The South Wales Programme

A public consultation about the future of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) for South Wales and South Powys

Consultation document

INSIDE: HAVE YOUR SAY
This consultation is about a small number of hospital services for people living in South Wales and South Powys:

**Consultant-led maternity services** (also known as obstetrics) – the medical specialty caring for women during pregnancy, childbirth and the postnatal period.

**Neonatal services** – the clinical specialty which provides care for premature and sick newborn babies

**Inpatient children’s services** (also known as paediatrics) – the care of very sick children who need to be admitted to hospital overnight

**Emergency medicine** – this refers to traditional accident and emergency (A&E) services for people with serious or life-threatening injuries or medical conditions and to urgent care and minor injuries services for people with less serious injuries and illnesses

The South Wales Programme is made up of:

- Abertawe Bro Morgannwg University Health Board
- Aneurin Bevan Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Health Board
- Powys Teaching Health Board
- Welsh Ambulance Services NHS Trust

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<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword by the South Wales Programme Board</td>
<td>4</td>
</tr>
<tr>
<td>Senior clinicians explain the case for change</td>
<td>7</td>
</tr>
<tr>
<td>Some important facts</td>
<td>10</td>
</tr>
<tr>
<td>Children’s services</td>
<td>10</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>12</td>
</tr>
<tr>
<td>Emergency medicine (A&amp;E)</td>
<td>12</td>
</tr>
<tr>
<td>What have we done to prepare for consultation?</td>
<td>17</td>
</tr>
<tr>
<td>How have we considered equality?</td>
<td>21</td>
</tr>
<tr>
<td>Has anything changed?</td>
<td>23</td>
</tr>
<tr>
<td>How have we developed the options for consultation?</td>
<td>26</td>
</tr>
<tr>
<td>What are the options?</td>
<td>27</td>
</tr>
<tr>
<td>The way forward</td>
<td>29</td>
</tr>
<tr>
<td>What does this mean?</td>
<td>30</td>
</tr>
<tr>
<td>Are the options affordable?</td>
<td>33</td>
</tr>
<tr>
<td>The impact on the Welsh Ambulance Service</td>
<td>35</td>
</tr>
<tr>
<td>Tell us what you think</td>
<td>36</td>
</tr>
<tr>
<td>What happens next?</td>
<td>38</td>
</tr>
<tr>
<td>Appendix —the options analysis</td>
<td>39</td>
</tr>
<tr>
<td>Glossary</td>
<td>42</td>
</tr>
</tbody>
</table>

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Welcome to the South Wales Programme public consultation, which outlines options for the future provision of a small number of hospital services – consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) – for the people of South Wales and South Powys.

Health boards have a responsibility to provide care for their local populations but, as a National Health Service, we also have a duty to do what's right for the whole of the population. This wider commitment has seen us come together to find ways to improve services for all patients living in South Wales and South Powys.

We have set aside individual organisational interests to work together to ensure we can provide safe and sustainable health services matching the best anywhere – this is not about cost-cutting or saving money but about improving quality, meeting clinical standards and addressing the shortage of doctors affecting these services.

We have been working together with the Welsh Ambulance Service; with our frontline clinicians - who have been at the heart of this process - with community health councils and with other partners, to find a long-term solution for these hospital services.

This has been a truly unique approach towards planning the future of our hospital services. We are working together in an innovative and collaborative way to develop a network of hospitals, which together, and with the support of primary and community-based care, provide secondary and very specialist healthcare for our populations.

“We’re putting the national back into the NHS”

The map shows the location of the hospitals with A&E departments and minor injuries units in the five health boards involved in the South Wales Programme.
We can no longer continue trying to provide the same services in every hospital; instead we are building on the successes we have already achieved in cancer, cardiac and stroke care. By pooling our resources and expertise and developing patient-centred pathways to centres of excellence we have already been able to demonstrate that we can deliver better outcomes for everyone, irrespective of where they live.

This is what we want for all our patients and by working together in this way we are truly putting the national back in the NHS.

The South Wales Programme is about improving the whole healthcare system so we make sure the small number of patients who need life-saving care get the best when they need it while the majority of patients get consistently great care from their local NHS services - at home, in the community or in hospital.

Between September and December last year we openly discussed the challenges we face in an extensive public engagement programme. We explained why things can't stay as they are and why it is so important we make changes before services start to really struggle to maintain the standards of care our patients deserve.

You told us you understood why services need to change. But you also raised understandable concerns about the future. We’ve listened to what you said and this has been reflected in the development of the options we will be consulting on.

We are now starting the formal consultation phase of the South Wales Programme. We will be consulting on four options for the future location of these services.

For each of these options, we’ve looked at how many people will have to travel further; how many extra doctors we will need; the impact on the Welsh Ambulance Service; the likely cost of such change and what you told us last year.

The evidence we have looked at so far indicates that providing these services on five hospital sites would better serve the needs of the population of South Wales and South Powys.

Each of the options for the location of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) for the most seriously ill and injured people has been assessed.

The result of this process indicates the option which strikes the best balance is for these services to be located at:

**Option 3**

University Hospital of Wales, Cardiff
Morriston Hospital, Swansea
Specialist and Critical Care Centre (SCCC), planned to be built in Cwmbran and completed in 2018/19
Prince Charles Hospital, Merthyr Tydfil
Princess of Wales Hospital, Bridgend

We are very clear that all our hospitals have a really important role to play in the future.
Concentrating these services in a smaller number of hospitals means there will need to be a corresponding move of other services in the opposite direction. All these moves would need to be centred around our ability to best meet the needs of all our patients and, at the same time, make full and best use of all the resources we have in the NHS.

This is about improving quality for all of our patients. We acknowledge that in the future some of our patients may have to travel a bit further to access a small percentage of our services but the benefits of these changes will be better standards of care and a stronger guarantee of clinical skills and expertise when people need them most. The majority of all care will continue to be delivered locally.

None of our hospitals will be closing as part of this work. We will not be losing any of our A&E departments but there will be some changes in exactly what is delivered in each of those departments - this is explained later.

The South Wales Programme is the start of a new future for NHS Wales - one where organisations work together across health board boundaries to plan and deliver high-quality services for all patients.

Importantly, clinicians will be working together, across the healthcare network, to focus on the needs and benefits for all our patients.

Over the next eight weeks – from May 23 to July 19 – the health boards will be consulting with you about how we provide consultant-led maternity care, neonatal services, inpatient children’s care and emergency medicine (A&E).

This is an important decision for all of us in providing the best hospital services but it is also an opportunity to embrace a new collaborative future for healthcare in South Wales and South Powys.

Andrew Davies Paul Roberts
Chair Chief executive
Abertawe Bro Morgannwg UHB

David Jenkins Andrew Goodall
Chair Chief executive
Aneurin Bevan Health Board

Maria Battle Adam Cairns
Chair Chief executive
Cardiff and Vale University Health Board

Chris Jones Allison Williams
Chair Chief executive
Cwm Taf Health Board

Mel Evans Andrew Cottom
Chair Chief executive
Powys Teaching Health Board

Stuart Fletcher Elwyn Price-Morris
Chair Chief executive
Welsh Ambulance Services NHS Trust

Peter Barrett, independent chairman, South Wales Programme

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In Together for Health, the Welsh Government said the NHS is facing unprecedented challenges and we agree. Now is the time to act to ensure we can deliver safe and sustainable services now and in the future.

Although most patients in South Wales and South Powys receive very good treatment, and standards are improving, we know that we don’t always provide the highest quality of care for everyone all of the time. If we carry on as we are, we will start to fall behind other countries in keeping people well and in treating illness and injuries, instead of being one of the very best.

Ideally, we don’t want anyone to have to come to hospital unless it is absolutely necessary. To make this a reality we must strengthen our primary care services, including out of hours. We need a strong system of community services, which together with our GPs and paramedic colleagues in the Welsh Ambulance Service, will be able to better identify and treat people in the community, without the need for hospital admission.

When our sickest patients need to come to hospital we want to have senior clinicians available to see them as soon as they arrive, whatever time of day or night. This means they will get the right diagnosis, start the right treatment quicker and get better faster.

We need to offer everyone the sorts of medical advances which mean tiny premature babies have the best chance of life; people involved in serious accidents have the best chance of survival and people with life-threatening illnesses get the expert care and treatment they need to save their lives.

This kind of medicine can only be delivered by teams of doctors, nurses and therapists who have specialist skills, which they use day in and day out so they remain experts in what they do.

It can’t be provided in every hospital because we don’t have enough specialists, but even if we did, they wouldn’t be able to keep up their skills because they wouldn’t be seeing enough patients.

We cannot continue as we are – the status quo is not an option for the future.

