

## Bundle Board Meeting 28 November 2019

### Agenda attachments

#### 00 - Board Agenda 3.docx

- 0 PATIENT STORY - MENTAL HEALTH THEME
- 1 Welcome and Introductions  
*Charles Janczewski*
- 2 Apologies for Absence  
*Charles Janczewski*
- 3 Declarations of Interest  
*Charles Janczewski*
- 4 Minutes of the Board Meeting held on 26 September 2019  
*Charles Janczewski*  
4 - Public Board Mins 26.09.19 - Final - CJ NF GM.docx
- 5 Action Log - 26 September 2019  
*Charles Janczewski*  
5 - Action log public following September meeting-nfcomments v2.docx
- 6 Chair's Action Taken Since Last Meeting  
*Charles Janczewski*
- 7 Frail Elderly Service Model: Outcome of Engagement  
*Abigail Harris*  
7 - Frail Elderly Service Model Outcome of Engagement.docx  
7 - Annex 1 Report on Engagement on Vale Frail OP Proposals Nov 2019.docx  
7 - Annex 2 Engagement Feedback and Health Board response FINAL.docx  
7 - Appendix 1 Engagement Plan.docx  
7 - Appendix 2 Notes of Frail OP Workshop 23 Sept.docx  
7 - Appendix 3 Notes of Frail OP Public Meeting 30 Oct 19.docx
- 8 ITEMS FOR REVIEW AND ASSURANCE
- 8.1 Chair's Report  
*Charles Janczewski*  
8.1 - Chairs Report November 2019 - Jan v2.docx
- 8.2 Chief Executive Report  
*Len Richards*  
8.2 - Board Chief Executive Report - Nov 2019.docx
- 8.3 Patient Safety, Quality and Experience Report  
*Ruth Walker*  
8.3 - QSE Board Report for 28.11.19 - V9 FINAL.pdf
- 8.4 Performance Report to include:  
a) *Mental Health Performance Measures*  
*Steve Curry*  
8.4 - Performance Report Nov 2019 (Draft) excl Appendices v2.pdf  
8.4.1 - Performance Report Nov 2019 (Appendices).docx
- 8.5 Transformation Report  
*Len Richards*  
8.5 - Transformation Update Report for Board November 2019.docx
- 8.6 Board Assurance Framework & Corporate Risk Register  
*Nicola Foreman*  
8.6 - BAF covering report - November 2019 -AF.NF.docx

- 8.6.1 - BOARD ASSURANCE FRAMEWORK (NOVEMBER).pdf
- 8.7 Update on implementing the new model of care for Community Mental Health  
8.7 - Mental Health Presentation.pdf
- 8.8 The Nurse Staffing Levels for Adult Acute Medical and Surgical Wards following the Bi-annual Calculation  
*Ruth Walker*  
8.8 - Nurse Staffing Act.docx
- 8.9 Update on Health Travel Charters  
*Fiona Kinghorn*  
8.9 - UHB Board update healthy travel v2.pdf
- 9 ITEMS FOR APPROVAL / RATIFICATION
- 9.1 Major Trauma Centre Business Case  
*Abigail Harris*  
9.1 - MTC Board cover report - Nov 19.docx  
9.1 - Major Trauma PBC Cover Note for Boards 1.0 - FINAL.pdf  
9.1.1 - Final Major Trauma Programme Business Case 18112019.pdf  
9.1.2 - Business Case Approval Timeline draft v0.2 18 Aug 19.pdf
- 9.2 Integrated Medium Term Plan  
*Abigail Harris*  
9.2 - Board Paper Draft IMTP 2020 to 2023.docx  
9.2.1 - Cardiff and Vale UHB IMTP 2020 to 2023 Draft Board 281119.pdf  
9.2.2 - IMTP 20120-23 Workforce & OD Draft for Board 281119.pdf
- 9.3 Funded Nursing Care Uplift  
*Bob Chadwick*  
9.3 - FNC Uplift.docx
- 9.4 Standards of Behaviour Policy  
*Nicola Foreman*  
9.4 - Standards of Behaviour - Board Report.docx  
9.4.1 - Standards of Behaviour Policy final.docx
- 9.5 Model Standing Orders  
*Nicola Foreman*  
9.5 - Model Standing Order Report.docx  
9.5.1 - Appendix 1 - Model Standing Order Report.xlsx
- 9.6 Membership of Committees of the Board  
*Nicola Foreman*  
9.6 - Membership of Committees of the Board.docx  
9.6.1 - Committee Membership - By Committee Oct 19.docx  
9.6.2 - Independent Members Committee Membership Oct 19.pdf
- 9.7 COMMITTEE MINUTES:
- 9.7.1 Finance Committee  
*John Antoniazzi*  
9.7.1 - CONFIRMED MINUTES OF THE FINANCIAL COMMITTEE 25th Sept 2019.docx
- 9.7.2 Strategy and Delivery Committee  
*Charles Janczewski*  
9.7.2 - Strategy and Delivery Mins - Oct 2019.docx
- 9.7.3 Health and Safety Committee  
*Michael Imperato*  
9.7.3 - Health and Safety Committee Mins 9 July 2019.docx
- 9.7.4 Local Partnership Forum  
*Martin Driscoll*  
9.7.4 - LPF 07.08.19.docx
- 9.7.5 WHSSC Joint Committee Minutes  
9.7.5 - WHSSC Mins - 23 July 2019.pdf

