents 33,500 local shops across the UK, the vast majority of which sell food products and are subject to food hygiene regulations. ACS recognises the importance of food hygiene regulations which prevent the contamination of food and the spread of disease, and continues to provide information and advice to members on this important area of the law.

2. However, ACS believes that these important measures must be proportionally implemented. New regulations should only be introduced in cases where there is clear public risk to customers, or where the outcomes justify the additional burden being placed on the food industry.

3. ACS outlines below the key reasons we do not believe it is necessary to introduce a compulsory Food Hygiene Rating Scheme (FHRS), which would create additional regulatory burden at a time when central Government is committed to reducing the amount of red tape faced by business.

Aim of the Bill

4. The consultation document on the draft Bill stated that the aim of the Bill is to reduce incidence of food-borne illness. However the Bill does not propose any measures which will strengthen food hygiene standards in stores. The Bill focuses on achieving two aims, firstly to create a compulsory FHRS, and secondly to require all food businesses to display their rating.

5. ACS argues that a compulsory scheme is unnecessary as the consultation's own Regulatory Impact Assessment (RIA) highlights that the current voluntary scheme is being operated by all 22 Local Authorities in Wales. As the current scheme has universal coverage, and there is no suggestion that any Authorities plan to withdraw from the scheme, further regulation is not required to achieve this aim.

6. The primary focus of the Bill, therefore, is to require premises to display their Food Hygiene Rating, in order to ensure customers have equal access to information and are better informed. While we understand the aim, this will not have any direct impact on the stated aim to reduce incidence of food-borne illness.

7. As a result, the estimated cost of £225,000 per year for the sector appears to be a disproportionate burden on businesses during what are already difficult economic times.

Impact on small firms

8. The consultation's own RIA acknowledged that this financial burden will be felt significantly more by small firms, many of whom may already be struggling due to the current economic climate. Much of the cost of the scheme will come from the reassessment of business ratings in cases where improvement works have been carried

out, or where ownership and food preparation and handling practices have been changed. While larger stores can more easily absorb these costs, for small businesses such fixed costs can signify a much greater hurdle. The result would be that larger stores would be able to afford to obtain and promote their newer ratings, which could constitute a commercial advantage over their smaller competitors.

Practical application

9. There are also likely to be practical considerations which would limit the intended result, even if the Bill were to be passed. The Bill states that a sticker showing the Food Hygiene Rating must be displayed in a prescribed location on the premises where it would be visible to customers. Due to the nature of some food businesses, this could prove problematic.

10. For shops, the key issue would be where the 'prescribed location' would be sited, and how prominent it must be. Convenience retailing involves the sale of many highly regulated products, most notably alcohol and tobacco. As a result, there is already a plethora of signage at the point of sale and throughout stores, from information highlighting that it is illegal to sell restricted products to those below the age of 18, to information on schemes such as Challenge 25, and educational material to promote how many units are in your drink.

11. While it may appear straight forward to require information to be publicly displayed, there is a real risk of the message getting lost amongst the existing signage, or worse, diluting the messages of the existing material displayed in store.

12. For these reasons, ACS does not believe that the Bill will be able to achieve its aims, and will instead place an unnecessary burden on convenience store retailers in Wales.

Alternative options

13. ACS believes there may be other solutions which should be explored before legislation is introduced. As the issue is predominantly the availability and use of Food Hygiene Ratings, the role of Government, Local Authorities, and the potential role of technology should be considered as a means of increasing the flow of information.

14. The Welsh Assembly or Local Authorities could maintain and distribute information on local amenities and their ratings as part of existing communications (such as tourism information). Technology could also play a role in making this information more accessible, through means such as mobile phone applications, which are able to identify local premises, and could include information as to their Food Hygiene Rating.

15. These measures are indicative of potential alternative solutions which would not place an additional regulatory or financial burden on the food industry in Wales.

The Draft Bill

17. Despite opposing the introduction of the Bill, ACS aims to also provide constructive comment on the proposed Draft Bill, in order to minimise the extent of the burden to the food industry should the Bill be enacted.

18. ACS outlines below a number of areas we feel would require improvement should the Bill be formally adopted.

Resourcing

19. The Bill makes no provision for additional resourcing. Local Authorities have assessed 13,500 premises to date, since the voluntary scheme came in in October 2010. In order to roll out this scheme to all 30,000 premises, and to ensure that all would be rated within a reasonable time and on a regular basis, ACS believes additional resources would be required. Without this, there is concern that re-ratings, which would provide a revenue stream for Local Authorities, could be prioritised over the day to day needs of businesses.

20. In order to ease the burden while the scheme was being rolled out, ACS believes a phased roll-out may also be appropriate. This would start with high priority establishments such as schools and hospitals, moving down to butchers, restaurants, stores etc. as appropriate. A phased roll-out would ease the pressure on resources and mean that the highest priority premises were covered as soon as possible.

Training of Food Authority (FA) officers

21. ACS is concerned of reports of inconsistencies in the application of the existing voluntary scheme, even within the same FA. ACS believes the Bill should contain a requirement for all officers receive standardised training, which would continue at suitable intervals during their employment. A sample of ratings should also be independently reviewed on an annual basis to ensure standards are applied consistently across the scheme.

Rating system and the need for public education

22. Members have expressed some concerns over the public understanding of Food Hygiene ratings. Customers who are not familiar with the ratings may consider that ratings reflect the public health risk of premises, rather than an officers view of legal compliance. The ratings also do not reflect the varying levels of risk between a small retail store compared to a busy high risk food restaurant or takeaway.

23. ACS believes that further work should be carried out to ensure the scoring criteria take account of these factors, and that the Welsh Government and Local Authorities should work together to create and provide materials to educate the public as to the meaning of the ratings.

Publication of inspection report summaries

24. ACS believes that inspection report summaries should only be published on condition that this would not further increase the costs and burden of this regulation on businesses.

Display of invalid stickers

25. The Bill would make it an offence to display an invalid Food Hygiene Rating sticker, however does not state how it could be identified as invalid. Would stickers carry an

expiry date, or date of next inspection? If not, administrative or postal errors could result in businesses inadvertently failing to comply with the regulations. Without a means of identifying invalid stickers, the public would also have no way of knowing if the rating displayed was still genuine or how old it was.

Right to reply

26. ACS does not believe comments made under the right to reply terms should only be made available on the FSA website. This information is an explanation by the business of any and all relevant circumstances at the time the assessment was carried out.

27. The consultation's underlying assumption is that simply publishing information online is not an adequate means of ensuring customers have access, hence the proposed requirement for the display of Food Hygiene Ratings at all premises. ACS believes that, if this logic is to hold, it must also apply to ensuring customers have access to all relevant information, including that contained in the right to reply.

28. ACS therefore believes that retailers should be permitted to display this additional information alongside their rating in store, and Local Authorities should be required to include this information as part of any publication of Food Hygiene Ratings.

Re-rating inspections

29. The consultation does not state how Local Authorities will determine whether it is 'reasonable' to conduct a reassessment of premises, or how they would calculate what the 'reasonable costs' are to be incurred for that inspection. Clear guidance would be required to ensure a consistent approach was adopted across all Local Authorities, and clear criteria, or a set fee, should be introduced so businesses are aware up front of how much the process may cost them.

30. The consultation also makes reference to the possibility of some premises, such as schools and hospitals, being exempt from re-rating costs. If this were to be introduced, safeguards must be put in place to ensure that these costs were not passed on to the rest of the food sector.

Power of entry

31. ACS agrees that FAs need power of entry to ensure compliance with food hygiene and safety standards. However, as such visits often cause disruption, premises should be given time to implement plans to minimise the impact on their business.

32. ACS therefore believes that regulations should include a requirement on FAs for prior notification of visits, except in cases where an imminent risk of harm has been identified.