“\nWe don’t want people to have to come to hospital unless it’s absolutely necessary”

Consultant-led maternity and neonatal care; inpatient children’s services and emergency medicine (A&E) for our most seriously ill and injured patients need to be provided together, in fewer hospitals as part of a wider integrated healthcare network.

The evidence is clear: doing this will improve the outcomes of care for patients even if they have to travel further for this

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treatment.

Each specialist team has, and is supported by, doctors-in-training – the specialists of the future. We need more of these doctors-in-training because of changes to European legislation governing working hours. And training has become much more complex, as medicine becomes more specialised.

Doctors-in-training need to see large numbers of patients to ensure they have the necessary experience and skills to specialise. So when they plan their training, not only do they choose hospitals where they will see enough patients but they also want to experience how the very best care is delivered and be well supported by consultants as they learn.

At the moment that’s not always the case in Wales. Because we are trying to run services in too many places we have frequent shortages of doctors-in-training and consultants. This means our reputation for high-quality training is not as good as it should be and we are finding it hard to attract doctors in some specialities to come to Wales to train.

Not only does this make providing safe services difficult, it makes it harder to fill consultant posts and impacts on the quality of teaching for the doctors-in-training we do have – it’s a vicious cycle, which needs urgent attention. The consultants we need now and for the future are not coming to Wales and are unlikely to move to Wales from elsewhere.

This is a particular problem for some important services – most notably the ones we’re now discussing with you. In many units we are relying on expensive temporary staff just to keep services going. This doesn’t always provide the best or most consistent care and we cannot always get them when we need them.

The Wales Deanery, which oversees the training of doctors in Wales, believes...
concentrating these services in fewer hospitals in South Wales will help to improve training and help the NHS recruit the doctors it needs to provide services.

Fortunately, most people who receive care from the NHS do not need these services and will continue to receive the majority of their care in their local community or hospital – just as they do now.

But we believe that if you do need one of these services it will be better and safer if they are delivered in fewer hospitals so we can consistently meet the best quality standards. We believe we can sustain these services in five locations in South Wales and deliver improvements.

If we don’t take action now, there’s a very real risk we’ll be forced to take emergency measures when one of these services fails. Instead of reacting to a crisis, it’s better and safer for our patients and staff to make any changes in a planned way.

We are all committed to providing the best possible healthcare for the people of South Wales and South Powys.

By working closely with our clinical colleagues, partners and the public we can ensure that in the future we have safe, sustainable and high-quality services, which are there when people need them.

Thank you
What is it about?

This consultation sets out the options for organising consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) to ensure patients in South Wales and South Powys have access to safe, high quality and sustainable care in the future.

We’re asking you what you think so we can take your views into account before any decisions are made. We’ve been working closely with the community health councils (CHCs), who represent your interests in the NHS in Wales, and this will continue during and beyond the consultation process.

Some important facts and commitments

Before we go into the detail of what we have done and what the options are for the future, there are a number of important facts we need to explain and some commitments we feel it is important to state up front in this consultation.

Children’s services

Modern day health services for children are rarely provided in a hospital bed. The majority of sick and injured children see a healthcare professional in the community, their GP surgery or their local hospital. They will have investigations and treatment without any need for admission to hospital. For all these children, nothing will change under the plans being considered as part of this consultation.

It is only a very small percentage of children - those who are seriously ill or badly injured – who need to stay in hospital overnight. For these children there is strong evidence that having paediatric doctors available 24/7 means their outcomes are better and lives can be saved.
Where do I go?

My school rang me to tell me my seven-year-old son has fallen off the climbing frame at school. He’s complaining his arm is sore. The school thinks I should get him checked by a doctor.

Your son should go to your local hospital where the experienced minor injuries team will undertake a full assessment of your son, including x-ray, if necessary. If there is no need for further specialist assessment, he will be given the appropriate treatment, including plastering if required, and can be discharged directly home.

It’s 2am and my 18-month-old baby will not go to sleep. I’ve given her Calpol but she still feels hot and is constantly crying and I’m worried that there might be something really wrong.

Call your local GP out of hours service for advice. You may be given an emergency appointment at the local hospital out of hours centre where a diagnosis and appropriate treatment may be provided and you and your daughter can return home. If the GP thinks it necessary, they can book your baby into an urgent appointment slot on the next morning’s consultant paediatric clinic at your local hospital.

My two-year-old son is complaining of a bad headache and he seems to be very sensitive to the early morning sun; he has also been sick. I’m worried he may have meningitis.

Call 999 for an emergency ambulance. Highly-skilled paramedics will take you and your son to your nearest hospital providing level two emergency medicine services (see p15) and inpatient children’s services. He will be assessed by senior clinicians and, if necessary he will be admitted to the children’s ward for ongoing investigation and treatment.
We can't continue to deliver that level of children’s care unless we reduce the number of sites where these services are provided. It is only this small group of children who will be affected by these proposals.

**Pregnant women**

For pregnant women, irrespective of any changes that might be proposed, community-delivered services; antenatal clinics (consultant and midwife-led), early pregnancy clinics and midwife-led birthing centres will continue to be available in all hospitals, as now.

During the nine months of pregnancy - and the first couple of weeks after a baby is born - almost all women will have the majority of their care delivered very locally by a team of midwives.

When it comes to giving birth, women will continue to have the choice of a home delivery, giving birth in their local midwife-led centre or at the nearest consultant-led unit, depending on their needs and any known risks.

For most women, childbirth is thankfully a normal process which requires little or no medical intervention at all. However, we do know that some pregnancies are higher risk right from the start and others become more complicated during labour. For these people, having skilled and experienced doctors available to support the labour ward 24/7 can be critically important to mum and baby.

To be sure we can always have that medical support when it is needed, we can't continue to provide the current number of consultant-led units in South Wales.

This could mean that for some women their time in labour and, on average the 48 hours spent in hospital after their baby is born, may be a bit further from home. But it will mean that help from highly-skilled doctors is available when they need it.

**Emergency medicine (A&E)**

Over the last 10 years we have seen many changes in the NHS which have resulted in different types of patients coming to our A&E departments.

Changes to primary care and ambulance services, the availability of new treatments and even changing public expectations have all had an impact on what turns up at the front doors to all our hospitals. No two A&E departments in Wales are exactly the same.

For many years, patients with serious chest injuries, head injuries and burns have been taken directly to Morriston Hospital, in Swansea or University Hospital Wales, in Cardiff, because this is where the experts who can deal with such
Where do I go?

Julie lives in Talgarth and is pregnant with her second child. Her first baby was born at her local midwife-led unit but this time the 28-year-old wants to have her baby at home - she has been assessed as low risk during her pregnancy. However, during labour, there are signs the baby is becoming distressed and Julie's dedicated midwife decides she needs to go to a consultant-led unit. Julie's midwife dials 999 for an ambulance to transfer her and Julie to the nearest consultant-led maternity unit, where she undergoes an emergency Caesarean section soon after arriving at the unit. Daughter Seren is a healthy 7lb 8oz and they are able to go home a few days later, where the midwife will check on mum and baby.

Sharon, 34, is pregnant with her second child; her first was born at her local midwife-led birth centre and she’d like to do the same this time around. She has regular appointments with her midwife who discusses her options for place of birth - she is suitable for the birth centre or for a home birth as she has been assessed as low risk and suitable for midwifery led care. Sharon’s daughter April is born healthy and well, weighing 8lb 2oz and, after receiving some help and advice about breastfeeding, she is able to return home as soon as she feels well enough just a few hours later.

Meera, 40, is expecting her first baby but has experienced some problems with her blood pressure during her pregnancy. She is advised that giving birth at a consultant-led unit will be the safest option for her and her unborn son. In the months before her due date, Meera has a number of appointments with her consultant, all of which take place in her local hospital, and it is decided that she will have a Caesarean section. Meera gives birth at her nearest consultant-led unit to son Mo – a healthy 7lb 12oz – and mother and baby are discharged home within 48 hours of his birth.
challenging problems are based.

We can now also offer new life-saving, highly-specialised treatments for certain types of strokes and heart attacks.

The increasing specialisation of A&E medicine has meant that a greater number of patients are taken directly to where the specialists are based, even if that means driving past their nearest A&E department.

We can't deliver this level of expertise everywhere - something the public understands and accepts. However, we can use technology, such as Telehealth, to enhance the range and scope of what can be delivered safely across large geographical areas.

Our stroke doctors are pioneering this work - they are working together across South Wales to diagnose patients who are suitable for clot-busting drugs using video links. The doctor, who could be based anywhere in South Wales, is overseeing the immediate and potentially life-saving care of a patient in their local hospital.

Such technology unlocks all kinds of opportunities to ensure expert opinion and assessment can still be received in hospitals even where specialists are not based.