- 9.7.6 WHSSC Joint Committee Brief  
[9.7.6 - 2019-09 JC Briefing v1.0.pdf](#)  
[9.7.6b - 2019-11 JC Briefing v1.0.pdf](#)
- 9.7.7 Emergency Ambulance Services Committee  
[9.7.7 - Confirmed EASC minutes 23 July 2019.docx](#)  
[9.7.7b - Confirmed EASC Minutes - 10 Sept 2019 EASC.docx](#)
- 10 ITEMS FOR NOTING AND INFORMATION
- 10.1 Update on Wellbeing of Future Generations Act  
*Fiona Kinghorn*  
[10.1 - WFG Strat & Deliv Flash report 191029-1.docx](#)  
[10.1.1 - WFG Board cover paper 191118-1.docx](#)
- 10.2 Update on Approach to Prioritisation and Management of Maintenance Requests  
*Abigail Harris*  
[10.2 Update on approach to prioritisation and management of maintenance requests.docx](#)
- 10.3 REPORTS FROM COMMITTEE CHAIRS
- 10.3.1 Quality Safety and Experience Committee  
*Susan Elsmore*  
[10.3.1 - QSE Chair's Report - Final\\_.docx](#)
- 10.3.2 Finance Committee  
*John Union*  
[10.3.2 - Finance Committee Chairs Report OCTOBER meeting.docx](#)
- 10.3.3 Strategy and Delivery Committee  
*Charles Janczewski*  
[10.3.3 - Strategy & Delivery Chair's Report 28.11.2019.docx](#)
- 10.3.4 Audit and Assurance Committee  
*John Union*  
[10.3.4 - Audit and Assurance Chair's Report - Final.docx](#)
- 10.3.5 Mental Health Capacity and Legislation Committee  
*Sara Moseley*  
[10.3.5 - Mental Health CLC Chair's Report - Final.docx](#)
- 10.3.6 Health and Safety Committee  
*Michael Imperato*  
[10.3.6 - H&S Chair's Report 28.11.2019.docx](#)
- 10.3.7 Stakeholder Reference Group  
*Richard Thomas*  
[10.3.7 - SRG Chairs Report - September 2019.docx](#)
- 10.3.8 Local Partnership Forum  
*Martin Driscoll*  
[10.3.8 - LPF Chair's Report.docx](#)
- 11 Agenda for Private Meeting  
*Corporate Risk Register*
- 12 Review of the Meeting
- 13 Date and time of next meeting:  
*Thursday, 30 January 2020 at 1.00pm*  
*TBC*

**CARDIFF AND VALE UNIVERSITY HEALTH BOARD  
BOARD MEETING**

**Thursday, 28<sup>th</sup> November 2019 at 1.00pm**

**Memo Arts Centre, Gladstone Rd, Barry, CF62 8NA**

**AGENDA**

<b>PATIENT STORY – MENTAL HEALTH THEME</b>		
<b>1</b>	Welcome & Introductions	Charles Janczewski
<b>2</b>	Apologies for Absence	Charles Janczewski
<b>3</b>	Declarations of Interest	Charles Janczewski
<b>4</b>	Minutes of the Board Meeting held on 26 <sup>th</sup> September 2019	Charles Janczewski
<b>5</b>	Action Log – 26 <sup>th</sup> September 2019	Charles Janczewski
<b>6</b>	Chairs Action taken since last meeting	Charles Janczewski
<b>7</b>	Frail Elderly Service Model: Outcome of Engagement	Abigail Harris
<b>8</b>	<b>Items for Review and Assurance</b>	
<b>8.1</b>	Chair's Report	Charles Janczewski
<b>8.2</b>	Chief Executive Report	Len Richards
<b>8.3</b>	Patient Safety, Quality and Experience Report	Ruth Walker
<b>8.4</b>	Performance Report to include: (a) Mental Health Performance Measures	Steve Curry
<b>8.5</b>	Transformation Report	Len Richards
<b>8.6</b>	Board Assurance Framework	Nicola Foreman
<b>8.7</b>	Update on implementing the new model of care for Community Mental Health	Steve Curry Presentation
<b>8.8</b>	The Nurse Staffing Levels for Adult Acute Medical and Surgical Wards following the Bi-annual Calculation	Ruth Walker
<b>8.9</b>	Update on Healthy Travel Charters	Fiona Kinghorn
<b>9</b>	<b>Items for Approval / Ratification</b>	
<b>9.1</b>	Major Trauma Centre Business Case	Abigail Harris
<b>9.2</b>	Integrated Medium Term Plan	Abigail Harris
<b>9.3</b>	Funded Nursing Care Uplift	Robert Chadwick
<b>9.4</b>	Standards of Behaviour Policy	Nicola Foreman
<b>9.5</b>	Model Standing Orders	Nicola Foreman
<b>9.6</b>	Committee Membership	Nicola Foreman
<b>9.7</b>	Committee Minutes: i. Finance Committee – 25 September 2019 ii. Strategy and Delivery Committee -3 September 2019 iii. Health and Safety – 9 July 2019	John Antoniazzi Charles Janczewski Michael Imperato