Offence by body corporate

33. The Bill also states that, where a business is run by a corporate body, an individual within the premises will also be liable under the proposed regulations. Clarity is needed over how the individual would be identified as being liable, for example whether it would be a store manager, a health and safety officer, or store assistant who had accidentally removed information from display? This information would be needed for in store training as well as for clarity on individual responsibilities under the Bill.

27 June 2012

Health and Social Care Committee of the National Assembly for Wales

Consultation on the Food Hygiene Rating (Wales) Bill

Introduction

The British Beer and Pub Association (BBPA), is the leading trade association representing the interests of over half of the 52,000 pubs in the UK. There are 52,000 public houses in the UK, of which 3,200 are in Wales. Nationally, the pub sector contributes over £19bn to the economy, representing 2% of GDP and employing almost 600,000 people in full and part-time jobs. Pubs are vital to our economy, at the heart of our communities, and are central to society. We are an industry with the potential to create many more much-needed jobs and investment throughout the country. However, in order to do this we need a tax and regulatory regime that supports our sector.

Only 10% or so of the 3,200 pubs in Wales are branded or chain outlets operated by a parent company. The pub sector provides 32,000 direct jobs in Wales, with 46,000 direct and indirect jobs being supported overall by the beer and pub sector. Since the vast majority of catering businesses, including pubs, are small, independent businesses, we believe the costs of introducing a mandatory food hygiene rating scheme will fall disproportionately on SMEs, inhibiting their ability to create new employment opportunities and much needed economic growth.

The Association has devoted significant resources and expertise to assist in the development of a voluntary national scheme that has been agreed and successfully implemented across England and Wales. Additional regulatory burdens will have a debilitating effect on Welsh food businesses which will place them at an economic disadvantage to their counterparts in other regions of the UK.

We welcome this opportunity to respond to the questions raised by the Health and Social Care Committee of the National Assembly for Wales below and hope that our views will be taken into account.

British Beer & Pub Association, Brewers Hall, Aldermanbury Square, London EC2V 7HR. 020 7627 9199

Consultation Questions

BBPA Response

General

1. Is there a need for a Bill to introduce a statutory food hygiene rating scheme in Wales? Please explain your answer.

The BBPA is a member of the FSA Food Hygiene Rating Scheme Steering Group, which has overseen the development of the national scheme over the last three years, and has been instrumental in ensuring local authority and business acceptance of the voluntary national scheme. We are very disappointed, therefore, that the Welsh Government is proposing to introduce the Food Hygiene Rating (Wales) Bill which will inevitably place additional bureaucracy and cost on small pub businesses in Wales, at a time when the scheme is just beginning to gain national recognition and credibility. We do not, therefore, believe that there is any need for a successful voluntary initiative such as the national voluntary Food Hygiene Rating Scheme to be made compulsory in Wales or any other part of the UK. The voluntary national scheme was only launched on 30th November 2010, and we would much prefer that it is given sufficient time to become established, and that some form of national evaluation of its impact is carried out before any consideration is given to introducing the scheme on a statutory basis in any part of the UK.

The proposals will also place a significant cost burden on pubs and other catering businesses, the vast majority of which are SMEs, which we believe is out of step with the UK Government's overall commitment to reducing burdens on business. The BBPA and the BHA were recently successful in opposing proposals for the compulsory display of ratings from the London (Local Authorities) Bill. Parliament, by rejecting the provisions of this Bill, signified its firm support for the voluntary display of hygiene ratings.

The Welsh Government consultation earlier this year suggested that a mandatory Food Hygiene Rating Scheme would help to avoid serious food poisoning incidents in the future. While we recognise the devastating impact of the outbreaks of E.coli O157 in Wales in 2005 and E.coli O104 in Germany last year, it is clear, contrary to the suggestion in the consultation, that the display of food hygiene ratings in catering businesses would not have prevented either of these. The source in the case of the Welsh outbreak was identified as a butcher (already operating under a licensing scheme) who was ultimately responsible for supplying contaminated meat, and in Germany, an organic vegetable farm was pinpointed as the origin of the problem. The food hygiene rating in a restaurant relates purely to compliance with food hygiene legislation and represents a "snapshot" based on an inspection at a given moment in time, and in neither case would hygiene ratings of restaurants have prevented the outbreaks and their consequences.

2. Do you think the Bill, as drafted, delivers the stated objectives as set out in the Explanatory Memorandum? Please explain your answer.

While we accept that it is not the Welsh Government's intention to depart significantly from the FSA Scheme in establishing a statutory food hygiene rating scheme for Wales, unfortunately the Bill will introduce additional requirements and mechanisms which do not form part of the voluntary national scheme.

Once legislation is introduced, then it will also be possible in the future to adapt the scheme further, which would cause further issues for businesses, particularly those operating across borders, and could also give rise to confusion amongst consumers. In our response to the Welsh Government's consultation earlier this year, we requested that should a statutory food hygiene rating scheme be introduced in Wales, that it should be in accordance with the requirements of the voluntary national scheme, to avoid imposing additional burdens on businesses and local authorities.

3. Are the sections of the Bill appropriate in terms of introducing a statutory food hygiene rating scheme in Wales? If not, how does the Bill to need to change?

We welcome a number of the amendments which have been made to the Bill following the public consultation, particularly with regard to the timescales for appeals and the clarification of the provisions relating to the right to reply. However, overall, the proposals will still create additional bureaucracy, penalties and costs for businesses.

We remain concerned about the following sections of the Bill in particular, which we also highlighted in our response to the Welsh Government:

1 - Overview

We do not support Clause 1(6) and Clause 1(7) in particular since these requirements depart from the national scheme and will create burdens on businesses, which we simply do not believe are necessary. We would prefer that the national voluntary scheme is given sufficient time to become established, and that some form of national evaluation of its impact is carried out before any consideration is given to introducing the scheme on a statutory basis. While we support the scheme itself, and in the interests of consistency, would accept that it could be made compulsory across local authorities in Wales, we believe that it would be better to retain the flexibility for businesses with regard to display of the signage and avoid imposing unnecessary burdens.

Technology is also constantly moving on, and the assumption in the Explanatory Memorandum is short sighted, as it does not appear to recognise that the situation with regard to internet usage and access to smart phones will be very different in just a few years time, even among those aged over 65, and that the web-based ratings will be even more widely available. This is not, in our view, sound evidence upon which to introduce a statutory requirement affecting over 3,000 pub businesses in Wales, which will have a lasting effect.

4 – Rating Criteria

We believe that the rating criteria and the scoring system should be a matter for guidance rather than primary or secondary legislation. A consistent approach to rating, as detailed in the FSA brand standard for the national scheme, is crucial to ensuring fair treatment for businesses and securing the credibility of the scheme. Prior to the development of the national brand standard, businesses were subject to inconsistent inspection criteria, which were not based on legal compliance with food hygiene law, but went beyond this to include a level of good practice which many smaller businesses were simply unable to achieve and which precluded them from achieving the top rating, even though they were legally compliant. The Food Hygiene Rating Scheme must remain a legal compliance scheme, and the Bill should reflect this and not introduce any scope to depart from this approach and gold-plate existing legislation.

7 – Requirement to display food hygiene rating stickers

As stated above, we do not support any mandatory requirement for the display of the FHRS sticker. We believe that it would be better to retain the flexibility for businesses with regard to display of the signage and avoid imposing unnecessary burdens. In our view, the level of display of the FHRS stickers nationally has made good progress considering the relatively short time that the scheme has been running (since November 2010), and especially as a significant number of local authorities (including London Boroughs) have only agreed to come on board with the national scheme in recent months, following an arrangement between the FSA and Transparency Data on the website platform for ratings. We were confident that the overall percentages for signage display would have increased over the coming months due to this important development.

As with any voluntary system, it is inevitably that not everyone will join in; in this case not all businesses will choose to display their rating, especially if it is below three stars. Feedback from our membership suggests that even companies achieving the top rating choose not to display the score for various reasons, not least because there are a number of other signs and stickers that are also jostling for priority space in pubs, such as National Pubwatch stickers, Unit Awareness Information, Best Bar None, local or national food awards, Good Beer Guide, BII etc). Sometimes, there are also aesthetic reasons for not displaying the stickers, as the design of the stickers does not always sit well with corporate branding.