The vast majority – 80% - of people who come to A&E do not specifically need the services of our emergency medicine doctors. Some have injuries, which can very appropriately be treated by experienced emergency care practitioners; others will be acutely unwell and need to be assessed and treated by other types of doctors in other specialties.

Unfortunately, A&E often becomes a "holding bay" for these patients, waiting for test results and for specialists to decide the most appropriate course of action. This is particularly true for the increasing numbers of frail elderly people who are often very unwell and are waiting to either be admitted to a bed or discharged home.

Both these groups of patients will not be affected by the changes outlined in this consultation.

However, about one in five people who come to A&E are more seriously ill or injured. For these people, the services provided by specially-trained emergency medicine teams can, and do, make a significant difference to their outcomes – sometimes it is the difference between life and death.

The UK-wide shortage of emergency medicine doctors and the fact they are spread too thinly across our hospitals means we can't provide the level of support to these seriously ill and injured
patients round the clock.

It is this group of patients who will be affected by the changes proposed in this consultation. We believe we will be able to provide better outcomes for them if we concentrate emergency medicine services in five hospitals.

**No A&E departments will be closing as part of this process of change.**

But it is important we spell out in more detail what differences there currently are, and will need to be, in A&E departments.

There is a piece of work taking place across the UK at the moment that will define the different roles - and possibly suggest some different names - for different types of A&E departments in the future. In the meantime, we hope this table provides you with some information to help you understand what A&E services will be available as a result of these proposals:

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<th>Name</th>
<th>What care is available?</th>
<th>Workforce</th>
<th>Location</th>
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<tr>
<td>Minor Injuries Unit (MIU)</td>
<td>Uncomplicated broken bones; minor burns, cuts, pain, infected wounds</td>
<td>Nurse practitioner and/or GP</td>
<td>All existing A&amp;E departments and MIUs</td>
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<tr>
<td>A&amp;E level three</td>
<td>All of the above PLUS care for patients with a worsening of a chronic condition; frail elderly patients; acute medical illnesses; mental health crisis response; uncomplicated long bone fractures. Departments are co-located with a GP out-of-hours service. We are also examining the possibility of providing a paediatric assessment unit on the same site.</td>
<td>Advanced emergency/resuscitation practitioner-led with consultant support Maximise presence of acute medicine doctors 24-hour radiology and pathology investigations</td>
<td>All five hospitals PLUS the sixth hospital, which currently has an A&amp;E department</td>
</tr>
<tr>
<td>A&amp;E level two</td>
<td>All of the above PLUS complex trauma, open fractures, uncontrolled bleeding and life-threatening emergencies</td>
<td>24-hour senior emergency medicine doctor cover</td>
<td>Five centres</td>
</tr>
<tr>
<td>A&amp;E level one</td>
<td>All of the above PLUS major trauma, including chest injuries, head injuries and major burns</td>
<td>24-hour senior emergency medicine doctor cover</td>
<td>UHW and Morriston Hospital together in a networked arrangement</td>
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Where do I go?
Terry Jones, 41, is painting a ceiling at home when he slips and falls off the ladder to the floor, hurting himself

If Terry is unconscious and bleeding from his head, his partner Clare should contact 999 for an emergency ambulance, which will take Terry directly to the University of Hospital in Wales, in Cardiff, which provides level one A&E services.

If Terry has a broken leg, Clare should contact 999 for an emergency ambulance, which will take Terry to the nearest hospital providing level two A&E care.

If Terry has hurt his ankle and can’t put any weight on it, worried it may be broken, Clare can take him to his local hospital providing level three A&E services.

If Terry has a cut which may needs stitches, he can be cared for at his local minor injuries unit.

The 20% of patients who will be affected by changes to emergency medicine in South Wales require level two or one care.

The Welsh Ambulance Service will play a key role in taking patients to the right place for the right services.

Changes to these services will lead to better outcomes for the most seriously ill and injured and improved care for patients overall.
What have we done to prepare for consultation?

Over the last 18 months, more than 300 frontline clinicians – doctors, nurses, midwives, therapists and paramedics – have been discussing the issues facing these services and developing ideas for their future at a series of clinical conferences and summits.

In addition, clinical reference groups (CRGs), made up of frontline clinicians working in each service area from all parts of South Wales and South Powys, were set up to advise the programme and carry out the detailed work to redesign services.

The result of this work was an agreement between the clinicians that to improve the level of care we can give to the sickest and most seriously-injured patients in South Wales and South Powys and to provide safe and sustainable services we need to concentrate consultant-led maternity care, neonatal care, inpatient paediatrics and consultant-led emergency medicine in fewer hospitals – four or five hospitals.

The problems facing these services and six scenarios describing their possible locations were discussed with the public during the 12-week engagement process, which ran from September to December 2012.

Full details of the engagement, including the feedback, are available at www.wales.nhs.uk/swp.

What you told us during engagement

During the engagement period (September to December 2012) you told us you understood why these hospital services need to change and agreed they should be located together in fewer hospitals.

But you also told us you were concerned about a number of key issues:

Primary and community care services You were concerned there was too much emphasis on hospital services. We recognise the importance of primary care and, as individual health boards, we are continually working to improve the services we provide close to people’s homes.

Although the South Wales Programme work focuses on four specific hospital services, the contribution of primary care, especially GPs and their teams, will be critical in providing the integrated care patients need. We fully accept that in some areas we will need to strengthen our GP services, particularly in the out-of-hours period.
Many people, especially those in our most deprived communities, need more support in the community to help them lead more healthy lives and support them when they are unwell.

We have already developed plans for significant investment in primary and community services in these areas. These will see an increase in the numbers of GPs, community nurses and other staff to redress the balance and start to make real progress in tackling the inverse care law.

These developments will be instrumental to the success of changes made to hospital services in the future.

The ambulance service

You were concerned about current emergency response times and whether ambulance services could support the proposed models.

The Welsh Ambulance Service is a key partner in the South Wales Programme and has been involved in the development of the clinical models to identify the impact on patients and its service.

Specific work has been carried out to look at journey times, how patients will be transferred between hospitals if they need more specialist care and how they will

Our commitments to you

During and after this consultation – from making a decision about the future of these services to implementing the agreed changes - these commitments will underpin everything we do:

1. We will provide as much care as locally as possible where it is safe to do so
2. Changes will be centred around the needs of our patients and will improve quality of care
3. Any changes will have the least possible impact on travel times for patients and their families
4. Where possible we will bring people back to their local hospital for any ongoing care and follow-up
5. We will continue to work with our staff to ensure their needs are taken into consideration in the planning and delivery of services
6. We are committed to all our acute hospitals having an important part to play in the future of the NHS
7. Where there is a need to move some services from one hospital to another, we will need to move other services in the opposite direction to ensure we make the best use of all the resources available to us
8. We will ensure that all hospital sites are used to their fullest potential and no individual health board is financially destabilised.

Tell us what you think swpresponse@wales.nhs.uk
be taken home, or closer to home when they are well enough.

The recent ambulance service review highlighted the importance of further developing the clinical emergency paramedic service to ensure out-of-hospital care is strengthened and patients are appropriately directed to the right place for treatment, according to the severity of their condition.

This is something we fully endorse and will be working together to achieve.

A significant piece of work is already underway, supported by Welsh Government, to review and develop new transport arrangements for sick and injured people. This ranges from acute retrieval services for small babies, children and adults to expanded ambulance fleet and air ambulance support.

Health boards and the Welsh Ambulance Service will continue to work together to deliver the necessary changes, to further improve response times, as well as help the public to understand how the ambulance service works and when to contact 999.

Access to services  You were concerned about what services would be available at which hospitals in the future and about whether patient safety would be compromised if people have to travel further for care.

In developing this consultation, we have worked on the principle of providing as much care as locally as possible but only when it is safe to do so.

It is important to recognise that it is the time to treatment that is the most important factor in getting the best outcomes for patients and not the time it takes to get to the front door of the hospital.

We have carefully analysed travel times between all our hospitals and identified how these would change for different people and populations across the South Wales and South Powys area if different hospitals were designated as regional centres within this plan.

This travel time study formed part of the consideration and the scoring each option was given, as will be explained later.

Public transport  Very few people use public transport when they need emergency care but good public transport links are important when visiting loved
ones in hospital and for accessing outpatient care, if this is necessary.

You told us you were particularly concerned about whether you could travel to hospital using public transport. We have carried out an initial analysis of public transport to all hospitals across South Wales and we are working with local authorities and other community and public transport providers to examine the impact of the options for change.

We recognise there may need to be improvements to public transport and are committed to ensuring this happens as part of any implementation process.

