

Health and Social Care Committee

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Health Board Reconfiguration Plans – Patients Association

There are few fiercer political battlegrounds in Wales than health funding. Not surprising, given that it makes up more than 40% of all devolved spending, or more than £5bn a year.

Warnings of a cash squeeze in the NHS have been growing for many years, with pressures on services and waiting list targets combined with a sprawling, inefficient estate of buildings and huge costs for locum doctors in rural areas.

Several LHB's have reported an overspend or other financial problems including:

- Abertawe Bro Morgannwg University Health Board (ABM) – in the four months to July, its overspend was £7.5m;
- Cardiff and Vale had an overspend for the four months to July of £12m, while it needs to hit a savings target of £72m by the end of the year;
- For the first three months to June, Betsi Cadwaladr in north Wales, had an £8.6m overspend, with £64.4m in savings to be found;
- For Cwm Taf, the overspend is £2.5m with a £23.7m saving required
- Hywel Dda in mid and west Wales has a £4m deficit and £36m in savings to find;
- Powys health board recorded an overspend of £3.8m with a savings target of £19m;

The cuts to health spending Wales (in real terms) are steeper than any other part of the UK – 11% over the next 3 years. This is compared to 2.2% by 2014/15 in Northern Ireland, 3.3% in 2011 in Scotland and in England spending was 0.9% lower in 2014/15 than in 2010/11.

The NHS is under huge financial pressure as can be seen in the cuts in real terms spending occurring not just in Wales but across the UK. Not only that, our ageing population and increased demand for services is stretching an NHS which is struggling to cope. The Patients Association work on waiting times has shown that larger numbers of patients are waiting for longer than 18 weeks in England and that patients are being denied access to services. In June, it was reported that 10,000 people a year are waiting longer than 12 hours in A&E departments in Wales. Hospitals also recorded 842 people waiting longer than 24 hours in the most recent year, according to their figures.

The majority of patients want to be treated as quickly as possible in hospital and then be back in their own homes, amongst family and loved ones. With a move to local control of health and the rise in the elderly population, we need to make sure the NHS adapts to fulfil this need. Inpatient care and local services must serve the

needs of patients so that they receive the best treatment possible and appropriate follow up community care. It may be beneficial to integrate and consolidate services into fewer sites and centres of excellence, as long as this does not restrict services available to patients. There is evidence that patients are less likely to die in the bigger, busier hospital units where surgical teams are more skilled because they do more of the operations.

We must never forget that by merging services to be provided from one site, there will be patients who may struggle to get to them because they are too far away. It is vital that services reflect the needs of the community and are available in a variety of formats including respite care and community hospitals. However, as is so often the case, political wrangling has the potential to get in the way of the changes that need to be made. We are faced with an NHS which is being forced to make cuts to services across the board. What is the point of having brand new hospital buildings if there are not enough funds to treat people in them? Politicians must not be afraid of making difficult decisions that will ultimately mean better and more efficient services for patients.

However, when changes are being planned, patients must be involved from the outset and throughout the process. If local services are to reflect the needs of local people they need real and meaningful input into the process, not simply just public consultation. We would like to see public forums, outreach programmes and direct patient participation in the decision making process. Without this type of input, we would fear that the same kind of distrust and disillusionment present in England about the NHS reforms may become more prevalent in Wales.

Patients deserve services that are relevant to them and appropriate for local needs. The only way this can happen is if patients and the public are involved in discussions and decisions about services from the outset.

Much of the Patients Association work on patient and public involvement has focused on the new, emerging health structures in England, and in particular Clinical Commissioning Groups (CCGs). In England, the public has a right to be involved in the planning and development of healthcare services and in decisions that may affect the operation of current services under the NHS Constitution. CCGs have a duty, as set out in the NHS Act 2006 to engage with the public when determining the healthcare needs of the local population and planning or designing new pathways or services.

Patient and public involvement must be proactive and not passive. . In Tower Hamlets, the PCT sought out community groups amongst the South Asian population which has a much higher incidence of long term conditions, many linked to lifestyle. They worked with community groups to look at ways of communicating with people including leaflets in other languages and using links with community groups to establish a dialogue. They have seen increased uptake courses about lifestyle choices and leaflets by ensuring that they are language tailored, culturally sensitive and well located. This is just one example of where active patient and public engagement can have a beneficial impact on patients.

As part of our work in this area, the Patients Association developed a Blueprint for patient and public involvement in CCGs which was published in December 2011. While not directly applicable to hospital reorganisation, we believe the principles that it rests upon are shared, especially given as both deal with patient involvement in the fundamental reconfiguration of health services.

Service Design and Delivery

1. CCGs should undertake active engagement with the public when determining the local public's healthcare needs and planning or designing new pathways or services. This engagement should be innovative, proactive and not passive; going out to find the public's views on specific issues, rather than waiting for the public to submit their views. CCGs should share learning and best practice with other CCGs. CCGs must continuously seek patient feedback and experiences to use as an indicator of the quality of the services they are commissioning.
2. CCGs should use effective local engagement structures and other channels to actively connect with a diversity of groups including community networks, local authorities, Healthwatch and third sector groups. This should include those who may not directly associate their concerns with health, e.g. housing associations and social groups, to ensure they engage with all members of the public, including those from traditionally ignored groups.
3. Members of the public involved in commissioning should be offered training and a role profile so that they understand the issues being discussed, the processes and procedures, and so can engage fully. The role of public representatives should be valued and as such they should be reimbursed for their time and given administrative support.

Accountability and Monitoring

4. CCGs should involve the public in the development of the CCGs' public engagement strategy. The CCGs public engagement strategy must form the basis and agenda of their wider commissioning strategy and be published in a variety of media and venues so that it is accessible to all members of the public.
5. The CCGs public engagement strategy should define Key Performance Indicators (KPI) for public engagement which must demonstrate how they support the KPIs defined for commissioning. The CCG will report every quarter regarding progress against these KPIs and publish a publically available action plan to show the public what actions they are taking to meet the KPIs, with particular reference to KPIs they are failing to meet.
6. CCGs must demonstrate how they will communicate with the local population on a regular basis to inform them of any changes to services and how they will actively gain and publish patient feedback on the services they are providing. Any action taken or not taken as a result of this feedback should be reported and justified to the public in a transparent and easily understandable format.

7. There must be public representation at every level of the commissioning process within the CCG. There must be a two-way flow of information between public representatives at every levels of the CCG, from the Board to the individual practice and every level in between.
8. There must be a clear accountability structure for public engagement within the CCG and this must be defined in the CCG's Governance. The responsibility for public involvement ultimately rests with the CCG Board. There should be:
 - a. On the Board – a nominated public involvement Governance lead who is a paid member of staff.
 - b. On the Board – a public involvement champion who is responsible for promoting public involvement.
 - c. Within the CCG structure – a person whose role it is to manage public involvement on a day to day basis and ensures that services meet the reasonable needs of service users.
9. CCGs must be transparent; keeping accurate records of previous actions, publishing their findings and reporting back to patients how they have decided to action feedback or recommendations and clearly outline the reasons behind this.
10. CCGs are accountable to the NHS Commissioning Board, HealthWatch and Health and Wellbeing Boards. They must establish and maintain relationships with these organisations as well as other key health stakeholders in the local health economy. They must report on locally agreed measures, and report on how patient engagement has influenced commissioning services. CCGs should also ask the NHS Commissioning Board for examples of best practice from other CCGs when developing their public engagement strategies.