However, the fact that the food hygiene ratings now reflect legal compliance rather than gold plating food hygiene law has meant that businesses have been increasingly happy to display their scores, and this will continue to grow over time.

Another relevant factor is that the voluntary FHRS in England and Wales is more complex in structure due to the six rating tiers compared to Scotland where there is a simpler approach which means businesses either pass their inspection or are rated as “improvement required”. While a requirement to display the stickers would not have a detrimental effect on those venues achieving a three, four or five star rating, previous consumer research by the Food Standards Agency has indicated that those venues with ratings of less than three stars could see a dramatic fall in custom, despite the fact that they are still compliant with food hygiene law, but could improve overall practice. The mandatory requirement will force such businesses to display their rating and as a result they could potentially lose trade, even though they are still legally compliant. Where a food business is not compliant with food hygiene law and poses a danger to public health, enforcement officers should, of course, close that outlet down.

In our view, in the event of a statutory scheme being introduced in Wales or in any of the UK regions, serious consideration should be given to legislating along the lines of the Scottish model which is simpler and fairer for both businesses and consumers.

The Association successfully petitioned against the proposals contained in the recent 10th London Local Authorities Bill which proposed the compulsory display of food hygiene ratings, on the grounds that this would create further legislative burdens on businesses which would undermine the efforts of the Food Standards Agency to reduce such burdens as part of its Simplification Plan,

and pre-empt the development of the voluntary national scheme. The House of Commons Committee supported our position, removing the requirement from the Bill.

We firmly believe that it is unacceptable to seek to codify something in law which is in need of further refinement and has not, as yet, been subject to proper evaluation. We remain concerned that the Welsh Government's proposals will result in enforcement efforts being diverted away from promoting good standards of compliance with food hygiene law, with enforcement officers focusing instead on the minutiae of valid stickers being properly displayed.

9 – Offences

We remain concerned about the creation of unnecessary bureaucracy and burdens on catering businesses such as the introduction of the proposed offences under law for failing to display valid food hygiene rating stickers, in the right place etc. These are minor failings, best dealt with by a good enforcement regime and dialogue with businesses. We are also disappointed that an additional offence has been introduced for failing to comply with a request by a person to be informed verbally of the food hygiene rating.

It is not clear how this would be enforced, and it also has the potential to be anecdotal and therefore difficult to prove. It could put operators at risk of vexatious or fictitious claims against them which they would equally find difficult to defend.

The removal of the requirement for businesses to display the stickers would negate the need to create a range of offences and fines, which ultimately will place unnecessary administrative and financial burdens on businesses.

12 – Payment of the costs of re-rating

This was not proposed by the Food Standards Agency (FSA) in its original consultation on "Scores on the Doors" in 2008 and the issue is still under discussion with the FSA in respect of the national voluntary scheme. The FSA has developed a robust national framework in the interests of consistency and transparency of operation and we do not think that the Bill should be going beyond the parameters set by the national scheme in this respect.

We have previously suggested to the FSA that it should provide guidance to local authorities setting out the circumstances in which re-inspections, re-visits, and documentary evidence would generally be acceptable.

In the absence of any legal framework, local authorities are able to retain an element of discretion to extend this to circumstances not specified in any guidance from the Agency. A mandatory food hygiene rating scheme in Wales will undermine the voluntary national scheme and leave no room for local discretion on the part of local authorities.

19 – Penalties

We remain very much opposed to the introduction of fines for what are essentially minor misdemeanors involving the display of food hygiene rating stickers.

A Level 3 fine (£1,000) is excessive in view of the type of offences outlined in Clause 9, and we suggest that a maximum fine at Level 1 (£200) would be a sufficient deterrent for catering businesses, the vast majority of which are SMEs. It appears that the proposals have taken the current position in relation to the display of smoking signage as its benchmark. The BBPA has always maintained that the penalties in respect to failing to display the correct "No Smoking" signage are too high, and indeed questioned the need to require this signage once the legislation was firmly established. Following the Government's "Red Tape Challenge" last year, we are delighted that the Government is now reviewing the need for "No Smoking" signage, and we are hopeful that this particular burden, and the related penalties, will be repealed. It follows, therefore, that the existing rules around "No Smoking" signage are not a suitable template for these penalties.

20 – Fixed penalties

We do not support the introduction of Fixed Penalty Notices (FPNs) and comment further on this issue in relation to the Schedule to the Bill (below).

21 – Use of fixed penalty receipts

We do not support the provision that, in the event of FPNs being introduced, the receipts should be paid to the Welsh Ministers to retain for the improvement of food hygiene in Wales. We do not think this would be the most efficient use of funds, and would prefer the Bill to allow receipts to be retained by local authorities in order to focus locally on those premises which would benefit from more intensive support.

Schedule (Section 20) – Fixed Penalty Notices

As stated above, we do not support the introduction of FPNs, but in the event that they are introduced, we do not support the proposed fine of £200, with a discounted penalty of £150 if the FPN is paid within a certain period.

This is far too high, given the nature of the offences it will cover. Current FPNs for traffic offences such as speeding, traffic light contraventions, failing to comply with yellow box junctions and no right/left turns, are £60 plus three points on the driving licence of the individual concerned. These offences are more serious than the failure to display a sticker, and yet the fine is much less. Similarly, FPNs for disorder are currently set at £50 for lower tier offences and £80 for higher tier offences. Again, we would argue that these cover more serious offences, but attract a lower rate. Parents who fail to ensure their child attends school regularly can be issued with FPNs for truancy which range from £50 to £100.

Again, the reference point for the FPN level is probably the offences related to "No Smoking" signage, but as we have pointed out above, this is not appropriate as the Government is currently committed to reviewing this in the light of its drive to reduce burdens on business.

In the event FPNs are introduced, then we suggest that they should be in the region of £50 with a reduction of 25% for early payment. If they are set any higher than this, then early payment should reduce the fine by 50%, as is the case with parking fines for example.

4. **How will the proposed Measure change what organisations do currently and what impact will such changes have, if any?**

As previously stated, businesses which do not currently display the FHRS stickers will need to do so, and, as far as pubs are concerned, may have to do so at the expense of displaying signage for other initiatives. Businesses will have to manage the display of the sticker, ie. ensure that it is displayed and has not fallen down, that it is in date, properly visible and so on. In the event of issues arising with managed venues, companies may also need to provide additional staff training and introduce disciplinary procedures in the event of offences being committed at unit level. Again, as referred to above, those businesses with lower ratings will be forced to display their stickers and may suffer detriment to trade, despite still being compliant with food hygiene legislation.

5. **What are the potential barriers to implementing the provisions of the Bill (if any) and does the Bill take account of them?**

The Food Standards Agency considered a report on the "Food Hygiene Rating Scheme and Food Hygiene Information Scheme – increasing provision of information to consumers on the hygiene standards of food premises" at its open meeting on Tuesday 22 May, and agreed that:

- a mandatory approach to display of ratings/inspection results will strengthen the FHRS and FHIS and increase their potential to improve public health protection; and
- the FSA, in consultation with other relevant Government Departments and with stakeholders, should assess the impact of introducing parallel legislation to give a statutory basis to the FHRS/ FHIS in England, Northern Ireland and Scotland once local authority uptake of the schemes is complete.

We believe it would be sensible for the Food Hygiene Rating (Wales) Bill to be part of this overall review, in order to ensure a co-ordinated approach to the introduction of any resulting legislation which will safeguard the consistency of the national scheme.

The Association believes it is essential that the Welsh Assembly consider the potential burdens on the tens of thousands of small catering businesses that the introduction of a statutory FHRS will impose, in the context of the Government's public commitment to reduce such burdens following the "Red Tape Challenge" last year. In the event that legislation is introduced, then consideration must also be given to removing burdens elsewhere, as part of the "one in, one out" principle.