	<p>Advisory Group Minutes:</p> <p>iv. Local Partnership Forum – 7 August 2019</p> <p>The Joint Committee Minutes:</p> <p>v. WHSSC Joint Committee – July 2019</p> <p>vi. WHSSC Joint Committee Brief – 16 September and 12 November 2019</p> <p>vii. Emergency Ambulance Services Committee - 23 July and 10 September 2019</p>	Martin Driscoll
<b>10</b>	<b>Items for Noting and Information</b>	
<b>10.1</b>	Update on Wellbeing of Future Generations Act	Fiona Kinghorn
<b>10.2</b>	Update on approach to prioritisation and management of maintenance requests	Abigail Harris
<b>10.3</b>	<p>Reports from Committee Chairs:</p> <p>i. Quality, Safety and Experience Committee – 15 October 2019</p> <p>ii. Finance Committee – 30 October 2019</p> <p>iii. Strategy and Delivery Committee – 29 October 2019</p> <p>iv. Audit and Assurance Committee – 30 September 2019</p> <p>v. Mental Health Capacity and Legislation Committee – 22 October 2019</p> <p>vi. Health and Safety Committee – 8 October 2019</p> <p>Reports from Advisory Group Chairs:</p> <p>vii. Stakeholder Reference Group – 24 September 2019</p> <p>viii. Local Partnership Forum</p>	<p>Susan Elsmore</p> <p>John Union</p> <p>Charles Janczewski</p> <p>John Union</p> <p>Sara Moseley</p> <p>Michael Imperato</p> <p>Richard Thomas</p> <p>Martin Driscoll</p>
<b>11</b>	<b>Agenda for Private Meeting:</b>	
	Corporate Risk Register	Nicola Foreman
<b>12</b>	<b>Review of the meeting</b>	
<b>13</b>	<b>Date and time of next meeting</b>	
	Thursday, 30th January 2020 at 1.00pm	
	Woodland House, Ground Floor, Nant Fawr 1, 2 and 3	

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

**Unconfirmed Minutes of the Board Meeting**  
**Thursday, 26 September 2019 at 1.00pm**  
**Nant Fawr Rooms 1 &2, Woodlands House, Heath, Cardiff**

**Present:**

Charles Janczewski	CJ	UHB Interim Chair
Len Richards	LR	Chief Executive Officer
John Antoniazzi	JA	Independent Member – Estates
Steve Curry	SC	Chief Operating Officer
Martin Driscoll	MD	Executive Director of Workforce and Organisational Development
Akmal Hanuk	AH	Independent Member - Community
Abigail Harris	AH	Executive Director of Strategic Planning
Michael Imperato	MI	Independent Member - Legal
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Sara Moseley	SM	Independent Member – Third Sector
John Union	JU	Independent Member - Finance
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Medical Director
Dawn Ward		Independent Member – Trade Union

**In Attendance:**

Nicola Foreman	NF	Director of Corporate Governance
Geoffrey Simpson	GS	Deputy Chair - SRG

**Secretariat**

Glynis Mulford	GM	Corporate Governance Officer
----------------	----	------------------------------

**Apologies:**

Stephen Allen	SA	Community Health Council
Gary Baxter	GB	Independent Member – University
Robert Chadwick	RC	Executive Director of Finance
Eileen Brandreth	EB	Independent Member - ICT
Indu Deglurkar	ID	Chair, Senior Medical Staff Committee
Susan Elsmore	SE	Independent Member – Local Authority

<b>UHB 19/09/001</b>	<b>WELCOME AND INTRODUCTIONS</b>	<b>ACTION</b>
	The UHB Chair welcomed everyone to the meeting.	
<b>UHB 19/09/002</b>	<b>PATIENT STORY</b>	
	The Executive Nurse Director read out a story related to a student who had moved to Cardiff from England to study and had suffered from a number of medical conditions. The story highlighted a number of themes around communication and support. The following was described:	

	<p>The patient had a number of health issues which had been treated in England. The patient had moved to Cardiff to study and all their health conditions were now being treated for by the Cardiff and Vale University Health Board. The family were very complimentary that there had not been a break in the care when transferred from England. After the procedures the patient had described that on both occasions after procedures they had not felt supported. They had felt that the communication could have been better and the discharge process could have been improved.</p> <p>The first procedure was undertaken at the Cardiac Day Surgery and the patient's mother had travelled a few hours to be with them but had been worried they had not met with anyone on the unit before the procedure. The patient explained that the unfamiliarity with the team had made them feel vulnerable. The patient's mother was not allowed on the ward and they wished that they had been informed of this prior to the procedure. The patient said they fully understood that the ward could be busy and appreciated that care had to be taken due to infection control. After the procedure the patient's mother was allowed on the ward.</p> <p>The same treatment was also experienced in Llandough. The patient's mother explained that she had wanted to provide support to her child and would have preferred if she could have been there for the consultation and to explain the medical issues of the patient. The nurse had advised them of the policy. The patient stated that she was anxious and it would be helpful to have someone with her to help take in the information. The mother was then allowed to sit in on the consultation and spent time with the patient post operatively.</p> <p>The key lesson to learn from this patient story was that students, although adults, were still someone's child.</p> <p>As part of discussions Board members raised the following questions:</p> <p>Had the policy in place at that time now been adapted to reflect what the patient actually wanted? In response it was stated that the policy was currently being reviewed by the Surgical Clinical Board and it would be expected that nursing staff would adapt to individual circumstances and be flexible. This had been conveyed to the nursing staff.</p> <p>In summary, it was stated our strategy was to value our staff and empower them to make decisions in the best interest of the patients. Policies were there to help but there were, and always would be exceptions to the rule.</p>	
UHB 19/09/003	<b>APOLOGIES</b>	