Deprivation You told us you were concerned about the impact any changes would have on the most deprived communities, where levels of ill health and reliance on health services are often higher and incomes are low. We have examined in detail how many people in the most deprived communities and the least deprived communities will be affected by longer journey times for each option and we have tried to reflect that in the option appraisal process.

One of the benefit criteria, which was used to score the options, specifically took deprivation into account.

Changes to our populations During the engagement period, we were asked if we would consider how changes in the population in the future might affect the options we develop.

We have looked at the predicted changes in birth rate and age profile of the South Wales and South Powys population in coming years and have applied age-standardised estimations of future demand on these services. Further details are available in the supporting documents on our website www.wales.nhs.uk/swp

Interim arrangements You were concerned about what would happen to services between now and when the agreed option for the final configuration of services is implemented, particularly if services become unsustainable in the meantime.

We recognise these concerns and there are real issues with recruitment to some of these services now. It is important we minimise the uncertainty about the outcome of the South Wales Programme and what it will mean for a number of our hospitals

“Our services face recruitment pressures now”

Tell us what you think swpresponse@wales.nhs.uk
All health boards within the South Wales Programme are working together to ensure we can provide safe, high-quality services for all our patients and we will continue to do so, before any changes are implemented.

If we do have to take unavoidable and urgent action in the meantime because of the risks posed to patients, the health boards will work with community health councils and local people to manage this, as required by the Welsh Government.

Any such action will be in line with the South Wales Programme’s proposed changes and in accordance with Welsh Government guidance.

**The benefit criteria**

Your feedback, together with feedback from clinicians at the clinical conferences, was used to develop six “benefit criteria” – the most important issues against which the options for consultation were analysed.

These criteria were scored by clinicians, other NHS staff and partners, and a small number of public focus groups at a series of events run by Opinion Research Services (ORS) in February 2013. The final weighted benefit criteria were approved by individual health boards and the Welsh Ambulance Services NHS Trust at board meetings in March and April 2013. These were subsequently used to score the six options for the future locations of these services.

The benefit criteria were: safety, quality, sustainability, access, equity and strategic fit. Full descriptions of these criteria, how they were scored and their rank are contained in the supporting documents available on the website [www.wales.nhs.uk/swp](http://www.wales.nhs.uk/swp).

**How have we considered equality?**

Equality is a core principle of NHS Wales. It is one of our values to treat others fairly and with dignity and respect. The South Wales Programme is a major review of services so it is essential the people who use our services, our staff and the public have the opportunity to tell us how they feel about the changes.

Gathering relevant evidence and assessing how the changes may affect people differently will help us to make the best decision. We want to make sure that as far as possible, any potential negative impacts are eliminated or minimised. This also gives us the opportunity to ensure the promotion of equality and human rights for...
everyone and to make a real difference for people who already experience significant barriers when accessing services.

Equality is about making sure people are treated fairly. It is not about treating everyone the same, but recognising that everyone’s needs are met in different ways. Our age, disability, faith or belief, gender, race, sexual orientation, being married or in a civil partnership, being transgender or being pregnant should not disadvantage us. These different characteristics are protected under the Equality Act 2010.

From the beginning of our discussions we recognised the need to engage with people from different groups to help identify the impact of any potential changes on them.

Having analysed the evidence received so far, we appreciate there are information gaps and groups whose views we still need to hear. This will be addressed by continuous engagement and information-gathering during the consultation.

Our framework for undertaking equality impact assessments requires us to work in partnership. This includes the five health boards, the Welsh Ambulance Services NHS Trust, the communities we serve and especially those groups who will be affected by the changes; our trade union colleagues; community health councils, the third sector and local authorities. Our overall approach is based on the principles of a sound evidence base, transparency, engagement and leadership. This provides a platform for partnership working which fosters good relations.

Our equality impact assessment evidence document is available on the South Wales Programme website. We want to know what you think about any positive or negative impacts of our proposals on different groups of people. Full details about how to get in touch can be found on page 36.

In terms of equality, the South Wales Programme gives us the opportunity to create centres of excellence, which will improve the patient experience.
We have listened to the feedback from the engagement period; looked at the evidence and, following further discussions and debates with clinical staff, have made some changes to our proposals, which affect children's services, neonatal services and the development of a trauma network for South Wales and South Powys.

Children's services Most of the services children need on a day-to-day basis are provided by GPs and other healthcare professionals, including health visitors and community nurses close to home and in schools.

During the engagement period, we spoke about the possibility of retaining assessment units for sick children in local hospitals. This is not as straightforward as we originally thought it would be because the experience from other parts of the UK is mixed.

However, this is something we want to achieve if we can deliver the right model and if it can be made sustainable. We are continuing to explore this as an option for those hospitals which would not have inpatient children's services in the future.

We believe we would need to develop a network solution for any local paediatric assessment unit and we will continue to explore this opportunity during consultation.

Maternity care In the engagement document we outlined that all four services covered by the South Wales Programme should be located on the same hospital site because of the significant joint working required between the different service areas.

In the Swansea area, Abertawe Bro Morgannwg UHB is planning to move maternity and neonatal services from Singleton Hospital to Morriston Hospital. This is supported by Abertawe Bro Morgannwg Community Health Council and will happen when capital funding is available.

Neonatal care In the engagement phase, we discussed the need for either two or three neonatal intensive care (level three) units, which would be based at University Hospital of Wales, Cardiff; Morriston Hospital, Swansea (see section above) and at the Specialist and Critical Care Centre (SCCC), in Cwmbran (this will
remain at the Royal Gwent Hospital, Newport until the SCCC is completed).

Following extensive feedback about the need to ensure the region has sufficient intensive care capacity, it has been decided that three intensive care units can continue to be supported as providing safe and sustainable services for South Wales and South Powys.

However, we know there is still a lot to be done to ensure the neonatal network works properly and we will continue to work to improve neonatal care across South Wales and reduce the number of babies needing to travel outside of Wales for this highly-specialised care.

High dependency (level two) neonatal care would be based alongside consultant-led maternity and inpatient children’s services.

**Emergency surgery** The feedback from our clinicians and the clinical reference groups was that emergency surgery should be co-located with emergency departments in the regional hospitals.

The College of Emergency Medicine and the Royal College of Surgeons of England recommend that emergency departments treating the most seriously injured patients should be in the same hospitals as 24/7 emergency operating facilities.

**Major trauma** Only a small proportion of the people who are taken to A&E departments every year in Wales have the most serious, life-threatening injuries, which are known as major trauma (see the level one A&E care description on p15).

These are often the result of serious road traffic accidents. It is estimated about 870 people in South Wales suffer major trauma every year and a further 1,200 people would initially be diagnosed as a major trauma case.

The evidence shows these people are more likely to survive and have better outcomes if their care is provided by expert clinicians based in a trauma centre within a trauma network that serves a region, rather than being taken to the nearest hospital with an A&E department.

South Wales does not currently have a dedicated trauma centre, although aspects of this highly-specialist service are provided at University Hospital Wales, in Cardiff and Morriston Hospital, in Swansea.

Following discussions with clinicians, we have agreed to set up a trauma network for South Wales, led by an experienced trauma clinician. Further details will be shared as they become available.

Tell us what you think swpresponse@wales.nhs.uk
We can’t continue as we are

We are concerned the current difficulties recruiting doctors could cause some of these services to fail suddenly, which would mean we would have to make emergency changes. Concentrating these services in fewer hospitals would help prevent this from happening and ensure changes are carried out in a planned way with extensive public consultation.

We want to provide services, which meet national clinical, safety and access standards for patients. We also need to provide services which meet these standards to ensure we can attract the doctors we need for the future and make sure they will want to work in Wales for the long term.

If we were to continue providing these services in all existing hospitals across South Wales, to meet these standards we would need to recruit very many more doctors, considerably more than we would need to recruit if we concentrate these services in fewer hospitals. We know these doctors simply aren’t there.

Concentrating services will help us to meet the clinical standards and improve safety and quality for patients, which will help support medical recruitment.

As the financial section later in this document outlines, the cost of continuing to provide these services in all hospitals is also considerably more than the cost of any of the options for change.
How have we developed the options for change?

In developing the options, we have drawn on expert guidance from frontline NHS clinicians working in South Wales, South Powys and for the Welsh Ambulance Service; their professional bodies, such as the Royal Colleges, and the national standards we are expected to achieve for each service area.

During the engagement exercise, we explained that these services must be provided in three fixed points in the future:

**University Hospital of Wales (UHW), Cardiff** The hospital not only provides local hospital services for people living in Cardiff and the Vale of Glamorgan, it provides specialist services for people living throughout the whole of South and West Wales.

It is a fixed point because of the size of the local population it serves and the range of very specialist care it provides to thousands of sick and injured babies, children and adults living in South and West Wales.