Powers to make subordinate legislation

6. **What are your views on powers in the Bill for Welsh Ministers to make subordinate legislation (i.e. statutory instruments, including regulations, orders and directions)?**

British Beer & Pub Association, Brewers' Hall, Aldermanbury Square, London, EC2V 7HR. 020 7627 9199

Notwithstanding our concerns about the Bill per se, we agree with the powers in the Bill enabling secondary legislation. We remain concerned about any amendment of the definition of "food business establishment" (Clause 2(6)(a)) as explained above.

Financial Implications

7. What are your views on the financial implications of the Bill?

The Association does not agree with the preferred Option 4 as detailed in Regulatory Impact Assessment, contained in Part 2 of the Explanatory Memorandum, and remains opposed to proposals to introduce a mandatory food hygiene rating scheme in Wales. We believe that this will undermine the voluntary national scheme, which has been developed by the Food Standards Agency in collaboration with local authorities and business representatives, including ourselves.

The voluntary national scheme has been the positive result of a successful partnership, resulting in an initiative which has wide ranging support, even from local authorities who had initially wanted to continue with their own "scores on the doors" schemes. The fact that the food hygiene ratings now reflect legal compliance rather than gold plating food hygiene law has meant that businesses are increasingly happy to display their scores.

Our preference is for Option 2, which we believe would drive up food hygiene standards, as this would become a point on which businesses would have to compete more than they do currently. Much more could be done to raise consumer awareness of the purpose of food hygiene ratings, as we believe that there is still a tendency on the part of some consumers to confuse the ratings with "quality" as opposed to legal compliance with food hygiene law. We would certainly like to see more work done on consumer understanding of the scheme. The aims of Consumer Focus Wales could also be met through greater consumer awareness of the voluntary national scheme, increasing the demand for food hygiene ratings to be displayed at premises.

The original consultation on the RIA stated in paragraph 22 that of the 13,500 food businesses in Wales which have a food hygiene rating, 3,000 have a score of less than "3" and are therefore less likely to be displaying their scores. This is just 22% of the total number of businesses. It should be possible to target this minority and work with them to raise their food hygiene standards to a level where they would be happy to display their score voluntarily. Where businesses have received higher scores but have not displayed them, there is no consumer detriment which would justify the introduction of mandatory display of food hygiene ratings. We are concerned that a Bill of this nature has been introduced to target an increasing minority of premises.

Compared with the current voluntary national scheme which is working well, we are naturally concerned at the imposition of any costs as a result of these proposals. It is difficult to assess whether the projected £690,000 for re-visits (Summary Table of additional costs of Option 4) is an

accurate assessment of the costs on food businesses, the vast majority of which are SMEs, but it is clear that business is shouldering half of the overall costs, the remainder being shared across local authorities, the FSA and the Welsh Government. We would suggest that these are costs that could be avoided in the spirit of the Government's commitment to reducing costs on businesses.

The RIA does not appear to take into account the costs of the associated bureaucracy that will also be introduced as a result of a mandatory food hygiene rating scheme in order to avoid committing an offence and receiving the associated penalty.

This will require businesses to monitor the state of their stickers to ensure their display remains valid, to put measures in place to raise staff awareness and introduce structures for possible disciplinary action. These additional burdens are difficult to quantify, but exist nonetheless.

Other comments

8. Are there any other comments you wish to make about specific sections of the Bill?

We would take this opportunity to make additional comments about the following sections of the Bill:

2 – Programme of food hygiene inspections

We understand the rationale behind the decision to include businesses that supply food to other businesses within the scope of the scheme, but would take this opportunity to repeat our original observation that in many cases these will already governed by other legislation requiring high standards of hygiene, such as the licensing regime for butchers for example.

We do not support the proposal in Clause 2(8)(a) which would allow for definitions of "a food business establishment" to be altered, since this has the potential to lead to further divergence between the voluntary national scheme and the statutory Welsh scheme which would not be helpful to either business or consumers.

13 – Duties of the Food Standards Agency

We note the requirement for a formal evaluation of the FHRS within three years of the commencement of the scheme, and subsequently every three years. We would reiterate our concern that such a formal evaluation of the voluntary national scheme should have been carried out prior to the consideration of any statutory requirement.

16 – Power of entry

We question the need for this clause. The food hygiene rating is ultimately the outcome of a food hygiene inspection, which is facilitated under existing food hygiene law. There should be no need for any separate power in this Bill to enable enforcement officers to enter food business establishments for the purpose of producing a food hygiene rating or re-rating (the latter being likely to have been requested by the food business in the first

place). We are concerned, therefore, that the inclusion of these requirements risk gold-plating existing requirements.

17 – Obstruction of authorised officers

18 – Offences by bodies corporate

We reiterate our concerns about potentially gold-plating existing legislation, as per Clause 16 above.

BBPA/RK
28.06.12

British Hospitality Association response the consultation on the Food Hygiene Rating (Wales) Bill

About the British Hospitality Association (BHA)

The British Hospitality Association represents the hotel, restaurant and catering industry, which employs 112,000 people directly and contributes £1.88 billion in annual gross value added (wages and profits) in Wales (*Source: Oxford Economics 2011*). The BHA Wales Committee brings together our members to represent their views to the National Assembly and the Welsh Government.

Introduction

The BHA has made a significant contribution to the development of the National Food Hygiene Rating Scheme through membership of the FSA national Steering Group and the various working groups which developed the scheme. We were also instrumental in the development of the Food Hygiene Information scheme in Scotland and have clearly stated on many occasions that we would have preferred a UK wide scheme which would be simple for consumers to understand and preferably based on the Scottish scheme. We recognised the FSA Board decision to develop a six tier scheme and therefore decided to assist its development and part of our consideration was that there would be a brand standard for the scheme which would be imposed on all participating Local Authorities in an effort to produce a consistent approach. We therefore do not see how the proposals in the Food Hygiene Rating (Wales) Bill will add value to the scheme and indeed are likely to result create confusion for businesses with associated added costs and potentially confusion for consumers.

1 Is there a need for a Bill to introduce a statutory food hygiene rating scheme in Wales? Please explain your answer.

We do not believe that there is a need for a statutory Food Hygiene Rating Scheme in Wales because:

1.1 The voluntary Food Hygiene Rating Scheme in Wales has not been given sufficient time to settle down since its introduction in October 2010. Many operators who have by now received scores 3 and above will be happy to display their scores as research indicates that 3 and above is where consumers are happy to eat. There are however significant differences in the rating scores between England Wales and Northern Ireland as follows:

Wales-**30%** of premises rated 0,1,2,
Northern Ireland- **9%** of premises rated 0,1,2,
England- **15%** of premises rated 0,1,2, (Source FSA Board Paper 12/05/04)

This suggests significant inconsistency in the way the schemes are being administered.

1.2 A major justification for compulsory display is claimed to be the opinion poll from Consumer Focus Wales, indicating that 94 per cent of consumers want to see FHRS scores displayed compulsorily. However, the research failed to ask the preliminary question: do you understand the ratings? Since only 50 per cent of respondents had even heard of the scheme, then 44 per cent were asking for something they had never heard of. Even if they were among the 50 per cent who had heard of the scheme, we suspect that very few will understand the significance of the scoring system, beyond the point made above that consumers will intuitively be happy to eat if the score is 3 or abovee

2. Do you think the Bill, as drafted, delivers the stated objectives as set out in the Explanatory Memorandum? Please explain your answer.

2.1 The local authorities in Wales are already operating the FSA National Food hygiene rating scheme and have been provided with funding by the FSA to implement the scheme. In addition the FSA in Wales carries out audits of Local authorities to ensure that they are carrying out their functions in relation to enforcement of food safety legislation in a competent manner. Therefore in our opinion there is no need for a statutory scheme in Wales and the Bill can only be seen as over Regulation.

3. Are the sections of the Bill appropriate in terms of introducing a statutory food hygiene rating scheme in Wales? If not, how does the Bill to need to change?

