Public Document Pack

Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
10 January 2013

Meeting time:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

Legislation: Steve George (Asbestos Bill) / Fay Buckle (Social Services Bill)
Legislation Office Clerks 029 2089 8242/8041

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

Agenda

1. Introductions, apologies and substitutions

2. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Evidence Session 1 (09:00-09:45)

Mick Antoniw AM, Member in charge of the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill
Vaughan Gething AM
Paul Davies, Associate of Welsh Institute for Health and Social Care

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill, as introduced

Explanatory Memorandum

3. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business: (09:45)

Items 4, 7, 8 & 12

Private session

4. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Consideration of Member in charge's evidence (09:45-10:00)

Public session

5. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Evidence Session 2 (10:00-10:45) (Pages 1 - 6)

HSC(4)-01-13 paper 1
HSC(4)-01-13 paper 2

Asbestos Awareness and Support Cymru

Joanne Barnes-Mannings, Community Outreach Officer
Lorna Johns, Strategic Research and Development Officer

Asbestos Victims Support Groups' Forum UK

Tony Whitston, Chair, Asbestos Victims Support Groups Forum - UK
Marie Hughes, Mesothelioma Support (Greater Manchester Asbestos Victims Support Group)

6. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Evidence Session 3 (10:45 - 11:30) (Pages 7 - 11)

HSC(4)-01-13 paper 3

Trade Unions
Unite Wales and GMB Wales & South West

Hannah Blythyn, Campaigns & Policy Co-ordinator for Unite Wales
Mike Payne, Regional Political Officer, GMB

Private Session

7. Social Services and Wellbeing (Wales) Bill: Consideration of Expert Advisers (11:30 - 11:45) (Pages 12 - 21)

HSC(4)-01-13(paper 4)

Private session

8. Social Services and Wellbeing (Wales) Bill: Factual Briefing (11:45 - 12:15)

Rob Pickford - Director of Social Services and Children, Welsh Government
Julie Rogers - Deputy Director Social Services Legislation & Policy Division, Welsh Government

(Break 12:15-13:30)

Public session

9. Health board reconfiguration plans – Evidence from Wales Deanery (13.30 – 14.15) (Pages 22 – 28)

HSC(4)-01-13 paper 5

Professor Derek Gallen, Postgraduate Dean
Professor Peter Donnelly, Deputy Postgraduate Dean
Dr Helen Fardy, Reconfiguration Lead for Paediatrics
Dr Jeremy Gasson, Reconfiguration Lead of Obstetrics & Gynaecology

10. Health board reconfiguration plans – Evidence from the National Clinical Forum (14.15 – 15.00) (Pages 29 – 41)

HSC(4)-01-13 paper 6

Professor Michael Harmer, Chair
Mary Burrows, Lead Chief Executive for NHS Wales

11. Papers to note (Pages 42 – 46)

Minutes of the meetings held on 29 November and 5 December 2012

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Letter from Presiding Officer (Pages 47 – 51)
HSC(4)-01-13 paper 7
HSC(4)-01-13 paper 7 (annexe)

Forward Work Programme – January to February 2013 (Pages 52 – 54)
HSC(4)-01-13 paper 8

Private session

12. Food Hygiene Rating (Wales) Bill: Consideration of Draft Regulations

Consultation on the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill.

Evidence of Asbestos Awareness & Support Cymru

Introduction

1. This evidence is submitted by Asbestos Awareness and Support Cymru (AASC), a support group for victims of asbestos related diseases and their families. It has a web presence plus Facebook and Twitter and offers a signposting service to improve access to the best services available within Wales.

2. It is a registered charity and is a member of the National Asbestos Victims Support Forum.

3. The overall aim is to be the leading connected community within Wales to enhance the quality of life for those victims of asbestos exposure and their families.

4. Financial compensation awarded to families who have lived and died from an asbestos related disease as a consequence of the negligence of employers has made a significant impact upon lives. The move to secure compensation has also strengthened the message that breaches of Health and Safety Law and putting workers lives at risk is not be to be tolerated. Human life is precious.

5. The Recovery of Medical Costs for Asbestos Diseases (Wales) Bill is welcomed as it is demonstrating not only a concern for the welfare of patients but also highlighting the costs incurred by the NHS for what has been negligent behaviour by employers.

Executive Summary

6. AASC welcomes this move to improve care to victims of exposure to asbestos related disease but also sees that financial resources could be used to enhance the care already being provided by the NHS.

7. As a health measure the financial compensation secured through the Bill create positive health outcomes for families affected by asbestos exposure.

8. There has been complacency around the dangers of asbestos exposure which heightens the risk that numbers diagnosed with illnesses such as mesothelioma are going to increase and this will naturally impact upon levels of NHS care provided.

9. The Bill will have the effect of improving care and support provided to asbestos victims.

10. The Bill will demonstrate to the rest of the UK and to the world that Wales does recognise the damaging effect asbestos has had upon workers.

11. The Bill illustrates a Wales wide responsibility for the NHS and that financial resources are needed to ensure that our high quality of care can continue but has been compromised by employers continuing to shirk responsibilities for their employees.

Financial Support

12. Care to victims of asbestos exposure requires financial resourcing, from the initial consultation with the General Practitioner to Consultant, nurse specialist, and other health specialists called upon to provide advice on mobility and breathing exercises such as physiotherapists and occupational therapists. Each of these professions requires payment and on top of that is the need to cover drug and surgical treatment costs.

13. Support to victims of asbestos related diseases and their families continues outside the NHS through the Third Sector with one to one meetings and group sessions, and hand holding through emotionally traumatic stages of an illness. Emotional support through the Third sector groups such as AASC is crucial not only for the victims but also the informal family carers. Any financial compensation acquired through this Bill and made available to the Third sector would be valued.