**Morrison Hospital, Swansea** The hospital provides local and specialist services for people living in Bridgend, Neath Port Talbot and Swansea, as well as for people living in the neighbouring Hywel Dda and Powys health board areas. It is also home to the Welsh Centre for Burns and Plastic Surgery, which provides very specialist care for children and adults in South Wales and burns care to people in South West England.

Specialist and Critical Care Centre (SCCC) – Aneurin Bevan Health Board, which provides healthcare for people living in Blaenau Gwent, Caerphilly, Newport, Monmouthshire, Torfaen and Newport, as well as parts of South Powys, has previously consulted on centralising specialist hospital services currently provided in the Royal Gwent Hospital, in Newport and Nevill Hall Hospital, in Abergavenny, in a new Specialist and Critical Care Centre (SCCC), which would be built near Cwmbran.

An outline business case has been submitted to the Welsh Government and, based on current plans, it is anticipated it will be completed in 2018-19.

It is considered to be a fixed point because of the size of the population it will serve and the specialist services needed by people living in the area.

When it is completed, the SCCC will be one of the five centres providing consultant-led maternity and neonatal care, inpatient children’s services and level two A&E services.

However, it is recognised the changes which are needed to sustain these services can’t necessarily wait until then. Aneurin Bevan Health Board will continue to work with its staff and community health council to agree a range of interim measures to ensure sustainability.

Tell us what you think swpresponse@wales.nhs.uk
The options

What are the options?

When we discussed the South Wales Programme with the public during the 12-week engagement period (September to December 2012), we described six scenarios for the location of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (level two A&E services).

Three of the scenarios described four of the current seven hospitals providing these services in the future:

**Four hospitals**

- UHW, Morriston, SCCC plus Prince Charles Hospital, Merthyr Tydfil
- UHW, Morriston, SCCC plus Princess of Wales Hospital, Bridgend
- UHW, Morriston, SCCC plus Royal Glamorgan Hospital, Llantrisant

The other three scenarios described five hospitals providing this pattern of services.

**Five hospitals**

- UHW, Morriston, SCCC plus Prince Charles and Princess of Wales
- UHW, Morriston, SCCC plus Prince Charles and Royal Glamorgan
- UHW, Morriston, SCCC plus Princess of Wales and Royal Glamorgan

These scenarios were assessed against the benefit criteria by a mixed group of about 200 clinicians, other NHS staff and stakeholders and separately by a number of small public focus groups, in April 2013. This assessment process was supported by information provided about:

- **Workforce** – clinical advice about how we might attract and retain staff for these services and how many extra staff we will need
- **Access** – how far patients would need to travel for hospital care and how much time this would take compared to now
- **Equity** - how any changes would affect our most deprived communities
- **Sustainability** – the impact on the rest of the South Wales hospital network, especially UHW, Morriston Hospital and the SCCC
- **Finance** – how the costs of proposals compare to what would be needed now to meet the national clinical standards
- **Ambulance** – the impact on the Welsh Ambulance Service

The process of assessment involved applying scores to each of the options based on the agreed benefit criteria.

As a result, two options scored considerably lower than the rest mainly because of the extra travelling time and
distance for patients to access these services; the likely impact on the Welsh Ambulance Service and the additional pressures these models would place on UHW, Morriston Hospital and the SCCC.

These two lowest scoring options were:

**UHW, Morriston, SCCC plus Princess of Wales Hospital**

**UHW, Morriston, SCCC plus Princess of Wales and Royal Glamorgan**

Based on this information, the South Wales Programme board – chairs and chief executives of the health boards and Welsh Ambulance Services NHS Trust - decided to rule these two options out of the consultation which means we are now consulting on **four options** for the future of consultant-led maternity services, neonatal care, inpatient paediatrics and emergency medicine (level two A&E) services.

The details of the benefits and drawbacks of each option, as identified by the process so far, are available in appendix one.

The four options:

**Option 1** UHW, Morriston, SCCC plus Prince Charles Hospital

**Option 2** UHW, Morriston, SCCC plus Royal Glamorgan Hospital

**Option 3** UHW, Morriston, SCCC plus Prince Charles and Princess of Wales hospitals

**Option 4** UHW, Morriston, SCCC plus Prince Charles and Royal Glamorgan hospitals

Tell us what you think swpresponse@wales.nhs.uk
After carefully examining each of these options, it became clear that a four-hospital model would mean large numbers of people would have further to travel to access these services, particularly very sick children and seriously injured or ill people who need level two A&E services.

Concentrating these services in five hospitals would have less impact on travel times overall, especially for those people living in deprived communities.

While a five-hospital model will arguably require more resources - people and money - than a four-hospital model, the process we have been through demonstrates it would provide a better balance of safety and quality with access and equity for the people of South Wales and South Powys.

One of the other key factors in the assessment process was the strategic significance of services on the Heads of the Valleys for the population of South Powys and the northern valleys communities. Any of the options which did not include Prince Charles Hospital, in Merthyr Tydfil as one of the five hospitals providing these services in the future created the most challenges in terms of access overall.

Putting all of these things together, the process so far has identified that option three is the best fit.

Option three: Consultant-led maternity and neonatal care, inpatient children's services and emergency medicine (level two A&E) services would be based in:
- University Hospital of Wales, Cardiff
- Morriston Hospital, Swansea
- Specialist and Critical Care Centre (SCCC), planned to be built near Cwmbran
- Prince Charles Hospital, Merthyr Tydfil
- Princess of Wales Hospital, Bridgend

All the information we used to analyse the options and the processes we followed in developing the consultation is available in the supporting documents, which can be found on the South Wales Programme website: www.wales.nhs.uk/swp. You can also call us on 0300 083 0020 (24-hour answer phone).

Tell us what you think about these options by completing the questionnaire (included in this document); write to us at South Wales Programme Feedback, PO Box 4368, Cardiff, CF14 8JN or email swpresponse@wales.nhs.uk

Want to know more? Visit www.wales.nhs.uk/swp
In the future, the vast majority of patients will continue to receive their hospital care locally, in the same way they currently do – any changes to these services will only affect the sickest and most seriously-injured patients and those women who need the help of a doctor during childbirth.

All hospitals involved in this process have an important role to play – they must work together as part of a new system, together with primary care and community services, to provide the same standards of care for all patients wherever they live. But this doesn’t mean that they all have to provide the same services.

There are a number of issues which are highly relevant whichever option is chosen as the way forward for South Wales and South Powys.

Any option which includes Prince Charles Hospital as one of the centres providing consultant-led maternity and neonatal services, inpatient services for children and level two A&E services would mean it needs to provide services for the broader population across parts of South Powys and the Heads of the Valleys communities.

This would require much closer working between Cwm Taf, Aneurin Bevan and Powys health boards to deliver joined-up services for the wider population.

Whatever the outcome of this consultation, it has become increasingly clear that Princess of Wales and Royal Glamorgan hospitals need to build on existing strong relationships to work as one integrated unit sharing expertise, staff and resources to the benefit of the wider population of the two areas the hospitals serve.

This does not take away from the very important relationship the Princess of Wales Hospital has with Neath Port Talbot, Singleton and Morriston hospitals or the relationship the Royal Glamorgan Hospital has with Prince Charles Hospital. It strengthens what can be delivered locally everywhere and ensures we retain our excellent staff and can recruit new high-calibre clinicians to strong integrated services.

The distance between Princess of Wales and Royal Glamorgan hospitals is relatively small and the two hospitals have a wealth of expertise and skills which can be put to much better use for patients if it is joined up in the way services are organised and delivered.

These hospitals will also need to continue to work very closely with UHW to ensure
we can maximise the opportunities for joint training, recruitment and, even more importantly, the delivery of truly patient-centred care which benefits from all available resources and expertise.

As we have explored the options further in preparation for consultation, it has become clear that if consultant-led maternity and neonatal care, inpatient children’s services and level two A&E services for the most seriously-ill and injured patients are concentrated in five hospitals, then there will need to be a corresponding move of other services in the opposite direction.

If these services are concentrated in five hospitals as described in option three, some services – for example some acute medicine and some planned (elective) surgery - which are currently provided at UHW and Princess of Wales Hospital, would need to be transferred to the Royal Glamorgan Hospital.

How we considered the future of hospital services

In considering the future for consultant-led maternity and neonatal care, inpatient children’s services and level two A&E care, we have made the following assumptions:

- Safe services should be provided as locally as possible, not local services provided as safely as possible
- Service delivery should be evidence-based and be consistent with national quality standards
- The workforce must be fit for purpose, sustainable and affordable
- The service model must be supported by patients, parents, the public, partners and other key stakeholders
- Sufficient resources are available to take patients to and from hospital quickly and safely in the future.