	Apologies for absence were noted.	
<b>UHB 19/09/004</b>	<p><b>DECLARATIONS OF INTEREST</b></p> <p>The Chair invited Board Members to declare any interests in relation to the items on the meeting agenda. The following declarations of interest were received and noted:</p> <ul style="list-style-type: none"> <li>Sara Moseley, declared her interest as Director of Mind in relation to agenda items 7.4 and 7.7</li> </ul>	
<b>UHB 19/09/005</b>	<p><b>MINUTES OF THE BOARD MEETING HELD ON 25 JULY AND 29 AUGUST 2019</b></p> <p>The Board reviewed the Minutes of the meeting held on 25 July and 29 August 2019, and noted that the following amendments should be made:</p> <ul style="list-style-type: none"> <li>Stuart Walker Medical Director was present at the Board meeting on 25 July.</li> <li>Page 8 first line bullet point change word from 'reactive' to 'proactive'.</li> <li>Page 9 change word from 'Amplified' to 'Amplify'.</li> </ul> <p><b>The Board resolved – that:</b></p> <ol style="list-style-type: none"> <li>the minutes of the meeting held on 25 July be approved subject to amendments;</li> <li>the minutes of the meeting held on 29 August 2019 be approved as a true and accurate record.</li> </ol>	
<b>UHB 19/09/006</b>	<p><b>BOARD ACTION LOG</b></p> <p>The Board reviewed the Action Log and noted the following:</p> <p><b>19/07/017 – Welsh Language Policy:</b> Independent Member – Third Sector informed the Board that they had reviewed the Welsh Language Policy in the context of Amplify 2025 and a good initial discussion had taken place. There would be further discussions with two Board Champions, Independent Member- Community in relation to equality and Independent Member- University in relation to LGBTQI.</p> <p><b>19/07/013 – IMTP – Process and Priorities:</b> A presentation on the IMTP was undertaken on an annual basis and the Executive Director of Strategic Planning would check when this would be undertaken again. Independent Member- Trade Union requested if she could be involved.</p> <p><b>19/03/059 – Performance Report – Part 1b of the Mental Health Measure:</b> This item was superseded by the paper presented later on the agenda.</p>	<p><b>SM/GB/EB</b></p> <p><b>AH</b></p>

	<p><b>19/03/012 – Winter Resilience Programme:</b> This related to the transformation piece with PCIC Out of Hours and the Lightfoot work. This work was in progress and would be monitored through Strategy and Delivery Committee.</p> <p><b>The Board Resolved that:</b></p> <p>(a) the action log and updates upon it be received and noted.</p>	<b>GM</b>
<b>UHB 19/09/007</b>	<p><b>REPORT FROM THE CHAIR</b></p> <p>The Chair introduced his report which provided an update on key meetings attended, activities and actions that had taken place since the previous Board meeting.</p> <p>Independent Member- Third Sector asked if the Round Table meeting convened during the Social Care Conference for Wales with Sam Everington was a strategic fit with some of the work being undertaken in Cardiff and Vale. The Chair responded that this was positive for the work being undertaken in the South Wales cluster with Karen Hardy who was taking a similar approach as part of the Transformation agenda. One of the projects related to social prescribing in primary care with monies received from the transformation fund. The learning from over the next year would be rolled out across the whole patch and was in line with Shaping Our Future Wellbeing.</p> <p><b>The Board resolved that:</b></p> <p>(a) the Chair's report be noted.</p> <p>(b) the affixing of the Common Seal be endorsed.</p> <p>(c) the reported Chair's Actions and signing of legal documents be endorsed.</p>	
<b>UHB 19/09/008</b>	<p><b>REPORT FROM THE CHIEF EXECUTIVE</b></p> <p>The Chief Executive provided an overview of the content of his report and provided an update on the following:</p> <p><b>Brexit:</b> A risk assessment and business continuity plan had been undertaken addressing key risks and plans which were in place if there was a no deal. The Executive Director of Strategic Planning chaired the Senior Responsible Officer (SRO) meetings where updates on internal risk assessments were received. There was nothing new to report but the response had been strengthened to ensure stock availability. Updates to the Board would be provided and by 17 October Cardiff and Vale's status would be clarified.</p> <p>Independent Member – Legal inquired whether we had a communication strategy for this. It was confirmed that the</p>	

	<p>Director of Communications sat on the group and was working on the best information available.</p> <p>Independent Member – Community wanted assurance over contingency plans which were in place. It was confirmed that Shared Services were leading on this area and working very closely with suppliers who had their own continuity plan in place and no significant risks had been highlighted.</p> <p>In relation to medical supplies the Health Board had stocked up to top stock levels. Welsh Government had provided more resilience to our stock and there was a warehouse for all of Wales which had approximately 12 weeks' worth of supplies. A mechanism was in place if something critical was in short supply and this would be flagged up. Wales would be part of a UK wide distribution chain which came in a national formation process. It was recognised that there were some products with a very short shelf life but new transport arrangements had been put in place to get these items into country. This had been tested.</p> <p><b>Major Trauma Centre:</b> The Health Board and Welsh Health Specialised Services Committee had developed a business case. A session was due to be held on 23 October to explain how the Major Trauma network Business Case had been developed. The business case would come to the Board meeting in November for approval.</p> <p><b>Welsh Government Letter:</b> A letter which had been received from Welsh Government had been circulated to Board Members. The letter stated that the Health Board had been de-escalated from Enhanced Monitoring to Routine Arrangements. Credit was given to the Executive team for their leadership and the Clinical Boards and front line staff were commended for the high levels of performance achieved and the work undertaken to progress the current financial position.</p> <p>Independent Member – Third Sector asked how clinicians were now feeling in relation to the thoracic surgery process and outcome. The CEO stated that there was a positive mood amongst staff. A 24 hour Team Leader at a senior consultant level had been included within business case. The size of the polytrauma ward had been a compromise but the clinical staff were on board. There was support for critical care beds at the level required. It was confirmed that what had been submitted from an emergency theatre list had been approved.</p> <p>Independent Member – Community raised concern in regard to the Trauma Centre and psychiatry services. The Executive Director for Therapies and Health Sciences informed Members that she had undertaken discussions with the lead and confirmed that this issue would be addressed.</p>	
--	--	--