14. Extra financial resources secured through the implementation of the Bill could help in the development of increased telephone helpline support, more face to face meetings and improved collaboration between victims, carers and health professionals. Enhancing connections between the 'care givers' and the 'care receivers' will bring about 'piece of mind'. Pathways of care will be strengthened thus minimising the sense of despair, distress, pain, suffering and isolation and replacing with confidence, respect and knowledge that someone does care.

15. It is recognised that administrative costs will be incurred through the processing of compensatory payments and it is hoped that these will not be too onerous and eat into the compensation secured.

Summary.

- AASC welcomes the opportunity to comment on the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill and recognises that this is s brave move for the Welsh Government to undertake but it is a move undertaken on behalf of the many who have fallen prey to evils of asbestos dust.

- We hope that the Bill continues successfully through the legislative process to secure extra financial resources which will be made available for improved care.

- The world is watching Wales for what will be an historic step forward in supporting asbestos victims.

Asbestos Awareness & Support Cymru

18 December 2012.

Submission to the Health and Social Care Committee

National Assembly for Wales

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill

The Forum is a national organisation representing asbestos victims support groups throughout the UK. The groups provide a dedicated service to asbestos victims including: home visits for benefits and compensation advice; representation at tribunals; support meetings for mesothelioma sufferers and their families. The Forum campaigns for: improved services and treatment for asbestos victims; justice and full compensation, and; a ban on the trade and use of asbestos world-wide.

Submission

We have addressed the consultation questions below which come within the scope of our work, knowledge and expertise.

1. Is there a need for a Bill to recover medical costs?

We think there is a need for the Bill for the following reasons:

To properly fulfil the 'polluter pays principle' by meeting the full societal cost of asbestos-related diseases.

The established principle that the polluter pays is only fully complied with in respect of asbestos-related diseases where: the full societal costs of asbestos disease is met by those employers who negligently caused damage to health or loss of life through exposure to asbestos, and; where appropriate, by those who insured negligent employers.

The exigencies of life result in many people suffering many different diseases, incurring costs of medical treatment within the NHS, which are rightly funded through National Insurance. However, asbestos diseases, in the majority of cases, are caused by negligence and could, and should, have been prevented. The cost to society of fully meeting the treatment and care needs of asbestos victims resulting from negligence should be borne by the guilty party, or their insurers, not through National Insurance.

To fulfil unmet medical needs, the costs of which fall on the wider society

Often, medical costs are met by asbestos victims and their families who try to make up for unmet medical needs, as shown in the two examples below.

Mesothelioma sufferers and their families provide an enormous amount of funding for research into the treatment of mesothelioma, which attracts very little funding from the Department of Health. The Mick Knighton Mesothelioma Research fund has donated over £1 million, supporting many research projects, as has the June Hancock Mesothelioma Research Fund. Since Action Mesothelioma Day was inaugurated in 2006 over £110,000

has been donated to these research funds by mesothelioma sufferers and their families in Greater Manchester. A similar sum has been collected by other Forum members.

Insurers have acknowledged this unmet need by donating £3 million for mesothelioma research. However, we ask the Committee to understand that insurers received a huge windfall from the tax payer through recovery of state lump sum payments for over a decade. The compensation insurers paid to successful claimants was reduced by the amount of the state lump sum payment until 2008 when the Government finally decided to recover those payments, ending the tax payers' subsidy to insurers. The DWP recovered £23,953,961.00 in 2011[1], which is the amount that insurers would have recovered in that year. It is clear that over a decade, insurers received a windfall from the tax payer of well over £100 million.

It is our view that the insurers' donation to research came from the tax payer, not the insurers. Notwithstanding that view, we believe that the unmet need for research could be supported by recovery of NHS costs as set out in the Bill, which provides for certain and dependable income based on the polluter pays principle, and not reliant on goodwill (sic).

Mesothelioma Nursing posts. The charity Mesothelioma UK has, to date, funded three specialist mesothelioma nursing posts. Funding has come from a wide source of charitable donations to provide more specialist care for mesothelioma sufferers. The cost to society of specialist care of mesothelioma sufferers could be met by those who negligently caused this disease through the recovery of NHS costs as set out in the Bill.

To relieve the cost of occupational ill health as well as injury, which falls mainly on those affected and by their families.

The HSE estimate[2] that in 2011, 54% of the cost of occupational injury and ill health (excluding cancer) was borne by individuals, with employers bearing 24% and Government 23%. The HSE Executive Board (22 Aug. 2012) indicated that the cost to society of occupational cancer is in the region of 'double billion figures'.

The cost of ill-health, injury and cancer places an unacceptable burden on individuals and their families: over double the burden on the rest of society. This Bill goes a small, but significant way in reducing that burden.

8. Does the Bill deliver the stated objectives?

The Bill seeks to recover NHS costs of treating asbestos victims negligently exposed to asbestos to Welsh Ministers for the general benefit of asbestos victims and their families. As set out, we believe that the Bill does deliver those objectives by providing for the recovery of NHS costs in cases of negligent exposure to Welsh Ministers (S2) in accordance with the National Health Service (Wales) 2006 for the purposes of treatment of, or other services relating to, asbestos-related diseases (S16).

4. How will the Bill change what organisations do? What will the impact be?

[1] http://www.dwp.gov.uk/other-specialists/compensation-recovery-unit/2008-diffuse-mesothelioma/

[2] HSE Costs to Britain of workplace injuries and work-related ill health: 2010/2011

A compensation system which reflects the true cost to society of employer negligence properly fulfils an important objective common to all compensations systems: the prevention of further injury and disease. In 2002, an HSE report[3] concluded that '*UK employers only bear a minority of the tangible costs of occupational ill health and injury through insurance premiums, and an even smaller fraction if non-tangible costs are included.*' It is unsurprising that the Report further concluded that employers did not cite the reduction of the cost of insurance premiums as a reason for improving standards of health and safety management.