Want to know more? Visit www.wales.nhs.uk/swp
If this is the case, the Royal Glamorgan Hospital would not only continue to provide care for its local population but it would also provide some health services for people living in the Bridgend, Cardiff and Vale of Glamorgan areas.

Under this scenario, the Royal Glamorgan Hospital would need to become a specialist centre of excellence for one or more key specialties serving the wider South Wales area.

The geographical proximity of these three hospitals and some of the overlapping catchment populations helps make this happen. For some communities, changing where they go for some services will have very little impact on travel times and where we are integrating clinical teams this will really help with continuity of care.

Option three has been used as an example to illustrate the types of moves which will need to happen; the same principles would apply if another of the options is implemented following consultation.

There is still a considerable amount of work to be done to clarify the details of any corresponding service moves, but this needs to be part of a whole-system change, which would need to happen at the same time as changes to consultant-led maternity and neonatal care, inpatient children’s services and level two A&E care.

This work will be carried out with clinicians and the community health councils as we go through consultation.

All health boards are committed to this work.

Irrespective of which option is finally chosen for the future, quality of care and the needs of patients will be central to any decision making.

We will use the tried and tested systems we have developed for cancer and other specialist services to ensure care pathways are in place for any services that will be moved.

This will ensure that deciding where patients are treated will be based on clinical need with very local delivery for ongoing care and treatment, where appropriate, from joint teams of professionals working together in a seamless system.

Tell us what you think swpresponse@wales.nhs.uk
Finance is an important consideration in the South Wales Programme but it is not the main reason for change.

However, we recognise the need to ensure we can afford the proposed model for the future location of these services and that there is sufficient capital funding available in Wales to make physical changes to hospital buildings and departments where they are needed.

An analysis of the costs of each option in comparison to continuing with the current pattern of services, but meeting the clinical standards has been carried out. No change is not an option but is included here for the purpose of comparison.

Although this sounds a lot, it is between 0.3% and 0.42% of the annual collective expenditure of the five health boards involved or just over a day’s spending in the NHS in South Wales and South Powys.

The total revenue impact includes the projected costs for medical and midwifery staffing and the anticipated costs for the Welsh Ambulance Service.

There is further work to be undertaken as the financial assessment has not taken account of any impact on other services, such as trauma, emergency surgery or acute medicine or on support services, for example theatres and radiology.

The financial table includes costs associated with Welsh Ambulance Services NHS Trust's national modernisation programme, on which the South Wales Programme will be dependent.

To sustain services on all current hospital locations and ensure they meet the clinical standards would require an additional investment of £20.9m; this is considerably more than the additional cost of each of the options, which range from £10.6m to £14.7m.
Capital funding

Any capital funding requirements will be determined during the implementation stage. Health boards will want to use all available existing hospital capacity before they consider building additional facilities.

This may involve moving some planned work, such as less complex surgery, from one of the five centres to a nearby hospital to make best use of the space in both.

Any such proposals would be discussed with the local community health councils when they are being considered. Any additional capital funding is likely to be requested from the Welsh Government’s capital programme.

The financial assessment work will continue beyond the consultation phase and will ensure all hospitals are used to their fullest potential and no individual health board is financially destabilised by the changes.

Tell us what you think swpresponse@wales.nhs.uk
Specific work has been carried out as part of the South Wales Programme to look at the impact of any changes to the location of consultant-led maternity and neonatal care, inpatient children's services and level two A&E services on the Welsh Ambulance Service.

All the options have implications for the service, this includes the potential for increased 999 activity as a result of changes to these services; longer travel times to hospitals and additional patient transfers between hospitals in South Wales.

Ambulance crews may need additional training to increase their clinical skills, giving them the ability to diagnose and treat patients on scene.

A key part of the Welsh Ambulance Service's clinical strategy is to reduce the number of patients who are taken to hospital unnecessarily by developing specialist and advanced paramedics who can provide care closer to patients' homes.

An emergency medical transfer and retrieval service will also need to be developed, and the existing neonatal retrieval service further developed and extended, to ensure patients admitted to hospitals further away from their homes are able to be cared for closer to home as soon as clinically appropriate.

This may also require a additional skills and training for a small number of ambulance service staff and it will need the support of doctors, nurses and midwives involved in a patient's care.

Investment will also be needed in ambulance control room staffing, leadership teams and support services. Additional clinical support will also be needed in the ambulance service's clinical contact centre to advise ambulance crews about patient care. Investment in ambulance service estate, vehicles, technology and equipment may also be required. The capital costs of this range from £1.1m to £1.5m.

The Welsh Ambulance Services NHS Trust has a clinical strategy, which is aimed at enhancing quality, patient-focused care, embedding clinical leadership and supporting clinical decision making. It will be improving services in line with this strategy over the coming years whatever the outcome of the South Wales Programme, however some changes may be implemented more quickly as a result.
We want to hear what you think about the future location of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) for people living in South Wales and South Powys.

You can email your views to: swpresponse@wales.nhs.uk

You can tell us what you think via the website: www.wales.nhs.uk/swp www.wales.nhs.uk/swp/hafan

You can write to us at: South Wales Programme Feedback, PO Box 4368, Cardiff, CF14 8JN.

You can telephone 0300 083 0020 (24-hour answer phone) if you need more information.

You can also tell us what you think by completing a questionnaire, which will be analysed by the independent company Opinion Research Services, on behalf of the health boards.

The questionnaire is included in this document. But you can also complete it by following the link on the South Wales Programme websites www.wales.nhs.uk/swp and www.wales.nhs.uk/swp/hafan.

Please note: All comments and responses about the South Wales Programme consultation will be published and shared by the health boards and the Welsh Ambulance Services NHS Trust.

Copies will also be sent to the community health councils and ORS.

If you do not wish your comments to be published, please state so in your response.
<table>
<thead>
<tr>
<th>Community Health Council</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Website</th>
<th>Email</th>
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<tbody>
<tr>
<td>Aneurin Bevan Community Health Council</td>
<td>Raglan House, 6-8 William Brown Close, Llantarnam Business Park, Cwmbran, NP44 3AB</td>
<td>01633 838 516</td>
<td><a href="www.wales.nhs.uk/sitesplus/901/home">www.wales.nhs.uk/sitesplus/901/home</a></td>
<td><a href="mailto:abchc@abchc.org.uk">abchc@abchc.org.uk</a></td>
</tr>
<tr>
<td>Cardiff and Vale Community Health Council</td>
<td>Third Floor, Park House, Greyfriars Road, Cardiff, CF10 3AF</td>
<td>029 2037 7407</td>
<td><a href="www.wales.nhs.uk/sitesplus/897/home">www.wales.nhs.uk/sitesplus/897/home</a></td>
<td><a href="mailto:tfh@cavogchc.org.uk">tfh@cavogchc.org.uk</a></td>
</tr>
<tr>
<td>Cwm Taf Community Health Council</td>
<td>10 Maritime Offices, Woodland Terrace, Maesycoed, Pontypridd, CF37 1DZ</td>
<td>01443 405 830</td>
<td><a href="www.wales.nhs.uk/sitesplus/903/home">www.wales.nhs.uk/sitesplus/903/home</a></td>
<td><a href="mailto:enquiries@cwmtafchc.org.uk">enquiries@cwmtafchc.org.uk</a></td>
</tr>
<tr>
<td>Brecknock and Radnor Community Health Council</td>
<td>First Floor, Neuadd Brycheiniog, Cambrian Way, Brecon, Powys, LD3 7HR</td>
<td>01874 624 206</td>
<td><a href="www.wales.nhs.uk/sitesplus/905/home">www.wales.nhs.uk/sitesplus/905/home</a></td>
<td><a href="mailto:breconchc@breconchc.org.uk">breconchc@breconchc.org.uk</a></td>
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The public consultation on the South Wales Programme proposals runs for eight weeks from **May 23 to July 19, 2013**.

During this time a wide range of discussions will take place with key interested groups and forums about the proposals as well as a range of formal public consultation meetings held to ensure a wide range of views will be heard.

These public meetings will be held across South Wales and South Powys, and the details of their locations have been agreed with the local community health council (CHC) for that area and details can be found on our websites: [www.wales.nhs.uk/swp](http://www.wales.nhs.uk/swp) [www.wales.nhs.uk/swp/hafan](http://www.wales.nhs.uk/swp/hafan).

Community health councils represent the interests of the public in the health services in Wales. Individually and collectively their primary task is to assess the impact of proposed changes on health services, not to take a partisan role. As a result, the local CHC will chair public meetings held in their area to ensure they are aware of the issues being raised by the public.

In addition, specifically targeted meetings and events are planned to ensure the health boards give full opportunity to equality and diversity groups to put their views forward on the options, identify any particular impacts due to their protected characteristic and anything we can do to minimise or remove these effects.