	<p><b>The Board resolved that:</b></p> <p>(a) the Chief Executives report be noted.</p>	
<b>UHB 19/09/009</b>	<p><b>PATIENT SAFETY QUALITY AND EXPERIENCE REPORT</b></p> <p>The Executive Nurse Director confirmed that there were good performance rates in relation to complaints and compliance was at 88% of response times in 30 days. During July and August there had been a significant increase in the number of complaints but no trends or themes had been identified. A number of retrospective Serious Incidents (SIs) had been reported proactively. Work was being undertaken at the request of the Welsh Risk Pool to review the negligent claims. If anything was found untoward these claims were addressed quickly. The Assistant Director of Patient Experience was asked to look at an all Wales approach to ensure continuity.</p> <p>The Executive Medical Director, Executive Director of Therapies and Health Sciences and the Executive Nurse Director was looking at critical care work and was reviewing the data with fracture neck and femur and vascular surgery.</p> <p>HIW had visited the Stroke Rehabilitation Centre in Llandough Hospital and the feedback had been very positive, particularly around staff and the quality of care they provided. There was one urgent request for immediate assurance relating to the checking of a resus trolley.</p> <p>The Executive Nurse Director answered questions raised by Independent Members prior to the Board meeting:</p> <p>The Chair raised a question whether the Board could have assurance that the incidents were being closely monitored by the Quality, Safety and Experience (QSE) Committee and that lessons were learnt? In response it was confirmed that SIs in mental health were separated on request at the July Board meeting.</p> <p>Independent Member – Local Authority asked what could be done in future to prevent unexpected deaths and what mitigating actions were in place? In addition to this a question was raised about how the Health Board were working with the local authority? The Board was assured that the October extraordinary QSE Committee concentrated on themes and trends that emerge from SIs over the year and that mental health deaths were due to be a theme at this meeting in October. The Clinical Boards had been asked to present with lessons learned and the actions put in place. It was emphasised that all actions and incidents were investigated.</p> <p>Independent Member – Local Authority asked what was the quality of listening to our mental health patients in our system?</p>	

	<p>It was explained there were a number of feedback mechanisms in place such as bespoke surveys and listening to patient stories. These were undertaken in the community as well as the hospital setting. Other approaches taken were volunteers sitting with patients who encouraged them to say what they were feeling and capture feedback. Voluntary Cymru was a small group of volunteers who put together activities in a mental health ward based environment. Activity nurses held meetings and had protected time where patients were able to talk about their experience. A small group of mental health volunteers who had experienced substance misuse were part of our Spread and Scale Academy and were working in a small project alongside those using the services and provided feedback.</p> <p>Independent Member – Legal asked if any trends could be seen at Board as they were viewed in isolation. The Chair said trends across each Clinical Board would be helpful to see in the report but the cause for concern related to unexpected deaths in mental health.</p> <p>Independent Member – Trade Union asked about the progress made regarding the implementation of the mental health model? The Chief Operating Officer said the model was progressing well and explained that this would be a locality based model and decentralising the mental health services. The first major development was in the Barry services where three mental health teams had been brought together into a single hub. There were early indicators to share with the Board at a later date which suggested access for patients had improved through this model and through a trusted assessor approach where individuals no longer had to go through a sequence of assessments.</p> <p>Independent Member Local Authority asked how we were working with local authority partners? In response it was stated that our local authority partners integrated into our community mental health teams. There were environmental issues with the Links Centre and it was acknowledged that the teams worked better when they were co-located. It was further stated that in terms of continuing healthcare packages and learning from joint working over a range of services including the winter plan, there was evidence of an integrated approach with the Local Authority such as executive to executive meetings between the health board and local authority.</p> <p>Independent Member – Trade Union acknowledged the ongoing discussions around the condition of the estate and the challenges this raised and asked how the Board could be assured that this did not undermine the progression of the integration. It was confirmed that there were good examples of integration such as Barry Mental Health Teams. The work</p>	<p><b>RW</b></p>
--	---	------------------



	<p>on the Links Centre would be completed in October. In both of the Public Service Boards joint asset management was being discussed as they recognised the Health Board and Local Authorities faced aging estates. The review of Cardiff and Vale UHB buildings would be progressed through the Estates Strategy.</p> <p>The Executive Director of Public Health highlighted the set of arenas of work ongoing between the Health Board, Local Authorities and Third Sector and provided examples of prevention and early intervention of mental health.</p> <p>The Chair suggested that a deep dive would be appropriate in relation to themes and trends after the October QSE Committee had taken place.</p> <p>The Chair stated that whilst he was encouraged to note a robust improvement plan was in place in relation to the Assessment Unit from the HIW visit, it was difficult to see the expected outcomes from the actions proposed. How and when would the Board be assured that the required standard of care had been achieved? Members were assured the plan was robust with dates and times in place. The action plan was also reviewed at the QSE Committee. It was envisaged that significant improvements would be seen by not having patients in the area and with the implementation of TACU and Surgical Assessment Units. It was acknowledged that more work was needed on Length of Stay and discharge processes in the Medicine Clinical Board.</p> <p>Independent Member – Finance asked what was the patient experience in the MEAU in Llandough as informal feedback stated it was poor? It was confirmed that from time to time patients waited in seated areas awaiting assessment in Llandough but not for the same length of times as in the Assessment Unit. The escalation process in Llandough was good in identifying patients. It was acknowledged that this was an area to monitor through the winter period.</p> <p>Independent Member – Community stated that he was not assured with the survey mechanism in place, the data and its robustness. Was an independent survey or patient experience survey an option? The Executive Nurse Director stated that a number of surveys including telephone surveys were used. Patients were not open and transparent whilst in hospital and therefore retrospective surveys were undertaken. More formal surveys were sent out to the patients and surveys could be completed online. There were Ipads placed in areas to fill in as patients finished their care. Bespoke surveys were also undertaken and kiosks had been placed in primary care settings to capture the user's experience. There were also a number of planned listening events. One hundred and twenty pharmacy volunteers had been recruited who would be</p>	<p><b>RW</b></p>
--	---	------------------