In making employers and insurers more responsible for the cost to society of asbestos disease, the Bill will encourage better prevention, affirming the view that employer negligence should not be a cheap option. This is especially important as the failure of duty holders to comply with the Control of Asbestos Regulations, especially in respect of asbestos in schools, has caused public dismay, particularly in Wales. Moreover, the HSE has asked that the asbestos Hidden Killer Campaign is urgently reinstated because of their deep-felt concerns about the lack of worker awareness of the hazards of asbestos and the failure of duty holders to comply with the law.

8. Financial implications of the Bill

We support option 2i for the reasons set out in paragraph 123 of the Explanatory Memorandum.

With reference to paragraph 129 of the Explanatory Memorandum, we do not think that the proposed tariff scheme for mesothelioma untraced insurance, as announced by Lord Freud on the 25 June 2012, will impact on the number of mesothelioma claimants in Wales which will allow for recovery of NHS costs. This is because the tariff scheme is to be funded by a levy on insurers, which is likened to a 'tax', so that payments to mesothelioma sufferers successful in a claim on the scheme will be paid by public funds. Furthermore, payments are envisioned to be paid at approx. 75% of average mesothelioma awards and will not conform to the usual civil law rules for payment, e.g. payment to the deceased's estate.

Had the Government adopted the main, and only costed option, in the consultation i.e. an Employers Liability Insurance Bureau (ELIB), similar to the Motor Insurers' Bureau (MIB), then mesothelioma sufferers would be treated no less favourably than injured drivers and would receive a payment from an insurance fund which could be vulnerable to recovery of NHS costs.

Tony Whitston

Forum Chair

20 December 2012

[3] HSE Report 436/2002. 'Changing business behaviour – would bearing the true cost of poor health and safety performance make a difference?'

Consultation – Recovery of Medical Costs for Asbestos Diseases (Wales) Bill

Joint response from Unite Wales and GMB Wales & South West trade unions

General

1. **Is there a need for a Bill to allow recovery of costs of NHS treatment for asbestos related diseases in Wales? Please explain your answer.**

Yes. We believe that there is a compelling case for a Bill to allow recovery of costs of NHS treatment of asbestos related diseases in Wales. Hundreds of Welsh workers die every year from asbestos related disease and exposure to asbestos at work has caused suffering and hardship for thousands of others over the past decades. Many of Unite and GMB's current membership have been exposed to asbestos. Our members who have worked in the insulation industry, ship building, power stations, manufacturing and construction are among the occupational groups most at risk of developing asbestos related disease.

What must not be overlooked here is the incalculable human suffering asbestos disease inflicts on Welsh workers and the devastating effect on their families. Those who suffer most are the estimated 100 people who will die each year in Wales from mesothelioma, the fatal asbestos cancer. There is no known cure for mesothelioma. The average life expectancy of a mesothelioma patient is 12 -18 months from the onset of symptoms with many dying in less than a year from diagnosis. HSE reports that most people who develop mesothelioma were exposed to asbestos at work.

We note from the Regulatory Impact Assessment that the treatment of patients diagnosed with asbestos related diseases has cost and continues to cost the Welsh NHS an average of £23,000 per patient, placing a considerable financial burden on the already financially hard pressed NHS in Wales. At diagnosis of the disease, there will be attendances to GPs, referral to consultants for radiology, biopsies, radiotherapy, and chemotherapy and in many cases, palliative care.

We believe that in cases where there is a clearly identifiable negligent employer and a civil compensation settlement is due it is only right that the negligent party (or their insurer) should reimburse the NHS for the cost of medical treatment paid for by NHS Wales. We believe that the 'polluter pays' principle should apply. The Bill will achieve this socially desirable outcome by requiring the negligent employer, or the insurer of the negligent employer, to contribute towards the

costs to society of providing medical treatment and support to Welsh workers who develop asbestos disease.

The Bill will displace the financial burden from the Wales NHS, which currently bears the cost of providing medical care and treatment, and transfer it to the negligent employer which caused the disease, or their insurer. The view of our members and, we believe, of Welsh working people generally, is that the aim of the Bill is entirely consistent with progressive social policy.

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

Yes. The Bill, as drafted, delivers the stated objectives as set out in the Explanatory Memorandum. It makes clear the intended purpose of the Bill and the mechanism for recovery of NHS costs.

3. Are the sections of the Bill appropriate in terms of introducing a regime to allow the recovery of costs of NHS treatment for asbestos related diseases in Wales? If not, what changes need to be made to the Bill?

We believe the sections of the Bill are appropriate, internally consistent and proportionate to the aims of the Bill. The Bill is clear in terms of introducing a regime to allow the recovery of costs of NHS treatment for asbestos related diseases in Wales. This is further expanded and illustrated in the Explanatory Memorandum. We therefore do not consider that any changes need to be made to the Bill.

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

Clearly the Bill will have a positive impact on the NHS in Wales in that it will reimburse the NHS in Wales for the significant costs for treatment of patients diagnosed with asbestos related diseases. In addition, as outlined by the Bill, the costs recovered will be of benefit to both the services provision of the NHS in Wales and the future treatment of victims of asbestos related diseases.

The establishment of an administrative process for the recovery of costs of the treatment of patients diagnosed with asbestos related diseases to the NHS in Wales will, of course, involve some initial change. However, we believe that the Explanatory Memorandum clearly outlines the available options. We support the proposed use of the existing injury compensation scheme coordinated by the CRU at the Department of Work and Pensions. We believe this would achieve the most cost effective balance by using established CRU structures and procedures, automated systems, data links to compensators and NHS bodies with the advantages of a single point of contact for data collection and administration of recovery of NHS treatment costs from compensators.

Moreover, the positive impact of these changes and the cost to society in the long term significantly outweigh any potential organisational adjustment at the outset.

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

We believe the Bill and the related Explanatory Memorandum make clear the provisions of the Bill and the mechanism of implementation.