All formal responses to the consultation, including completed and returned questionnaires, will be shared with CHCs as well as being sent to and analysed by the independent organisation Opinion Research Services (ORS).

At the end of the consultation period each CHC within the South Wales Programme area will have the opportunity to consider all comments received from local populations and record its own observations on them.

It is anticipated that the analysis of the consultation responses will be completed by September when it will be shared with CHCs. Each CHC will then formally respond to its respective health board, indicating whether it agrees to the proposals or if it is not satisfied they would be in the interests of health services in its area.

Health boards will meet in October to make a decision.

Tell us what you think [swpresponse@wales.nhs.uk](mailto:swpresponse@wales.nhs.uk)
**The options analysis**

**Option 1:** UHW, Morriston Hospital, SCCC and Prince Charles Hospital

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Meets the current national standards for inpatient children’s services, emergency medicine and maternity services</td>
<td>More people will need to travel further to access emergency medicine and inpatient children’s services</td>
</tr>
<tr>
<td>Supports the principles of low-risk birthing services being provided locally networked to a centralised obstetrics service</td>
<td>There would be a higher number of emergency transfers than in the five hospital models</td>
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<tr>
<td>Rotas for trainee doctors would be compliant with the European Working Time Directive which will improve current working conditions for doctors and is in line with the Welsh Deanery’s strategy for improving recruitment to junior doctor training posts in Wales</td>
<td>Almost one in four patients would have to travel more than 30 minutes for some hospital services</td>
</tr>
<tr>
<td>Lower risk of not being able to recruit enough doctors compared to the five site options as fewer additional doctors will be required to staff this option</td>
<td>Requires the Rhondda and Ogwr valleys, Bridgend and western Vale of Glamorgan populations to travel further to access these services.</td>
</tr>
<tr>
<td>Maintains access to these services for the population with the highest access and some of the highest deprivation challenges.</td>
<td>Prince Charles Hospital, as the fourth hospital, would be considerably smaller than the other three hospitals (less than half the size of UHW). It would have a smaller catchment area and therefore a smaller critical mass of patients, which could impact on its long-term sustainability. Demand and activity at the other three centres would be considerably higher with the greatest additional pressure on UHW</td>
</tr>
<tr>
<td>Would successfully deliver a network of integrated care as UHW, Prince Charles and Morriston hospitals would work closely with Royal Glamorgan and Princess of Wales hospitals to develop these sites as centres of excellence for some planned (elective) services and some other non-emergency services</td>
<td>To accommodate the additional activity, there is likely to be a need for significant development and capital investment in infrastructure at UHW, Prince Charles Hospital and Morriston Hospital</td>
</tr>
<tr>
<td>Additional medical staff will be required and new ways of working to manage acute medical patients</td>
<td></td>
</tr>
</tbody>
</table>

Want to know more? Visit [www.wales.nhs.uk/swp](http://www.wales.nhs.uk/swp)
### Option 2: UHW, Morriston Hospital, SCCC and Royal Glamorgan Hospital

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets the current national standards for inpatient children's services, emergency medicine and maternity services</td>
<td>More people will need to travel further to access emergency medicine and inpatient children’s services</td>
</tr>
<tr>
<td>Supports the principles of low-risk birthing services being provided locally networked to a centralised obstetrics service</td>
<td>There would be a higher number of emergency transfers than in the five hospital models</td>
</tr>
<tr>
<td>Rotas for trainee doctors would be compliant with the European Working Time Directive which will improve current working conditions for doctors and is in line with the Welsh Deanery’s strategy for improving recruitment to junior doctor training posts in Wales</td>
<td>Almost one in four patients would have to travel more than 30 minutes for some hospital services</td>
</tr>
<tr>
<td>Lower risk of not being able to recruit enough doctors compared to the five site options as fewer additional doctors will be required to staff this option</td>
<td>Additional medical staff will be required and new ways of working to manage acute medical patients</td>
</tr>
<tr>
<td>Would successfully deliver a network of integrated care as the Royal Glamorgan will work closely with Princess of Wales and Prince Charles hospitals to develop these sites as centres of excellence for some planned (elective) and some other non-emergency services</td>
<td>This option would not provide services for the populations with the highest access and some of the highest deprivation challenges – requires the Heads of the Valleys, South Powys, Ogwr valley, Bridgend and western Vale populations to travel further to access services.</td>
</tr>
<tr>
<td>The disruption to sites in terms of infrastructure development will be confined largely to one site: Royal Glamorgan Hospital.</td>
<td>There would need to be major capital investment and development of the Royal Glamorgan Hospital site, which would more than double the current capacity for these services</td>
</tr>
<tr>
<td>This option would provide a more even provision of hospital services with four similarly-sized emergency departments for the South Wales population.</td>
<td></td>
</tr>
</tbody>
</table>
**Option 3:** UHW, Morriston Hospital, SCCC and Prince Charles and Princess of Wales hospitals

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets the current national standards for inpatient children’s services, emergency medicine and maternity services</td>
<td>Additional medical staff will be required and new ways of working to manage acute medical patients</td>
</tr>
<tr>
<td>Supports the principles of low-risk birthing services being provided locally networked to a centralised obstetrics service</td>
<td>Higher risk of not being able to recruit enough doctors compared to the four site options as additional doctors will be required to staff this option</td>
</tr>
<tr>
<td>Rotas for trainee doctors would be compliant with the European Working Time Directive which will improve current working conditions for doctors and is in line with the Welsh Deanery’s strategy for improving recruitment to junior doctor training posts in Wales</td>
<td>Based on population projections, there is unlikely to be sufficient numbers of births at the consultant-led maternity unit at Prince Charles Hospital to meet national standards for training junior doctors from 2030</td>
</tr>
<tr>
<td>There would be a higher number of emergency transfers than currently but less than in the four site models</td>
<td>Higher risk of not being able to recruit enough doctors compared to the four site options as more additional doctors will be required to staff this option. Need to develop innovative ways of working.</td>
</tr>
<tr>
<td>Maintains a regional hospital service for the population with the highest access and some of the highest deprivation challenges and provides better access than the four site options</td>
<td>Almost one in eight patients would have to travel more than 30 minutes for some specialist services</td>
</tr>
<tr>
<td>Requires Rhondda valleys populations to travel further to access regional services</td>
<td></td>
</tr>
<tr>
<td>Would successfully deliver a network of integrated care as the Princess of Wales and Royal Glamorgan particularly will work closely to develop an integrated service for their catchment populations. The Royal Glamorgan site is likely to be developed as a centre of excellence for some planned (elective) services</td>
<td>In order to accommodate the additional activity, there is likely to be a need for significant development and capital investment in infrastructure at Princess of Wales, and Prince Charles Hospitals and some at UHW.</td>
</tr>
</tbody>
</table>
### Option 4: UHW, Morriston Hospital, SCCC and Prince Charles and Royal Glamorgan hospitals