	<p>involved in gathering feedback retrospectively and in real time using a number of these methods.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the content of this report was considered.</li> <li>b) the areas of current concern be noted and agreed that the current actions being taken were sufficient.</li> </ul>	
<b>UHB 19/09/010</b>	<p><b>PERFORMANCE REPORT</b></p> <p>The Chief Operating Officer provided an update on the Performance Report. The following comments were made in relation to questions raised by Independent Members prior to the Board meeting:</p> <p><b>Cancer:</b> There had been an increase of 20% in demand for cancer services during this year and the Health Board had encountered some capacity issues across some specialties. Work had been undertaken with clinical teams in terms of making improvements at a tumour site level and a process level.</p> <p>The Chair asked what the key indicator was to show the back log had been brought down? It was stated this had reduced from 50 patients who were breaching 62 days to 13 patients currently. This was being fed into the headline performance. June showed 74% performance for 62 day compliance and the July performance was 80%. August showed that they would be reporting at 84-85%. It was indicated that September performance would be at a higher position with sustained improvement. In going forward the Board was assured the backlog was reducing and the key indicator showed that there was good access for patients. The reason the performance tailed off before improvements were seen was because patients were treated in most need first.</p> <p>In terms of capacity this was more challenging with non-resource dependent issues and resource dependent issues. Non resource issues related to securing skills that were needed to undertake work, for example, 40% of urology capacity was lost due to unplanned leave. A post had been advertised and indications showed that in the second round of interviews someone would be appointed. There were various diagnostic roles to be appointed to that were key in a single cancer pathway. Several risks highlighted related to the ability in recruiting the right skills, the effect on pensions and tax changes that were impacting on the ability for consultants to provide extra work and that the demand profile changes that could recur.</p> <p><b>Mental Health - part 1B:</b> There had been significant demand increases and at the end of last year primary care mental health referrals rose by 1,400 patients. This had reduced but</p>	

stayed higher than expected. There were small changes in the Health Boards capacity which provided difficulties with a gap between numbers leaving and joining. Part 1a, the 28 day assessment, was back on track performing at 93%. The key going forward was continuing to provide capacity and there was a need to fundamentally change the Health Boards approach to reduce demand.

There had been significant investment in Primary Care's first point of contact services. Currently the Health Board were providing 2000 GP slots through a multidisciplinary team. It was envisaged to see less demand coming through the primary care 28 day assessment. Due to increased volumes they could no longer report manually. The changes meant this would be achieved through PARIS. This produced its own challenges and it was explained work was being undertaken with Welsh Government and the Delivery Unit to resolve this. It was considered a definition issue and further explained how variances in data could occur and how the validation process could influence the figures.

**Mental Health Part 2:** This was also a definitions issue and related to patients with care and treatment (CT) plans. It was described, when speaking to staff, that they considered that they were fully compliant. Members were assured that the Delivery Unit had undertaken three CMHT reviews over the last year and at each review it was identified that every patient who needed a CT plan had one in place. This would need to feed through on the PARIS system. A workshop was undertaken with the Cardiff and Vale Team and the Welsh Government on 16 September and the information was validated on 19 September. The lessons learnt were that the Cardiff and Vale Teams were erring on the side of caution by including more patients not required in the cohort. The DU were knowledgeable and ensured that Cardiff and Vale would be compliant.

Independent Member – Third Sector commented in relation to Part 2 of the measure and that the DU would be looking at a number of CT plans. One of the reviews from the DU reported that the CT plans that were in place were poor and not completed in conjunction with the individual and therefore not meaningful for their progress. In addition, they were not embedded in the culture and the way teams were working. What did this mean for individuals who were coming to Cardiff and Vale services unwell as it was important to ensure the figures were helpful around compliance and quality and outcomes? In response, it was stated that significant work was ongoing on how care and treatment plans could be co-produced and improved in relation to quality and seen as a mechanism for the treatment plan. What emerged from the piece of work was how well this was undertaken by a member of the team. The work to improve quality was ongoing.