We are aware that the Association of British Insurers (ABI) have indicated in their initial consultation response that they object to the Bill. We believe that the commercial interests of insurers should not take precedence over the principle of social justice which the Bill aims to deliver. Insurers who may claim that the impact of the Bill will result in the increased cost of insurance to employers in the current marketplace should be reminded that those insurers have already received, invested, reserved and profited from the premiums they were paid by employers in the past whose negligence is the cause of Welsh workers currently developing asbestos disease.

We also reject the specious objection from ABI that the NHS in Wales has already received the cost of treatment in the form of National Insurance Charges paid by workers – and that the Bill would result in duplication of payment. This ignores the obvious fact that if the insured employer had not negligently exposed Welsh workers to asbestos those workers who develop asbestos disease would not have done so and the substantial cost to the NHS in Wales of treating those patients would never have arisen. The ABI objection to the Bill offends the 'polluter pays' principle.

6. **Do you have any views on the way in which the Bill falls within the legislative competence of the National Assembly for Wales?**

We believe the Bill falls within the legislative competence of the National Assembly for Wales, under subject heading 9 of Part 1 of Schedule 7 to the Government of Wales Act 2006. This specifically includes the prevention, treatment and alleviation of disease, illness, injury, disability and mental disorder; and the organisation and funding of National Health Service. The purpose of this Bill is relevant to the 'treatment of disease, illnesses under this subject heading and the proposal of the Bill fits within 'organisation and funding of National Health Service.'

<u>Powers to make subordinate legislation</u>

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

In answering this question, you may wish to consider Section 5 of the Explanatory Memorandum, which contains a table summarising the powers delegated to Welsh Ministers in the Bill to make orders and regulations, etc.

The Bill strikes an effective balance between provision outlined in the Bill itself and the provision that will be made by subordinate legislation. This is similar to the

Health and Social Care (Community Health and Standards) Act 2003. Much of the procedure of the Bill in practice will be administrative, technical and incredibly detailed. Parts of provision of the Bill will also necessitate flexibility. This is therefore more suitable to subordinate legislation rather than the Bill itself.

Financial implications

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

In answering this question you may wish to consider Part 2 of the Explanatory Memorandum (the Regulatory Impact Assessment), which estimates the costs and benefits of implementation of the Bill.

It is estimated that the cost of care of victims of asbestos related diseases to the NHS in Wales is £2 million a year. The recovery of the costs of the treatment of asbestos related diseases in Wales would be significant to the NHS in Wales at a time when it is financially hard pressed.

The scale of the costs associated with the administration of the scheme are dependent on the administrative system used, the level of charges agreed within the tariff system and the amount of cases processed. However, the Explanatory Memorandum clearly outlines a number of options at varying initial and recurrent costs per annum. We refer to our response to Q4 outlining support for making the most effective use of existing CRU procedures for recovery of NHS treatment costs in order to minimise the administrative and business costs and maximise the net return.

We believe it is necessary and desirable to keep the administrative and business costs of the recoupment process to a minimum. We support the introduction of a tariff system for the calculation and recovery of NHS treatment costs. We note from the Explanatory Memorandum that there is a close correlation between the average cost in the proposed standard tariff (£25,361) with the average figure for the actual cost of treatment (£23,299) although we appreciate that there is potential for wider variation due to the relatively small sample of cases that formed the basis of the treatment cost analysis. In principle we consider that a form of capped tariff system is a reasonable and proportionate means of delivering the objectives of the Bill whilst minimising the operational costs.

We also believe that the combination of a capped standard tariff system with a CRU based recovery mechanism will provide an efficient means of dealing with any appeals and challenges by compensators or other parties and should minimise the scope for challenges due to the simplicity and clarity of a tariff based approach.

In addition, in relation to the costs for organisations liable for paying NHS charges the Bill does not create any new entitlement to compensation where a claim would not already exist. Successful claims arise when it is proven that a party such as the employer has been negligent. The status quo means that the NHS in Wales and therefore the public purse and the taxpayer must pick up the tab for the negligent party. We believe that this Bill is necessary, just and would ensure that the right party, or their insurer, is held responsible for their wrongdoing.

Other comments

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

It is important to GMB and Unite that the Bill binds the Crown so as to achieve parity of treatment between the recovery of NHS costs from commercial sector employers and insurers as well as government departments and former nationalised industries where many of our members worked and were negligently exposed to asbestos. It would be inequitable that a Crown employer who would also have made provision for risk, and who was as negligent as any private sector employer, should not bear the same responsibility to pay the same dues to society.

We reiterate our full support for the Bill which we believe is representative of Wales leading the way on matters of political substance and principle and delivering on the practicalities of implementing social justice. GMB and Unite in Wales commend this Bill for the benefits it confers on the NHS in Wales and the improved level of support and treatment it will generate for the people of Wales who will suffer the devastating effects of asbestos disease due to the legacy of employer negligence.

For further information please contact:

Unite - Hannah Blythyn on 07980 237694 or hannah.blythyn@unitetheunion.org
GMB – Mike Payne on 07980 753124 or mike.payne@gmb.org.uk

By virtue of paragraph(s) ix of Standing Order 17.42

Document is Restricted

Wales Deanery Deoniaeth Cymru

Health and Social Care Committee

HSC(4)-01-13 paper 5

Health board reconfiguration plans - Evidence from Wales Deanery

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

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

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

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

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

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

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

Specialty	2012 England fill rate	2012 Wales fill rate	2011 Wales fill rate
Paediatrics (end of round 1)	99%	87%	76%
Psychiatry	68%	38%	56%
Core Medical Training	99%	72%	82%

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

A further example is that in the last 3 years despite having advertised in excess of 15 posts, Wales has only recruited 4 trainees to Emergency Medicine.

Recruitment gaps impact heavily upon rotas which then puts undue service pressures on the trainees, to the detriment of their educational experience. It is the Deanery's recommendation, based upon findings from the Temple Report[2], that rotas should have 11 participants to prevent vulnerability from recruitment gaps, less than full time (LTFT) training, sickness absence, out of programme training opportunities and maternity leave. This approach will provide Wales with sustainable training programmes for the future.