3.1 While we welcome some of the changes which have been made to the Bill following the consultation we do however believe that there should be any variation in Wales whatsoever from the FHRS branded scheme which has been developed by the FSA and the UK Steering Group which covers issues such as re inspection, appeals, scoring, application to food premises etc. Any variation will add to the costs of multi-site businesses that operate not only in Wales but also England and will cause confusion for consumers who have had to deal with a plethora of different schemes run by local authorities.

3.2 The proposal to extend the Food Hygiene Rating Scheme to businesses who supply food to other businesses but not directly to the consumer is not part of the FSA scheme and therefore in our view conflicts with the stated aim of the Bill which is to inform consumers about the hygiene standards of the premises they visit.

3.3 In particular we do not agree with Clauses 1(6) and 1(7) which introduce the statutory requirements those food businesses must inform members of the public of the food hygiene rating and to display stickers as these requirements fall outside the FSA scheme. In deed there are practical difficulties in some premises which have more than one entrance e.g. a hotel may have a separate entrance to a banqueting room to that of the restaurant or it may have a main external entrance (maybe 2) and the internal entrance to the restaurant. Some quick service restaurants have a restaurant and often a drive through. In our view food businesses should be provided with a sticker but then given flexibility where or whether they display that sticker. The requirement for verbal information with respect to the Food hygiene rating to be provided creates an unnecessary burden on businesses in ensuring that every member of staff has all the relevant information and will be difficult to enforce for local authorities. There is potential for time consuming investigations of frivolous complaints.

3.4 The payment of costs for re-rating in our opinion is an unnecessary burden on small businesses. Businesses should be encouraged to improve by working with the local authority Environmental Health Officer and the introduction of payments could result in a change to the relationship between the business and the EHO.

3.5 We oppose the introduction of fines for failure to display Food hygiene rating stickers and believe that the proposal for a level 3 fine is excessive. If such a fine is to be imposed then a level 1 fine should be the maximum. Similarly we believe that the level of fixed penalty notices is far too high for this offence and suggest a lower amount e.g. £50 with a discount of 25% for early payment.

4. How will the proposed Measure change what organisations do currently and what impact will such changes have, if any?

4.1 There will be an increases in costs for businesses with respect to the management of display of Food Hygiene Rating Stickers i.e. ensuring that the sticker is permanently on display, in date, and properly visible.

5. What are the potential barriers to implementing the provisions of the Bill (if any) and does the Bill take account of them?

5.1 The Food Standards agency has recently agreed to carry out an assessment of the impact of introducing parallel legislation in England, Scotland and Northern Ireland with respect to introducing a mandatory approach to the display of Food hygiene ratings and we believe that the Food Hygiene Rating (Wales) Bill should be included in that assessment to ensure consistency with the national scheme.

5.2 The commitment by the Government to reduce the burden of regulation following the "Red Tape Challenge" should be considered by the Welsh Assembly Government and therefore if the Bill is to be made law in Wales then the removal of a burden on small businesses on the basis of "one in, one out" should be introduced.

Powers to make subordinate legislation

6. What are your views on powers in the Bill for Welsh Ministers to make subordinate legislation (i.e. statutory instruments, including regulations, orders and directions)? In answering this question, you may wish to consider Section 5 of the Explanatory Memorandum, which contains a table summarising the powers delegated to Welsh Ministers in the Bill to make orders and regulations, etc.

6.1 We have no concerns about the powers to make subordinate legislation which are appropriate.

Financial Implications

7. What are your views on the financial implications of the Bill? In answering this question you may wish to consider Part 2 of the Explanatory Memorandum (the Regulatory Impact Assessment), which estimates the costs and benefits of implementation of the Bill.

7.1 We believe that the voluntary scheme has had a positive effect on businesses and that the competitive nature of business means that many businesses will wish to display ratings as consumers become increasingly aware of the scheme. The our preferred option as decribed in the Regulatory Impact Assessment would be "option 2 " We would support moré action in raising awareness of consumers to the voluntary scheme.

Other comments

8. Are there any other comments you wish to make about specific sections of the Bill?

8.1 No

Our response to the initial consultation on the Wales Food Hygiene Rating Bill is attached to this document.

John Dyson
Food and Technical Affairs Adviser
British Hospitality Association
Queen's House
55-56 Lincoln's Inn Fields
London
WC2A 3BH

British Hospitality Association response to the Welsh Government Consultation Document

Proposals for a Food Hygiene Rating (Wales) Bill

About the British Hospitality Association

The British Hospitality Association represents the hotel, restaurant and catering industry, which employs 112,000 people directly and contributes £1.88 billion in annual gross value added (wages and profits) in Wales. The BHA Wales Committee brings together our members to represent their views to the National Assembly and the Welsh Government.

Response to Consultation questions

Question 1: Do you have any comments on the first clause in the Bill (Welsh Food Hygiene Rating Scheme)?

We do not believe that the Food Hygiene Rating Scheme in Wales should require the compulsory display of the Food Hygiene ratings because:

- The voluntary FHRS scheme in Wales has not been given sufficient time to settle down since its introduction in October 2010. Many operators who have by now received scores 3 and above will be happy to display their scores as research indicates that 3 and above is where consumers are happy to eat. Given that 3 and above is likely to cover 80% of food businesses and the remainder will be subject to closer scrutiny/enforcement by EHO's then we believe that additional regulation is totally unnecessary. We are aware of the FSA research currently being carried out into whether compulsory display of Food hygiene ratings is necessary and therefore we believe that the decision to proceed with the Bill should be delayed until the results of that consumer research is known. Hence we oppose the clauses relating to criminal offences, fines etc.
- A major justification for compulsory display is claimed to be the opinion poll from Consumer Focus Wales, indicating that 94 per cent of consumers want to see FHRS scores displayed compulsorily. However, the research failed to ask the preliminary question: do you understand the ratings? Since only 50 per cent of respondents had even heard of the scheme, then 44 per cent were asking for something they had never heard of. Even if they were among the 50 per cent who had heard of the scheme, we suspect that very few will understand the significance of the scoring system, beyond the point made above that consumers will intuitively be happy to eat if the score is 3 or above

- We do believe that Local Authorities should be compelled to follow the national scheme to ensure a consistent approach and less confusion for consumers. However, we would much have preferred that Wales adopted the 'pass'/ 'improvement required' Food Hygiene Information Scheme operating in Scotland, which is simpler for both consumers and operators to understand."

- We also believe that there should be no variation in Wales whatsoever from the FHRS branded scheme which has been developed by the FSA and the UK Steering Group which covers issues such as re inspection, appeals, scoring, application to food premises etc. Any variation will add to the costs of multi site businesses who operate not only in Wales but also England and will cause confusion for consumers who have had to deal with a plethora of different schemes run by local authorities.

- We do not believe that operators should be required to pay for re inspection. Encouraging small to medium enterprises to improve their standards without additional cost burdens should be inherent in the scheme.

Question 2 Do you agree that assessments of the food hygiene standards of an establishment carried out prior to the commencement of this Act can be used as the basis of a rating under the mandatory scheme?

We do not agree with mandatory display but it makes sense for all businesses who are inspected under FHRS to be able to display their ratings.

Question 3: Do you agree that all food businesses supplying food directly to consumers should be included in the scope of the FHRS?

Yes

Question 4: Are there any food business establishments that provide food directly to consumers that you think should be exempt from the FHRS?

Very low risk premises selling wrapped confectionery, sweets etc

Question 5: Should those businesses involved in food business-to-business trade be included in the scope of the FHRS?

Yes

Question 6: Do you have any comments on the appeals process including the timescales? Please provide details of how the appeals process could be strengthened. Comments:

See answer to Q1

Question7: Do you think summary inspection reports (in addition to the Food Hygiene Rating Scores) should be routinely published on an FSA's website or otherwise made available?

No, summary reports can be misleading

Question8: Do you think the operator should be required to display the FHRS sticker at their establishment in a place where consumers can see it easily? Or you have any suggestions on where this location should be?"