<table>
<thead>
<tr>
<th>Benefits</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Meets the current national standards for inpatient children’s services, emergency medicine and maternity services</td>
<td>Additional medical staff will be required and new ways of working to manage acute medical patients</td>
</tr>
<tr>
<td>Supports the principles of low-risk birthing services being provided locally networked to a centralised obstetrics service</td>
<td>Higher risk of not being able to recruit enough doctors compared to the four site options as additional doctors will be required to staff this option</td>
</tr>
<tr>
<td>Rotas for trainee doctors would be compliant with the European Working Time Directive which will improve current working conditions for doctors and is in line with the Welsh Deanery’s strategy for improving recruitment to junior doctor training posts in Wales</td>
<td>Based on population projections, there is unlikely to be sufficient numbers of births at the consultant-led maternity unit at Prince Charles Hospital to meet national standards for training junior doctors from 2030</td>
</tr>
<tr>
<td>There would be a higher number of emergency transfers than currently but less than in the four site models</td>
<td>Higher risk of not being able to recruit enough doctors compared to the four site options as more additional doctors will be required to staff this option. Need to develop innovative ways of working.</td>
</tr>
<tr>
<td>Maintains a regional hospital service for the population with the highest access and some of the highest deprivation challenges and provides better access than the four site options</td>
<td>Almost one in eight patients would have to travel more than 30 minutes for some specialist services</td>
</tr>
<tr>
<td>Requires Bridgend, Ogwr valley and Western Vale populations to travel further to access services</td>
<td></td>
</tr>
<tr>
<td>Would successfully deliver a network of integrated care as the Royal Glamorgan and Princess of Wales hospitals particularly will work closely to develop an integrated service for their catchment populations. The Princess of Wales site is likely to be developed as a centre of excellence for some planned (elective) services.</td>
<td>In order to accommodate the additional activity, there is likely to be a need for significant development and capital investment in infrastructure at Royal Glamorgan Hospital and some at Prince Charles and Morriston hospitals.</td>
</tr>
</tbody>
</table>
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and emergency – hospital departments providing urgent and emergency care for sick and injured people</td>
</tr>
<tr>
<td>Acute care</td>
<td>Immediate or urgent care in a hospital setting</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>The immediate and early specialist management of adult patients with a wide range of medical conditions who come to hospital as emergencies. About 80% of patients seen in emergency departments are acute medicine cases.</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>Care for a pregnant woman before she gives birth</td>
</tr>
<tr>
<td>Assessment unit</td>
<td>A unit where clinicians are able to make immediate assessments and decisions about a person’s care when they arrive at hospital</td>
</tr>
<tr>
<td>CHC</td>
<td>Community health councils are statutory organisations which represent the public’s independent voice in the NHS. CHCs monitor the quality of local NHS services provided and also provide advocacy for the public if things go wrong. They play an important independent role when the NHS wants to change services, assessing the impact proposed changes will have.</td>
</tr>
<tr>
<td>Chronic conditions</td>
<td>A condition which a patient has that lasts for three months or more</td>
</tr>
<tr>
<td>Clinical reference groups</td>
<td>CRGs were set up as part of the South Wales Programme to look at the challenges facing maternity, children’s and emergency medicine (A&amp;E) services, develop the service models for the future and to advise the South Wales Programme board. Frontline doctors, nurses, midwives, therapists and paramedics were members of the three CRGs.</td>
</tr>
<tr>
<td>Clinical specialty</td>
<td>A specific clinical area, for example paediatrics</td>
</tr>
<tr>
<td>Clinician</td>
<td>A qualified and registered health professional, for example, a doctor, nurse or physiotherapist</td>
</tr>
<tr>
<td>Configuration</td>
<td>A pattern of services</td>
</tr>
<tr>
<td>Consultant</td>
<td>A very senior doctor or surgeon with specialist training and expertise in a particular area of medicine.</td>
</tr>
</tbody>
</table>
Consultant-led

A consultant-led service is one where a consultant retains overall clinical responsibility for the service, care team or treatment. The consultant will not necessarily be physically present for each activity but they will take clinical responsibility for each patient’s care. This differs from consultant-delivered care, where consultants personally deliver each episode of care.

Doctor-in-training

Also known as a trainee doctor. A doctor who is still training to be a specialist or a GP. There are different stages and lengths of training according to the specialty.

Elective care

Planned care or operations.

Emergency department

A major A&E centre.

Emergency medicine

This term refers to traditional accident and emergency (A&E) services for people with serious or life-threatening injuries or conditions and to urgent care and minor injuries services for people with less serious injuries and illnesses.

EWTD

European Working Time Directive. A directive introduced across the European Union, which limits the hours people can work. This was introduced in 1998 but junior doctors were exempt until its full implementation in August 2009. All doctors are limited to a 48-hour maximum working week, but it also entitles them to 11 hours rest a day and a right to a day off each week; a right to a rest break if the working day is longer than six hours and four weeks paid leave each year.

Home birth

A birth at home with a midwife present.

Inpatient

Someone who needs to be assessed in hospital, including an overnight stay.

Maternity services

Services for pregnant women and new mothers and babies.

Midwife-led

Midwives are the professionals providing the care before and during labour, delivery and the immediate postnatal period.

Minor injuries unit (MIU)

A unit dealing with less severe injuries and illness treated by nurses and therapists with advanced skills but without specialist doctors. Part of a network of emergency and urgent care services.
<table>
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<tr>
<td>Midwife-led unit (MLU)</td>
<td>Midwife-led units or birth centres run by midwives without the medical facilities of a hospital. They can be next to a hospital maternity unit (alongside) or completely separate from hospital (free-standing or standalone)</td>
</tr>
</tbody>
</table>
| Neonatology | Clinical specialty that provides care to premature and newborn babies who require medical support. There are three levels of neonatal care:  
  **Special care baby unit** (level one) - a unit for new born babies who require a little extra care or observation. Also called level one neonatal care  
  **High dependency** (level two) – a specialist unit for ill newborn and premature babies who do not require intensive care  
  **Intensive care** (level three) – a specialist unit for seriously-ill newborn and premature babies. |
| NPT | Neath Port Talbot Hospital, Port Talbot (Abertawe Bro Morgannwg University Health Board) |
| Obstetrics | The medical specialty dealing with the care of women during pregnancy (prenatal period), childbirth and the postnatal period |
| Obstetrics unit | Also known as a consultant-led unit (CLU). A unit where women are cared for during pregnancy, childbirth and the recovery period. These units are led by consultant obstetricians who are specialist doctors |
| Outcomes | Results |
| Paediatrics | Children’s health services |
| PCH | Prince Charles Hospital, Merthyr Tydfil (Cwm Taf Health Board) |
| POW | Princess of Wales Hospital, Bridgend (Abertawe Bro Morgannwg University Health Board) |
| Premature | A baby born before the 37th week of pregnancy |
| Primary care | Care provided in community settings, including the home, by a range of qualified health professionals, including GPs and district nurses. This is usually the first point of contact for healthcare. |

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<tr>
<td>Reconfiguration</td>
<td>The process of reorganising services in an area to provide better care and a different organisational structure.</td>
</tr>
<tr>
<td>RGH</td>
<td>Royal Glamorgan Hospital, Llantrisant (Cwm Taf Health Board)</td>
</tr>
<tr>
<td>Royal Colleges</td>
<td>The professional bodies for certain health professionals, including Royal College of Midwives (RCM); Royal College of Nursing (RCN); Royal College of Obstetrics and Gynaecology (RCOG) for doctors specialising in obstetrics and gynaecology; Royal College of Paediatrics and Child Health (RCPCH) for doctors specialising in the health of children and young people; Royal College of Surgeons of England (RCS) for surgeons in England and Wales and the Royal College of Physicians, which supports the medical profession.</td>
</tr>
<tr>
<td>SAS doctor</td>
<td>Staff grade and associate specialist doctors. These are doctors who are no longer in training and work alongside consultants.</td>
</tr>
<tr>
<td>SCCC</td>
<td>Specialist and Critical Care Centre. A major new hospital planned to be built near Cwmbran, which will provide specialist services currently based at Royal Gwent Hospital, in Newport and Nevill Hall Hospital, in Abergavenny. Part of Aneurin Bevan Health Board’s Clinical Futures programme. It is anticipated the SCCC will be completed in 2018-19</td>
</tr>
<tr>
<td>Secondary care</td>
<td>Care provided in a hospital setting</td>
</tr>
<tr>
<td>Specialist</td>
<td>A professional who provides a service which meets the specific needs of people who have complex conditions or injuries</td>
</tr>
<tr>
<td>ST4</td>
<td>Specialty trainee doctor who is in their fourth year of training in their chosen specialty (for example paediatrics). They will have completed foundation training before this.</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>A group of people who are involved or have an interest in healthcare. Stakeholders include healthcare professionals, trade union representatives, voluntary and third sector representatives, local authorities, patients and patient groups.</td>
</tr>
</tbody>
</table>

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<table>
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<tr>
<td>Trauma centre</td>
<td>A designated hospital which receives the most severely-injured or multiply-injured patients, usually following a road traffic accident</td>
</tr>
<tr>
<td>Trauma network</td>
<td>An organised collection of hospitals working together with the emergency ambulance services to agreed protocols to provide care for people injured, usually following accidents. Different levels of care may be provided in different hospitals in the network.</td>
</tr>
<tr>
<td>UHW</td>
<td>University Hospital of Wales, Cardiff (Cardiff and Vale University Health Board)</td>
</tr>
<tr>
<td>Unscheduled care</td>
<td>A term used to describe any unplanned health or social care. The current range of services includes support to patients in their homes, booking of urgent or emergency GP appointments, 999 ambulance services and emergency department/hospital treatment</td>
</tr>
<tr>
<td>Wales Deanery</td>
<td>School of Postgraduate Medical and Dental Education at Cardiff University, which oversees and is responsible for the post-qualification training of doctors in Wales</td>
</tr>
<tr>
<td>WIMD</td>
<td>Welsh Index of Multiple Deprivation</td>
</tr>
<tr>
<td>YYF</td>
<td>Ysbyty Ystrad Fawr, Ystrad Mynach (Aneurin Bevan Health Board)</td>
</tr>
</tbody>
</table>
The South Wales Programme is made up of:

Abertawe Bro Morgannwg University Health Board
Aneurin Bevan Health Board
Cardiff and Vale University Health Board
Cwm Taf Health Board
Powys Teaching Health Board
Welsh Ambulance Services NHS Trust