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

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

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

2. How staffing difficulties are best explained:

It is best to continue to focus on the difficulties we are having in the recruitment of junior doctors, in Wales in the first instance. The NHS in Wales has had an over-reliance on the presence of junior doctors for service provision, dating back many years. The European Working Time Directive in 2005 reduced the available hours that doctors could work to 56 per week and the only way that the service could manage this reduction was to increase the number of junior doctors. Unfortunately, in Wales there was a marked increase in the number of Senior House Officer (now

called core training) posts across all Trusts in order to make the rotas compliant. This had a detrimental knock on effect to recruitment to higher specialty training in Wales as it meant our competition ratios going from core training to higher training were out of sync with the rest of the UK.

2. Temple, J (2010). Time for Training. A review of the impact of EWTD on the quality of training

When deciding upon what specialty and locality to apply to for Specialty training, applicants now have access to information from various sources. For applicants today opportunities for career progression is an important factor. The more core posts there are compared to higher posts the less the likelihood that a trainee will progress from core to higher training. For example, in 2009 the applicant to post ratios for surgical specialties peaked at 58 applicants per post advertised. This information is known to trainees and can be tracked and is available on the web.

This in itself made Wales an unattractive place to come as it was felt that the competition ratios were too risky to warrant an application. Successive years with vacancies have resulted in recruitment panels lowering the acceptability threshold resulting in a lower quality of appointees. These doctors have difficulty passing the Royal College examinations, league tables for which are published and available on the web UK-wide, and again this is a negative factor in applying to a locality with low pass rates. This is supported by evidence from the annual review of progress reviews of trainees. In 2012 the number of trainees requiring a formal extension to training as a result of failure to progress increased by 35% and the number of trainees withdrawn from training increased by 44%.

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

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

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

The medical employment pool is evolving. UK graduate numbers increased by 76% in the 10 years to 2006, of which two thirds were female. Currently 53% of all trainees in Wales are female. The demand for LTFT training, for either ill health or disability or as a result of carer responsibilities either for children or dependents, has risen from 87 in 2007 to 173 in 2011. Currently in 2012 this figure is 203 with another 48 predicted to start by the end of 2012. This equates to approximately 10% of the trainees in Wales.

In 2011, 100 trainees took maternity leave and 50% of these applied for LTFT training following their return to work. During an average training programme trainees may take maternity leave more than once and may alternate between full and LTFT employment.

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

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

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

3. How staffing difficulties in Wales are best addressed:

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

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

The Deanery also believes that training should be undertaken on fewer sites to enable a critical mass of trainees. This will ensure that trainees get sufficient clinical experience, that their rotas for out of hours are robust with a minimum of a 1 in 11 out of hours commitment and that they will get protected time during the working day

for education, attendance at out-patient clinic and exposure to theatre time within the craft specialties. This we believe will improve their experience, improve the examination pass rates and improve patient care.

To date the Deanery has introduced a number of initiatives to aid recruitment and retention across Wales. In some specialties the Deanery has reduced the number of fixed term positions. These unattractive posts have been converted to long-term sustainable posts offering the security that trainees require.

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

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

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

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

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

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

The Deanery recognises that the very many positive aspects of training in Wales should be highlighted to potential applicants. This work started in 2010 with the introduction of the ‘Smart Choice’ marketing campaign with Welsh Government and work continues on this in collaboration with the NHS Confederation. The Deanery actively promotes ‘Training in Wales’ at various medical careers fairs across the country. The Deanery recognises, however, more work is needed to emphasize the excellent and highly regarded research facilities, excellent trainers and excellent teaching and training facilities available across Wales.

In 2012 the Professional Support Unit of the Deanery, whose work supports the development of doctors and dentists, were runners up in the Healthcare People

Management Association (HPMA) Excellence Awards under the category: Healthcare Performance award for best coaching and personal development strategy. The Professional support Unit was commended on being the first Deanery submission in the UK for HPMA awards.

The Deanery continues to publicise as best it can the quality of training in Wales and has recently won the Medical Women's Federation Award for being the most Family Friendly Deanery in the UK. This is the second year in a row that we have been the outright winner of that award and is a reflection of our commitment to provide not only the best possible training for trainees here in Wales, but also a positive work-life balance in order to promote the retention of doctors who come to Wales.

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

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

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

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

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

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

We are committed to working with the Health Boards, particularly when their service reconfiguration plans are predicated on the presence of trainees, to ensure that the trainees have access to the best possible teaching and training and that we deliver the best possible care for patients.

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

HEALTH AND SOCIAL CARE COMMITTEE CONSIDERATION OF LHB SERVICE RECONFIGURATION PLANS

THE ROLE OF THE NATIONAL CLINICAL FORUM IN THE RECONFIGURATION PROCESS

EVIDENCE SUBMISSION BY THE NATIONAL CLINICAL FORUM

1. Introduction and Background

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

The NCF has its own formal Terms of Reference. Given the Forum will continue for a further year, these Terms of Reference are in the process of being reviewed by members of the Forum and will be discussed at the Forum's January meeting. **The original Terms of Reference are attached as Appendix 1**.

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

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

2. Governance Arrangements

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

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

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

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

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

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

3. The Role Of The NCF In The Reconfiguration Process

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

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

The NCF hopes to establish an ongoing relationship with all LHBs and Trusts through the service planning process, and is there to be used as frequently as those organisations feel it is necessary to obtain expertise, advice and guidance on their emerging plans. As a minimum though, it has been agreed by the LHBs with the NCF, that they will attend a meeting with the NCF at the pre-engagement and pre-consultation stages of the process. The NCF then provides its formal public response to the LHB consultation process as any other stakeholder would do during the formal consultation period.