No, some premises have more than one entrance e.g. a hotel may have a separate entrance to a banqueting room to that of the restaurant or it may have a main external entrance (maybe 2) and the internal entrance to the restaurant. Some quick service restaurants have a restaurant and often a drive through. In our view food businesses should be provided with a sticker but then given flexibility where or whether they display that sticker.

Question 9: Are the requirements in relation to the duty to remove out of date or invalid food hygiene rating stickers from display practical and reasonable

Yes

Question 10: Do you think that the list of offences is reasonable?

See answer to Q1

Question 11: Should all operators be required to display the food hygiene rating certificate at the premises in addition to the food hygiene rating sticker?

See answer to Q1

Question 12: Do you think the publication of the "right of reply" gives sufficient voice to the operator?

See answer to Q1

Question 13: Do you agree that operators that have actively taken steps to improve their food hygiene rating should be allowed to apply for a re-rating, rather than have to wait until their next planned inspection?

Yes

Question 14: Do you agree that food authorities should be required to charge operators the reasonable cost of undertaking a re-rating inspection?

No

Question 15: Should any food establishments be excluded from the charge for re-rating inspections?

No see answer to Q14

Question 16: Do you have any comments on the duties of the FSA? Are there any omissions? If so, please provide details:

No

Question 17: Do you think it is useful for a sticker to be displayed which informs customers that a food hygiene rating has not yet been issued to the food business establishment?

YES

Question 18: Is a level 3 fine (currently £1000) in relation to offences committed under the legislation appropriate?

See Answer to Q1

Question 19: Do you think food authorities should have the ability to issue Fixed Penalty Notices

See answer to Q1

Question 20: Do you consider the discounted penalty (£150) for early payment (within 14 days) of a Fixed Penalty Notice provides an appropriate discount for early payment?

See answer to Q1

Question 21: Do you agree with the preferred option in the Regulatory Impact Assessment (option 4 – Introduce the mandatory scheme with cost recovery for food hygiene re-rating inspections)?

No see answer to Q1

Question 22: Do you agree with the estimated costs/benefits regarding the implementation of this Bill?

No see answer to Q1

Question 23: Do you have any comments on the expected costs to food businesses and food authorities? :

See answer to Q1

Question 24: Please provide your comments on the impact that the introduction of a mandatory food hygiene rating scheme will have on: small businesses, the voluntary sector, equality, sustainable development, rural issues and the Welsh Language:

The proposal for charging for re inspection will disproportionally affect SME's and the voluntary sector and therefore damage their sustainability from an economic point of view. Many SME's are already subject to a high level of regulation in comparison to their size and the vast majority desire a supportive culture rather than that of regulation, enforcement and prosecution.

Wales has the opportunity to reinforce a "Welcome Culture" through communication, cooperation and commitment.

We should be pleased to discuss this response further with you. I confirm that we have no objection to it being made publicly available.

John Dyson

Food and Technical Affairs Adviser

British Hospitality Association

Agenda Item 5

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 – Senedd**
Meeting date:	**Thursday, 28 June 2012**
Meeting time:	**09:00 – 15:25**

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_28_06_2012&t=0&l=en
http://www.senedd.tv/archiveplayer.jsf?v=en_200002_28_06_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Mr Phil Banfield, BMA Wales** **Mr Bryan Beattie, Royal College of Obstetricians and Gynaecologists** **Julia Chandler, Royal College of Midwives** **Elizabeth Duff, National Childbirth Trust** **Polly Ferguson, Welsh Government** **Professor Jason Gardosi, West Midlands Perinatal Institute** **Fiona Giraud, Betsi Cadwaladr University Health Board** **Shirley Gittoes, Sands** **Dr Alexander Heazell, Manchester Academic Health Science Centre** **Angela Hopkins, Cwm Taf Health Board** **Dr Siobhan Jones, Public Health Wales** **Isobel Martin, Holly Martin Stillbirth Research Fund** **Dr Shantini Paranjothy, All Wales Perinatal Survey** **Dr Heather Payne, Welsh Government** **Janet Scott, Sands** **Prof Gordon Smith, International Stillbirth Alliance** **Dr Mark Temple, BMA Wales**

	Marilyn Wills, National Childbirth Trust **Dr Jean White, Welsh Government**
Committee Staff:	**Llinos Dafydd (Clerk)** **Mike Lewis (Deputy Clerk)** **Victoria Paris (Researcher)**

1. Introductions, apologies and substitutions

1.1 Apologies were received from Darren Millar.

2. One-day inquiry into still births in Wales - Oral evidence

2.1 The witnesses responded to questions from members of the Committee on stillbirths in Wales.

2.2 Siobhan Jones agreed to provide examples of Public Health Wales engagement with ethnic minority communities on the issue of stillbirths.

3. Papers to note

3.1 The Committee noted the minutes of the meeting held on 14 June.

4. Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for item 5 and for the meeting on 4 July for item 1

4.1 The Committee agreed the motion.

5. One-day inquiry into still births in Wales - Consideration of evidence

5.1 The Committee discussed the evidence it had received on stillbirths in Wales.

TRANSCRIPT

View the meeting transcript.

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Wednesday, 4 July 2012**
Meeting time:	**09:15 - 11:00**

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_04_07_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Lesley Griffiths, Minister for Health and Social Services** **Dr Chris Jones, Welsh Government** **David Sissling, Director General for Health and Social Services, Welsh Government**
Committee Staff:	**Llinos Dafydd (Clerk)** **Catherine Hunt (Deputy Clerk)** **Victoria Paris (Researcher)**

1. Inquiry into Residential Care for Older People - Consideration of key issues

1.1 The Committee discussed the emerging key issues for the inquiry into Residential Care for Older People.

2. Introductions, apologies and substitutions

2.1 The Chair welcomed everybody to the meeting. There were no apologies.

3. Scrutiny of the Minister for Health and Social Services

3.1 The Chair welcomed the Minister and her officials to the meeting. Members questioned the Minister.

3.2 The Minister agreed to provide the following additional information as requested by the Committee:

- Examples of any district general hospitals in the UK where acute services are not provided;
- A copy of the independent assessment of the public engagement exercise carried out by Hywel Dda Health Board as part of its reconfiguration plans.

4. Papers to note

4.1 The Committee noted the minutes from the meeting on 20 June.

TRANSCRIPT

View the meeting transcript.

Health and Social Care Committee

HSC(4)-23-12 paper 5

Inquiry into Residential Care for Older People – Note of Reference Group meeting 24 May 2012

Background

1. The Health and Social Care Committee established a reference group for its inquiry into residential care for older people in spring 2012. The group comprises those who have recently – or who are currently – supporting friends and family in residential care settings, or who are facing the prospect of doing so in the future.

2. The role of the external reference group is to provide a view to the Committee on the key issues raised during the course of the inquiry. This includes their views on the extent to which they feel that the information being provided in evidence reflects their own personal experiences and the extent to which they agree with the current policy direction for residential care for older people.

3. The reference group will meet on a monthly basis during the course of the oral evidence gathering, considering evidence already received and proposing lines of inquiry for future evidence sessions. All notes of reference group meetings will be agreed by the group prior to publication.

Summary

4. The group met on 24 May 2012 to discuss the key themes emerging from the Health and Social Care Committee's evidence sessions on 26 April and 2 May 2012, both of which considered the role of third sector providers and alternative models of provision.

5. The group also considered matters relating to the regulation and inspection of care, and potential questions which could be asked at the evidence session with CSSIW, HIW and CCfW on 30 May.

Key themes

6. The reference group agreed that the key themes emerging from the formal evidence sessions listed in paragraph 4 are as follows:

    - The focus of service provision should be **person-centred care**. People need to be seen holistically, and there must be support for the whole person with all their existing and potential conditions being identified and treated.