	<p>The Chief Operating Officer suggested that since we were close to completion of the transition, that we receive assurance from the Delivery Unit by ensuring the correct definitions were being used. Thereafter, to review the performance against the revised position and consider whether there were gaps compared to where we needed to be.</p> <p>The Executive Medical Director stated he would like to link the patient safety and performance discussion about the metrics used. The clinical view shared that the metrics used to measure our performance in mental health did not reflect the metrics of genuine clinical risk. The quality element for the CT plan was key but also our threshold for entry into service, our processes for risk assessment for individuals in severe crisis would not be reflected in the figures presented. The key principle to adopt was to trust our clinical staff to identify the best ways to deal with the risk we faced whilst acknowledging we must be seen to be performing against our performance targets.</p> <p>The CEO stated the indicators looked at had to include what we were regulated on and additional indicators could be added to get across the complexities encountered in areas where there was concern for a period of time.</p> <p>The CEO suggested that as there was good discussion around Mental Health that it should be brought back to the next Board meeting and centre on the mental health issues discussed and work our way through how this could be applied in this particular setting.</p> <p>The Chief Operating Officer informed Members that Part 3 and 4 measures were compliant.</p> <p>The Chair raised a question on the new eye care measures with performance against the measure at 58.6% - why were we adrift of this target and how did we compare to our peers? In response it was stated these were new measures for follow up patients for ophthalmology where higher risk patients were placed in categories. The new baseline measures started at 51% and had moved to 58%. The overall Wales average position was approximately 63% and to improve the position in the first instance would be through the validation process. Of importance was the reform of the pathway for outpatients and moving outpatient's follow-up out of a hospital setting into the community. Work was being procured to establish the first six centres across our three localities.</p> <p>Independent Member – Local Authority asked if there was more that needed to be done in outpatient follow up. It was confirmed that there was more to be done in outpatient follow</p>	<p>LR</p>
--	--	-----------

	<p>up through validation and pathway reform.</p> <p>Independent Member – Finance raised a question in regard to the stroke unit performance being 45 minutes QIM at 11% and why was this? It was explained that this was expressed as a percentage as there were very low volume patients. The target was an improvement target. There was improvement work being undertaken with medical staff by raising awareness of timely intervention. Another piece of work was being undertaken by the Clinical Board Director of Nursing by realigning consultant availability with stroke at the front door across our stroke services. All stroke patients eligible for thrombolysis received treatment.</p> <p><b>Finance:</b> Members were informed the Finance Committee received a presentation of the actions in place to deliver a break even position by the end of the year but this was not without risk. There were plans in place to get to a good position with actions being taken at Clinical Board level and through taking advantage of corporate opportunities by minimising our risks in order to deliver a balanced position. This would be reported to Welsh Government</p> <p><b>The Board resolved that:</b></p> <p>a) the UHB's current level of performance and the actions being taken where the level of performance was either below the expected standard or progress had not been made sufficiently quickly to ensure delivery by the requisite timescale was discussed.</p>	
UHB 19/09/011	<p><b>BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER</b></p> <p>The Director of Corporate Governance confirmed that the Board Assurance Framework provided members with the six key risks to the organisation. There was ongoing work in relation to risk management across the organisation. Risks registers were in place in all Clinical Boards but a piece of work was ongoing to ensure consistency in terms of scoring and how the risk registers were being developed and managed.</p> <p><b>The Board resolved that:</b></p> <p>a) the BAF and progress which has been made in relation to the actions, management and mitigation of the key risks to the achievement of objectives be approved.</p>	
UHB 19/09/012	<p><b>PRIMARY CARE MILESTONES AND DELIVERY AGAINST THEM</b></p> <p>The Chief Operating Officer presented a general overview and update on the Primary Care Milestones report stating the Health Board had been called to the Public Accounts</p>	

	<p>Committee in relation to the Primary Care Out of Hours service. This had been considered at the Strategy and Delivery Committee and there would be a fuller presentation in January. In the Public Accounts Committee report there were a number of recommendations and Cardiff and Vale Health Board had been referred to as an exemplar in terms of how the Health Board were driving access performance, The Chief Operating Officer stated that he would like to recognise the team for the work which had been undertaken to achieve this.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the requirements for reporting against delivery milestones and other Primary Care standards and measures to Welsh Government be noted.</li> <li>b) the paper on Urgent Primary Care/OOHs which had been considered by the Strategy and Delivery Committee on 3 September be noted.</li> <li>c) the proposal for quarterly reports to be considered by the Strategy and Delivery Committee be approved. Reports would be provided for the Board on an annual basis, or if there were exceptions in relation to delivery.</li> <li>d) the Chief Operating Officer arrange for the Primary Care Team to present to the Management Executives on future priorities for primary care. This would include delivery milestones and access standards and that he would also arrange for this to be presented to the Strategy and Delivery Committee (likely to be in November) be noted.</li> </ul>	<p><b>SC</b></p> <p><b>SC</b></p> <p><b>SC</b></p>
<b>UHB 19/09/013</b>	<p><b>CAMHS – RESPONSE TO MIND OVER MATTER REPORT INCLUDING DELIVERY UNIT REPORT AND ACTION PLAN</b></p> <p>The Chief Operating Officer provided an overview of the report and answered questions raised by the Independent Members prior to the Board meeting:</p> <p>The CAMH Service was repatriated to Cardiff and Vale Health Board from Cwm Taf in April. The Board had been made aware of the extreme increases in demand on the CAMH service and on a number of occasions reported on further capacity input to meet the demand. It was realised that putting in more capacity was not the answer but changing the model was being considered. Two reviews had been undertaken. The Delivery Unit Review related to Primary Care and the Specialist Care Review was commissioned by the Health Board to provide guidance on the services. A way forward had been realised through the actions the team had outlined. The sharp decrease and increase in performance was because they were dealing with patients in turn by managing the patient and not the target. The sequential access route to the service was explained and how in two steps they should arrive at the correct service for the patient.</p>	