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

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

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

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

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

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

4. Lifespan Of The National Clinical Forum

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

During the course of its second year, the NHS Wales Chief Executives will again consider the future lifespan of the NCF, and any role it might have, if any, in providing LHB's and Trusts with impartial expert clinical advice beyond November 2013.

The NCF believes it is adding value to the current service change planning process, and could see how such a role might be of benefit in the longer term. However, it is the NHS Wales Chief Executives that will determine what role may be required going forward.

APPENDIX 1

NATIONAL CLINICAL FORUM

Terms of Reference and Operating Arrangements

Introduction

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

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

Purpose

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

The Forum will consider if proposals for service change:

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

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

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

Scope and Duties

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

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

The Forum may provide advice to the LHBs:

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

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

Membership

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

Chair
The Forum will be Co-Chaired by an independent Chair from Wales identified by the NHS Wales Chief Executives, and a Co-Chair identified within another UK health system, and who has experience of significant service reconfiguration.

The Chairmanship of each meeting will alternate from meeting to meeting between the two co-chairs.

Vice Chair
One of the Co-Chairs will always have to be present for the Forum to proceed, and so there is no requirement to appoint a formal vice chair. The Co-Chairs will provide cover and support to each other in the absence of one of them.

Members

The following clinical groups will be represented:

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

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

Secretariat

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

In attendance

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

Terms and Length of Office

Appointments to the Forum will be made through the National Director, *Together for Health* on behalf of the LHB Chief Executives. Members will either be invited on to the Forum in their role as Chair of an All Wales Professional Group/Committee, or as a nomination from such a group, committee or stakeholder organisation. The Forum is a task and finish group which is anticipating needing to meet for a minimum of one year. The need for the continued role of the group will be reviewed regularly. In the interests of consistency in discussion and review of plans/information, Members will serve for the duration of the Forums' work, even if during the life of the Forum, they cease to be Chair of the Group or Committee that led to the original invitation. In this situation the Co-Chairs will have the option to invite the new Chair of that Committee to the Forum, if it is felt that the Committee concerned is no longer appropriately represented.

The appointed Co-Chairs of the Forum will hold those positions for the life of the Forum.

Members Responsibilities and Accountability

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

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

The Co- Chairs will cover for their colleague co-Chair in their absence for any reason.

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

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

Resignation and removal of members

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

If the Forum Co-Chairs and the nominating body or group, considers that:

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

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

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

Handling Conflicts of Interest

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

Relationship with LHBs Chief Executives

The Forum's main link with the LHBs Chief Executives is through the Co-Chairs.

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

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

Relationship with Local Healthcare Professionals Fora

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

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

Support to the Forum

The National Director, *Together for Health*, will ensure that the Forum is properly equipped to carry out its role by:

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

Forum meetings

At least one Co-Chair plus 50% of the agreed membership must be present to ensure the quorum of the Forum.

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

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

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

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

Withdrawal of those on attendance

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

8th December 2011.

National Clinical Forum

Evaluation of Service Reconfiguration Plans

Introduction

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

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

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

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

Criteria for the Evaluation of Service Reconfiguration Plans

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

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

Evaluation Criteria

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

Access and Integration of Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Workforce

There must be evidence of a cohesive workforce plan.

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

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

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

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

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

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

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

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

Quality and Safety

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

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

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

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

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

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

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

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

Buildings and Facilities

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

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

Compatibility across Wales

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

Agenda Item 11

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 – Senedd**
Meeting date:	**Thursday, 29 November 2012**
Meeting time:	**09:15 – 12:30**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_29_11_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Nicola Davis-Job, Royal College of Nursing Wales** **Dr Chris Jones, Welsh Government** **David Sissling, Director General for Health and Social Services, Welsh Government** **Lisa Turnbull, Royal College of Nursing Wales** **Dr Phil Evans, Diabetes and Endocrinology National Specialist Advisory Group** **Dr David Millar Jones, Diabetes and Endocrinology National Specialist Advisory Group** **Julie Lewis, Diabetes and Endocrinology National Specialist Advisory Group** **Dr Mike Page, Diabetes and Endocrinology National Specialist Advisory Group** **Richard Roberts, Diabetes and Endocrinology National Specialist Advisory Group**
Committee Staff:	**Llinos Dafydd (Clerk)** **Lara Date (Clerk)**

Catherine Hunt (Deputy Clerk)
Philippa Watkins (Researcher)

1. Introductions, apologies and substitutions

1.1 There were no apologies or substitutions.

2. Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction – Oral evidence

Diabetes and Endocrinology National Specialist Advisory Group

2.1 The witnesses responded to questions from members of the Committee.

2.2 Dr Evans agreed to provide a copy of the document submitted to the Welsh Government in 2010 on the availability of structured education on type 1 diabetes in Wales.

Diabetic Retinopathy Screening Service for Wales

2.3 Mr Roberts responded to questions from members of the Committee.

RCN Wales

2.4 The witnesses responded to questions from members of the Committee.

2.5 The witnesses agreed to provide additional evidence in writing on the alleged reduction in the number of diabetes specialist nurses in recent years and on the role played by diabetes specialist nurses on the Diabetes Planning and Delivery Groups.

Welsh Government officials

2.6 Mr Sissling and Dr Jones responded to questions from members of the Committee.

2.7 Dr Jones agreed to provide additional information in writing on podiatry services across Wales and to provide copies of the letters issued to health boards following the National Diabetes Audit.

3. Motion under Standing Order 17.17 to establish a sub- committee to take evidence on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

3.1 The Committee agreed the Motion.

4. Papers to note

4.1 The Committee noted the minutes of the meetings held on 15 & 21 November.

TRANSCRIPT
View the meeting transcript.

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Wednesday, 5 December 2012**
Meeting time:	**09:30 - 11:20**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200002_05_12_2012&t=0&l=en

Concise Minutes:

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

1. Introductions, apologies and substitutions

1.1 There were no apologies or substitutions.

2. Scrutiny of the Minister for Health and Social Services

2.1 The Minister and officials responded to questions from members of the Committee.

2.2 The Minister agreed to provide further information in writing on the capital project slippages, a breakdown by health board of how the additional £82m for the NHS would be allocated, how the Welsh Government would be feeding in to the review of the balance of competences between the UK and the EU, and on the provision of mental health services for staff working in the armed forces and emergency services.