- **Reablement**, and other such services should be **available for everybody**, **at all points** of the residential care journey. A key part of recovery is allowing and encouraging people to be as independent as possible. Work should be undertaken to **raise the awareness** of all available services.

- There is a need for **better partnership working and sharing of good practice and expertise**. There should be an increase in flexible working and fewer silos within health and social care sectors. There should be better communication between organisations, especially with respect to record keeping, to ensure continuity of treatment for the patient.

- There **needs to be sufficient funding** for services, and **a minimum payment level** for care services, whether delivered at home or in residential care. Commissioning for cost rather than quality is potentially damaging to the services people receive.

- There **needs to be better, more accessible information about the types of care available**. This will help to provide answers to questions such as what good quality care looks like. There should be clear definitions of what reablement is, which will help to provide consistency and guidance about what constitutes reablement to those delivering it.

- **Training on issues such as dementia and Parkinsons** needs to be **wider than just awareness-raising**; it should also be about how to deal with these conditions and should aim to up-skill staff across the board in hospital wards, GP Surgeries and care homes.

- A **greater value needs to be placed on staff working within the care sector**. A care worker both in care homes and domiciliary care has a number of responsibilities, as well as often being constrained by financial pressures and pressures on their time, which should receive more recognition.

7. In exploring the key themes and the evidence heard, the group made the following points:

   - **Discussions about people's future care** needs should take place **at an appropriate time**, with all the relevant people. Typically this should be as early as possible – but this will vary depending on the situation and people involved. There is a need for support and advocacy to make sure this is effective.

- The **assessment process** for those receiving care, or identified as potentially needing care, **must be ongoing**, and should not be a one-off occurrence. People can potentially appear lucid during the course of a one-off assessment, but a more comprehensive understanding of the individual's wellbeing can be established if continuous assessments are undertaken. Furthermore, people's needs can increase or decrease depending on their conditions and the treatment they receive, which should be monitored through the assessment process.

- The group felt that there needed to be **more information available about reablement**. They discussed what reablement involved and the difficulty in defining it. This was an area they felt needed clarification, along with the need for some baseline data about reablement services, in order to move forward in this area. The group felt that, at present, the provision of services like reablement were not properly formalised and were delivered in an ad hoc fashion. They felt that there should be a greater amount of awareness about these services and a standard provision for everybody.

- The group discussed how **isolation was an issue** for those in rural and urban settings. They felt that the involvement of third sector through projects like befriending was very valuable. They also felt there were **a number of challenges delivering home care in rural locations** as often there was little or no provision for travelling times or cost within contracts. This can result in the contracts being unviable or unattractive to suppliers.

- The **risk averse nature of health professionals needs to be addressed**. The group felt that there need to be a change in attitude and less focus on the *'what ifs'*. They felt this would help with making people more independent, and could help reduce costs in the long term.

- The group felt that **direct payments** for older people are paid at a level which is too low to enable people to purchase regulated services, which currently makes them unviable. It appears that the system does not want to support older people in their homes.

- The group felt that better regulation of the Home Care system would be a positive thing.

- The **time allocated**, and **support for home care visits** is **often inadequate** for the tasks they are required to undertake. This is especially the case where the patient may be suffering from dementia and it may take time to access the home and win the trust of the client. The insurance and liability payments required for homecare staff to administer medicine is inhibitive to most providers being able to offer

this service.

- **Good design**, which takes account of elements such as sensory loss and dementia, is essential in developing new care settings. The development of new housing should also account for the changing needs of the population, and they should be future proofed for the elderly. The group felt that without sufficient grants to adapt people's homes, some of the choice of staying home is taken away.

- The group discussed that it was often **difficult to hold conversations with family members about their care needs**, especially when they did not want to acknowledge their condition. Many of the issues about lack of information, and the difficulties around having conversation with older family members, were considered by the group to be generational, and the group felt that they and future generations would be more prepared for the choices and discussions they would need to have.

- The group felt that dementia and the need for care **should not be seen as a one way street of decline** and that it was essential for **people to have choice and independence**. This is vital to give people a purpose for life.

- There was a previous assumption amongst group members that all nursing staff in residential care settings were trained in dealing with dementia. They noted that the need to check what training staff had received when choosing a home had not occurred to them.

- The **language used around treating dementia patients is often unhelpful** – for example, the group felt that a description of an individual suffering from dementia as being "stubborn" may in fact be a case of the individual having difficulty communicating.

Questions for future sessions

8. The group discussed areas of concern for the inquiry regarding inspection and regulation. They also suggested that the following questions and observations should be put to CSSIW/HIW and CCfW:

    - The inspection process must include spending sufficient time with residents and their families.
        - What is being done to ensure that more focus is placed on residents' experiences of the care home?

    - In the group's experience there seems to be very little enforcement of, or repercussions from, bad inspection reports. There needs to be clear

follow up on actions for enforcement – similar things seem to come up year after year.

- What is being done to strengthen enforcement of the inspection regime findings?
- Is there any follow up around ensuring that care home managers and staff do not seek employment in other care homes following dismissal?

– There are a number of professionals working in homes with residents such as social workers and complex care assessors (if patient is funded by the health service).
    - Do CSSIW work with these people in advance of an inspection to establish any areas of concern? Is there any on-going liaison with them about the key concerns emerging from homes?

– The reference group felt that care homes were aware of when inspections were likely to occur as they tend to follow the same pattern across regions. They felt there needed to be more spot checks and lay inspectors.
    - What is being done to bring lay inspectors back into the system? [It is the group's view that there needs to be a greater involvement of people and procedures including lay inspectors.]
    - HIW are doing unannounced inspections in hospitals around dignity – are these being rolled out to care homes as well?

– There should be regulation for other staff below managers- the cost of registration should not be put forward as a restriction.

– The group raised concerns about why there has been an increase in self-assessment of homes – as family members they felt a great deal of concern about this.

– The group used the written inspection reports as a source of information for making a decision about where to send family members – they think they could be improved, and could contain more accessible and informative information, which gives a clearer illustration of the reality of a resident's life in a particular residential setting. Furthermore, the group thought

    - more consideration of the potential audience for reports was needed, and the reports should explain matters in laymen terms;
    - the inspectorate should give consideration to the inclusion of things like interesting facts and figures about the homes;

- reports should be widely available, not just on the internet;
- reports are currently too heavily weighted with procedure and paper work and that more work should go into hearing the voices of people involved with the care home through direct contact; questionnaires are not enough;
- resident meetings should be considered as useful sources of information for inspectors.

– The group questioned what CSSIW did to ensure data protection is being implemented in homes. Examples from the reference group included family pictures being used as advertising for homes, which there has not been any consent for. It is important that the residents' privacy is maintained.

– Given the prevalence of certain conditions such as sensory loss /dementia / mental illness, the group wanted to know what level of training do inspectors have around these areas to identify if they are being addressed sufficiently within the homes.

– The group was interested to know if there is any monitoring of the numbers/types of falls occurring in residential settings and, if so, the extent to which this is followed up.

– The group wanted to know how staff morale is captured in inspection reports. This includes the extent to which:
  - adjustments are made for questioning those whose 1st language isn't English or Welsh; and
  - consideration is given to things like the living accommodation supplied for staff, which the group believed could be of a very low standard and thus impact on the ability of care workers to do their jobs.

– The group believed that there must be monitoring for staff training and that an increase in compulsory elements of training is needed e.g. mandatory training on dementia.

9. The group agreed to consider potential questions for the Committee's session with private providers, which is scheduled for 14 June 2012.

10. The group agreed to consider matters relating to funding and a job description for a care worker at the next meeting.

Health and Social Care Committee

HSC(4)-23-12 paper 6

Inquiry into Residential Care for Older People – Note of Reference Group meeting on 12 June 2012

Background

1. The Health and Social Care Committee established a reference group for its inquiry into residential care for older people in spring 2012. The group comprises those who have recently – or who are currently – supporting friends and family in residential care settings, or who are facing the prospect of doing so in the future.