3. Papers to note

European update

3.1 The Committee noted the paper.

Letter from the Minister for Health and Social Services & Deputy Minister for Children and Social Services : Actions arising from 17 October meeting on Budget Scrutiny

3.2 The Committee noted the letter.

4. Social Services and Wellbeing (Wales) Bill: Consideration of appointing an Expert Adviser to assist on the scrutiny of the Bill

4.1 The Committee discussed the option of appointing an expert adviser to assist them with the stage 1 scrutiny of the Social Services and Wellbeing (Wales) Bill.

4.2 The Committee agreed in principle that assistance from the relevant policy field would be helpful and the option was worth exploring. The Committee agreed that it may be beneficial to consider seeking advice from a number of advisers, each of whom could assist with consideration of particular issues, rather than the appointment of a single expert adviser.

4.3 The Committee asked the clerking team to undertake some further work and to provide Members with the names of possible candidates at the next meeting.

5. Human Transplantation (Wales) Bill – Stage 1: Approach to Scrutiny

5.1 The Committee agreed its terms of reference and approach to scrutiny of the Human Transplantation (Wales) Bill and agreed to launch a public consultation shortly.

6. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill : Stage 1 – Approach to scrutiny

6.1 The Committee Chair referred to a letter he had received from the Presiding Officer indicating that, in her opinion, the Bill was within the legislative competence of the Assembly. However, she also pointed out that her decision had been finely balanced in relation to some parts of the Bill. The Chair outlined the parts of the Bill concerned and that the letter would be circulated to Members in due course.

6.2 The Committee agreed that the issues raised by the Presiding Officer would need to be taken into account during the Stage 1 scrutiny process. The Committee's legal advisers were asked to provide further briefing on the issues raised by the Presiding Officer so that areas for questioning could be developed to help the Committee explore the issues with relevant witnesses.

6.3 The Committee then discussed its approach to Stage 1 scrutiny of the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill.

6.4 The Committee was content with the general approach suggested in the Committee paper but was agreed that an additional question, regarding the National Assembly's legislative competence, should be added to the consultation letter.

6.5 It was also agreed that representatives of cancer charities, Health Boards, the construction industry and organisations manufacturing asbestos should be considered as additional oral witnesses.

7. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill : Stage 1 - Evidence session 1 - POSTPONED

TRANSCRIPT
View the meeting transcript.

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales

Mark Drakeford AM
Chair
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Your ref:
Our ref: PO/RB/SG

3 December 2012

Dear Mark

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill

I have written today to Mick Antoniw to confirm my view that, in accordance with section 110(3) of the Government of Wales Act 2006 (GoWA), the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill, is within the legislative competence of the Assembly and I intend to make a statement to that effect upon the Bill's introduction.

However, my decision in this case was not straightforward. I have received advice that credible arguments can be made that a number of provisions of the Bill may not be within the Assembly's legislative competence. The decision I have made is, therefore, a finely balanced one in these areas.

I enclose for your information a summary of the issues I considered in reaching my view on legislative competence. I feel it is appropriate, and important, to share this with you, so as to recognise and facilitate the role of Assembly Members on your Committee in scrutinising the Bill. The lawyer and Clerk supporting the Committee in that scrutiny will be able to provide more detailed information on the issues.

Bae Caerdydd
Caerdydd
CF99 1NA

Cardiff Bay
Cardiff
CF99 1NA

Ffôn/Tel: 029 2089 8911
Ebost/Email: private.office@wales.gov.uk

This is the first time we have taken the approach of revealing difficult issues of competence considered by me. It is also the first case that has thrown up such issues since the recent Supreme Court judgment. There are undoubtedly sensitivities arising from how the Assembly debates matters of legislative competence during the progress of a Bill. The staff supporting your committee will be able to advise you on these and I would, of course, be happy to discuss in person.

In the meantime, I am writing in similar terms to David Melding as Chair of the Constitutional and Legislative Affairs Committee.

I must stress that the advice I have received, and on which I have based my decision, is that the provisions of the Bill can legitimately be determined as being within the legislative competence of the Assembly. Nevertheless, I wish to ensure that the issues I have considered are shared with Committees so that further consideration can be given to them during scrutiny of the Bill, if Members so wish.

Financial Memorandum

Standing Orders also require me to decide whether the Bill will require a financial resolution. After considering the Explanatory Memorandum accompanying the Bill, I consider a financial resolution will be required for this Bill, in accordance with Standing Orders 26.69(ii) and 26.70.

Rosemary

Rosemary Butler AM, Presiding Officer

The Recovery of Medical Costs for Asbestos Diseases (Wales) Bill

Summary of Legislative Competence Issues

Background

1. The Recovery of Medical Costs for Asbestos Diseases (Wales) Bill has been submitted to the Presiding Officer by the Member in charge of the Bill, Mick Antoniw AM, to enable the Presiding Officer to state her view on whether the Bill is within the legislative competence of the Assembly. In accordance with section 110(3) of the Government of Wales Act 2006 (GoWA), and Standing Order 26.4, this statement must be made on or before the Bill being introduced.

2. After receiving advice from the Assembly's legal advisers, the Presiding Officer has decided that, in her view, the Bill is within competence. However, the Presiding Officer considers it appropriate to bring certain issues relating to competence, which she considered in reaching her view, to the attention of the Committees that will be scrutinising the Bill, so that they can decide whether or not to probe these issues further as part of the scrutiny process.

Overview of the Bill

3. The purpose of the Bill is to ensure that a person who pays compensation to a 'victim' of an 'asbestos-related disease' also has to reimburse the Welsh Ministers for costs incurred by the NHS in Wales in providing care to the 'victim'. The same applies if the compensation is paid by someone else on behalf of the person responsible for the harm to the 'victim', including insurance companies.