2. The role of the external reference group is to provide a view to the Committee on the key issues raised during the course of the inquiry. This includes their views on the extent to which they feel that the information being provided in evidence reflects their own personal experiences and the extent to which they agree with the current policy direction for residential care for older people.

3. The reference group will meet on a monthly basis during the course of the oral evidence gathering, considering evidence already received and proposing lines of inquiry for future evidence sessions. All notes of reference group meetings will be agreed by the group prior to publication.

Summary

4. The group met on 12 June 2012 to discuss the key themes emerging from the Health and Social Care Committee's evidence session, on 16 May 2012, with staff bodies and professionals.

5. The group also considered matters relating to financing residential care and a staff profile for those involved in the care profession, and potential questions which could be asked at the evidence session with independent providers on 14 June and the Deputy Minister for Children and Social Services on 20 June.

Key themes

6. The reference group agreed that the key themes emerging from the formal evidence sessions listed in paragraph 4 are as follows:

   - The **use of terminology** such as *sufficient or further work* by the staff and professional bodies is too vague and lacks definition.

- More needs to be done to address the issues around the **recruitment and retention of staff at all levels within care** . Working in care should be considered a profession, with a clear career path and reflective pay scales.

- The **need for appropriate and practical training for care staff**. This must be more than a tick box exercise, with the training being meaningful and relevant to those involved in delivering care.

- There needs to be **wider planning for the future**, which accounts for future changes in the demography of Wales.

- The need for a **minimum staffing levels** in care homes, to ensure that there are appropriate numbers of staff working at all times, in particular overnight.

7. In exploring the key themes and the evidence heard, the group made the following points:

   - There appears to be a number of good intentions, and rhetoric about different bodies working together, however this does not appear to have been supported by positive action and forward movement.

   - There appears to be a **disregard for the work and potential contribution of the third sector by the professional bodies**. Although they recognise the importance of volunteers, the work of the third sector has a much greater reach and influence than this.

   - Throughout all the evidence sessions, there appears to be **little reference to the Social Services Bill** and the potential impact this could have on the landscape of residential care.

   - There is a **tendency in hospital settings when caring for the elderly to focus on the deficits** and what people cannot do, rather than the abilities that people still have. This can lead to a deterioration of patients.

   - Throughout the evidence sessions, **none of the witnesses have referred to the significant issue of bereavement**. People often need to grieve for those relatives who are not deceased but have been diagnosed with dementia, Parkinson's or similar conditions, in particular when entering into residential care. Associated with this is the development and sharing of end of life plans with families.

   - There should be **better mechanisms for sharing good practice between homes**. This could potentially be through the inspection regime, and inspectors could have a role in trying to encourage the

engagement of those homes which had been performing less well through suggesting examples of good practice.

- If the levels of pay within a care home are less than you could earn working in a supermarket, then the job will remain unappealing. This is a particular issue, given that there is no clear career path within the sector.

- Concern was expressed by the group that if working in care was not attractive to those people in higher paid professional roles such as psychiatrists, then it was even less likely to appeal to those entering lower paid jobs like care workers.

- **E-learning is not a sufficient substitute for more practical 'hands on' learning**. In considering the provision of training, the group asked whether consideration had been given to knowledge transfer and potentially visiting other care homes as part of a training programme.

- **People's lives should be worth the cost of regulation and registration** of staff at all levels within the care setting.

- Effective regulation must start with good leadership.

- A lot of good work has been undertaken by the Care Council for Wales around the initial stages of registering staff. This should now be built on, and Wales should not fall behind.

- There needs to be a greater awareness from professionals providing care for older people, such as nurses and occupational therapists, of what services and other support are available in the community.

- The need to consider individual preferences about where people want to live was considered important by the group. In particular they felt that recognising why people want to stay at home and independent was important, and could be used to develop the care sector.

- The group **were concerned about the tendency for risk averse decision making amongst the professional bodies** when it comes to older people. The group would like to see greater amounts of empowerment and leadership for these groups to ensure they make the best decision for the patient and not just the least risky from their perspective.

- A longitudinal survey ought to be carried out amongst 60 year olds in order to plan for the future. It is important that the Government communicates with future users and funders of the residential care system in developing new care models.

- The group considered **training as a key element of delivering a better service for residential care**, particularly in areas like dementia where even a little bit of training can transform the care provided in a home. However, the group felt that there were often issues of quality when training was delivered internally by homes and also electronically.

- Training within care settings can often be a tick box exercise, especially for things like health and safety and manual handling which has very little relation to what actually happens. When staff have been asked about training they cannot always relate what they have learnt to their experiences on the job.

- Concern was expressed by the group that there was a potential for residents to suffer if staff were taken off site for training and replaced by agency staff who are unaware of the needs of residents.

- The group thought the concept of a central point for information was a good idea, and a useful to have a way of guiding people through the process of choosing and entering residential care. However, there was concern that there would need to be buy in from everybody involved in delivering residential care and be properly resourced to ensure that people are able to access the information in a timely fashion. The group suggested that in developing any such resource consideration should be given to existing models to learn from best practice.

- Much of the evidence received has suggested that larger homes provide a negative experience for residents, in comparison to smaller homes. However, the group emphasised that there are some benefits to larger care homes as they can provide a greater choice of activity, more opportunity to socialise and generally stay more active.

- The Trade Unions assertion that there was a lack of training and development for staff, low wages and a lack of professionalisation within care sector was, for the group, reflective of how staff are viewed and emphasised the need to raise the level of the profession.

8. In addition to considering the issues arising in the evidence sessions, the group also considered a number of points relating to reoccurring themes of funding and the staff profile:

Funding

- A minimum level of funding is not sufficient; it will lead to money getting to be less and less. Just because somebody is funded through the local authority should not mean that they automatically only have access to a lower quality home.

- Consideration must be given to the system for top up payments.

- There needs to be more work around continuing care payments as they are currently awarded inconsistently. The group felt that there was a lottery with regards to accessing these payments and that it was down to how you answer the questions on the assessment rather than being truly evaluated on need. Patients in Wales (especially those with dementia or cognitive conditions) currently appear to be at a disadvantage to those in England because of the tool used in assessment.

Staff Profile

- The skills and requirements for staff working in residential care are much higher than acknowledged. For example, staff need to have a good awareness of, and to be able to act on signs of a number of conditions such as Alzheimers, Parkinsons and sensory impairments.

- More work needs to be undertaken to raise the profile of care staff, and improve attitudes towards staff.

- The group thought the characteristics needed by those working in residential care could be summed up as the four 'S''s : ***Steady*** (to handle any challenges); ***Sensitive*** (in terms of dignity); ***Sense of humor***; and a ***Strong stomach***.

- Care work should be considered a profession, and work should be done to ensure a clear career structure within it.

- Working within the care sector and the benefits and rewards associated with it should be promoted. Although this would also need to include all aspects of what was involved in the job to help address the rates of retention.

- The group suggested it would be useful if a standard agreed person specification for a care worker was available, which could be used by the inspectorate to make sure the necessary skills were present within a home, and that agency staff are appropriately qualified.

Questions for future sessions

9. The group suggested the following areas the Committee may like to discuss with the Deputy Minister for Children and Social Care at the meeting on 20 June 2012:

    - The need for different financial models in delivering residential care to ensure the future viability of care services and that individuals have a

choice about where they end up. This should include options where individuals could invest in their care as a stakeholder.

- Paying for care and establishing what the Welsh position on the Dilnot Commission is.

- Making sure there is a transparency of information around private care homes in areas like financial viability, staffing numbers and training/qualifications, which will enable people to make informed choices.

- Government planning for future care needs –the group felt there was a need for a survey of people in their 50s/60s to see what future health/care needs profile might be.

- Ways to address the poor public perception of care homes and care work.

- The need to get away from residential/retirement 'homes' and broaden the horizon to retirement villages where different needs could be accommodated.

Other Business

10. The group agreed to hold a further meeting in late July / early August to consider emerging key themes and recommendations from the inquiry in order to feed into the draft report.