Competence Issues considered by the Presiding Officer

4. The first issue concerns section 15 of the Bill. This deals with the liability of insurers to pay the new charges which the Bill introduces. Schedule 7 to GoWA contains an exception from competence drafted in these terms: "Financial services, including … insurance". This exception is set out under Heading 4, "Economic Development", whereas the provisions of the Bill relate to Subjects listed under Heading 9, "Health and Health Services". However, exceptions from competence apply equally to all the Subjects listed in Schedule 7.

5. The Presiding Officer considers, on balance, that section 15 is within competence, on the grounds that it is incidental to the other provisions of the Bill, or appropriate to make the Bill fully effective.

6. The second issue concerns section 17 of the Bill. This provides that the Bill binds the Crown. As such, it will affect UK Government Departments. The question arises whether, in doing so, it will modify a function of a Minister of the Crown, or impose a new function on such a Minister, or merely create a liability to which such Ministers will become subject in certain circumstances..

7. Paragraph 1 of Part 2 of Schedule 7 to the GOWA 2006 prohibits a Bill from modifying a pre-commencement function of a Minister of the Crown. These are functions held by a Minister of the Crown since before 5th March 2011. The paragraph also prohibits a Bill from imposing a function on a Minister of the Crown. However, a Bill can do any of these things if the Secretary of State consents. Alternatively, a Bill can modify a function (but not impose one) if to do so would be incidental on, or consequential to, another valid provision of the Bill.

8. The Presiding Officer considers that section 17 should not be seen as outside competence, given that there are credible arguments that it does not modify a function of a Minister of the Crown or impose a new function on such a Minister; or that, if it does modify a function of a Minister of the Crown, the modification is incidental to other provisions of the Bill.

9. The third issue concerns whether section 2, the core provision of the Bill, relates sufficiently closely to one or more Subjects listed in Schedule 7 to GoWA.

10. Paragraph 4 of Part 2 of the Explanatory Memorandum cites heading 9 (Health and health services) in Schedule 7 to GoWA as providing the legislative competence to permit the National Assembly to pass this Bill. The subjects that appear under that heading, and that are potentially relevant to the Bill, are:

- "Prevention, treatment and alleviation of disease, illness, injury [and] disability ... Provision of health services… Organisation and funding of national health service."

11. The decision as to whether a provision of a Bill "relates to" a Subject is to be made primarily by reference to the "purpose" of the provision.

12. None of the Bill's provisions have as their purpose the 'prevention, treatment and allevation of disease (etc)'. The same applies to the Subject "provision of health services".

13. However, the Presiding Officer considers that all the provisions of the Bill do, on balance, "relate to" the subject 'Organisation and funding of national health service'. This is because the purpose of section 2, and therefore of the whole Bill, is to reimburse the Welsh Ministers – the funders of the Welsh NHS – for the cost of funding certain asbestos-related NHS services. This is a sufficiently close relationship with the Subject to bring section 2, and therefore the whole Bill, within competence.

14. In reaching her decision that the provisions of the Bill were within competence, the Presiding Officer also considered all the other tests for competence set out in GoWA: compatibility with the Convention rights; compatibility with EU law; protection of certain other enactments; protection of the position of the Comptroller and Auditor General; and the test that the Bill must not have a prohibited effect on the Welsh Consolidated Fund. She was satisfied that the Bill clearly met all these tests.

15. Finally, the Presiding Officer considered whether it would be necessary for the consent of Her Majesty the Queen and of the Duke of Cornwall would be required for the Bill to be passed by the Assembly. She concluded that these consents may be necessary and the Member in Charge has been asked to address this issue before Stage 3 of the Bill. This is not an issue of legislative competence as such.

Health and Social Care Committee

HSC(4)-01-13 paper 8

Health and Social Care Committee Forward Work Programme: January - February 2013

To: Health and Social Care Committee

From: Committee Service

Meeting date: 10 January

Purpose

1. This paper invites Members to note the Health & Social Care Committee timetable attached at Annex A.

Background

2. Attached at Annex A is a copy of the Health & Social Care Committee's timetable until the February half term recess.

3. It is published as an aid to Assembly Members and any members of the public who may wish to be aware of the Committee's forward work programme. A document of this kind will be published by the Committee at regular intervals.

4. The timetable is subject to change and may be amended at the Committee's discretion as and when relevant business arises.

Recommendation

5. The Committee is invited to note the work programme at Annex A.

ANNEX A

THURSDAY 10 JANUARY 2013

Morning and afternoon

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill
Oral evidence sessions

Social Services and Well-being (Wales) Bill*
Factual briefing
Consideration of expert advisers

Local Health Board service reconfiguration plans
Oral evidence sessions

Food Hygiene Rating (Wales) Bill – draft regulations
Private briefing

WEDNESDAY 16 JANUARY 2013

Morning only

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill
Oral evidence sessions

Social Services and Well-being (Wales) Bill*
Consideration of expert advisers

THURSDAY 24 JANUARY 2013

Morning and afternoon

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill
Oral evidence sessions

Human Transplantation (Wales) Bill
Oral evidence sessions

WEDNESDAY 30 JANUARY 2013

Morning only

Social Services and Well-being (Wales) Bill*

ANNEX A

Stage 1 – Approach to scrutiny

Human Transplantation (Wales) Bill
Oral evidence sessions

THURSDAY 7 FEBRUARY 2013

Morning and afternoon

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill
Consideration of key issues (private)

Human Transplantation (Wales) Bill
Oral evidence sessions

Monday 11 February – Sunday 17 February 2013: Half term recess

---

Please note that items marked with a star (*) are dependent on legislation being introduced by the respective Members in Charge and remitted to the Health and Social Care Committee for Stage 1 scrutiny by the Business Committee.