	<p>In summary, progress was seen in regard to the backlogs of patients being treated. In regards to recruitment, out of 60 people in the combined service, there were 11 vacancies outstanding. A number of posts had been recruited to with currently only two vacancies outstanding. Good work was being undertaken to right size the service with definite improvements seen. In terms of delivering a comprehensive integrated service going forward this would be a process and would work with specialist and Primary Care teams to integrate the service into the Health and Care System.</p> <p>Independent Member, Trade Union, asked on the staffing mix and if it was visionary enough and fit for the future? Was there a way of knowing the referral to assessment target and could this be addressed at the November meeting. In response it was confirmed the Welsh Government would track the DU plan. The plan also went to Clinical Boards QSE sub committee and would be tracked by the Strategy and Delivery Committee who had oversight of the plan and forms part of the Executive Performance Reviews.</p> <p>In terms of future proofing the service there was a need to concentrate on new ways of working. There was a need to move upstream and a significant amount of work needed to be undertaken at different cluster levels. This was on the wellbeing agenda for young people to remain resilient in the community. The Health Board would have to provide more and use different skills and the future was to get ahead and support young people in various events of their life to avoid them coming into the service.</p> <p>Independent Member – ICT asked if the performance measures on CAMHS could be analysed in the December QSE meeting.</p> <p>The Director of Therapies and Health Sciences asked if the Board would consider if children of armed forces could be given priority to the CAMH Service.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the findings and recommendations of the PCAMHS and SCAMHS external reviews be noted</li> <li>b) the action plan presented in response to the PCAMHS recommendations be noted</li> <li>c) the broader service redesign intentions of the CAMH service which will support service improvement and sustainability be endorsed</li> </ul>	<p>SC</p> <p>SC</p> <p>SC</p>
UHB 19/09/014	<p><b>WINTER PLAN</b></p> <p>The Chief Operating Officer provided an update on the position of the winter plan. The following comments were made:</p>	

	<p>Over the summer an integrated plan had been amalgamated with a number of partners. There were three points of note regarding additional measures to help cope with pressures over winter. A significant piece of work had been undertaken on improving the unscheduled care system. The Strategy and Delivery Committee were shown pathways using data. There were a number of schemes around particular pathways and frailty. This work was ongoing and should lead the Health Board into a better position year on year. The measures taken fell into two categories, firstly, how the Health Board would mitigate the demand on our services through working upstream and having senior decision makers in place and secondly ensuring there was the capacity to meet the demand. This would include bed equipment capacity in the community.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the collaborative work with partner organisations to develop the Winter Plan and support the Cardiff and Vale Integrated Winter Preparedness and Resilience plan be noted.</li> </ul>	
<b>UHB 19/09/015</b>	<p><b>SEXUAL ASSAULT REFERRAL CENTRE</b></p> <p>The Executive Director of Strategic Planning informed Members that this was a key stage in a piece of work triggered by concern that the sexual assault services were not delivering the right kind of services for our citizens. An intensive piece of work had been undertaken with input from the NHS Wales Health Collaborative in terms of project management support.</p> <p>Independent Member – Trade Union asked whether there was any infrastructure behind the services for staff and did we have any support mechanisms for staff wellbeing going forward. It was confirmed that this was a key part of the conversation. It was further explained that they had sought assurance around some of the provider organisations who sat outside the health service and looked at how we provided support and resilience across the system as it developed. It was confirmed that we had strong clinical leadership for our staff.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the overarching model and recommendations be approved</li> <li>b) the costs associated with the implementation of phase 1 only be approved</li> <li>c) work to commence on phase 2 and 3 be approved</li> </ul>	



UHB 19/09/016	<p><b>STRATEGIC CLINICAL SERVICES PLAN</b></p> <p>The Executive Director for Planning stated the plan was in draft stage and had been endorsed by the Board. Attached to the report was an engagement proposal which outlined the timeframe and engagement process. It was asked if the plan could be reviewed by Management Executives in regard to the conversation with the South Glamorgan Community Health Council as they were concerned that this was being undertaken in the run up to Christmas over an eight week period. Also, in light of the engagement with Barry Hospital Health and Wellbeing Centre and the frailty pathway model conversation in the Vale of Glamorgan. It was requested that the informal engagement continue until after Christmas. The Board was asked to adjust the formal engagement process timetable and continue with continuous engagement as part of normal business.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the draft Strategic Clinical Services Plan for production by Medical Illustration and subsequent wider engagement as per the draft engagement plan with staff, general public and stakeholders between 4<sup>th</sup> November and 31<sup>st</sup> December 2019 be approved.</li> <li>b) Executive Directors to reconsider dates of the formal process and when this would begin.</li> </ul>	<p><b>AH</b></p> <p><b>AH</b></p>
UHB 19/09/017	<p><b>ANNUAL MEDICAL EDUCATION REPORT</b></p> <p>The Executive Medical Director introduced Ben Hope-Gill, Director for Medical Education who presented the report and answered questions raised by Independent Members relating to post graduate risk areas. The following comments were made:</p> <p>It was explained that paediatric trainees and surgery trainees were being reallocated to the Health Board next month and HEIW and the Specialist Advisory Committee had put in place safeguards which had been implemented to ensure there was a good training environment and experience.</p> <p>In regards to obstetrics and gynaecology the Chair asked what was being done about this? In response it was stated that the labour ward and acute gynaecology was a highly pressured clinical area and the Health board therefore had difficulties in recruiting middle grade to this specialty. Because of the nature of recruits there was a high level of flexible working which had an effect on the level of supervision for junior trainees. As the ward was busy the modular teams had to hold onto decisions they would like an answer to more quickly. This was a regular item on the agenda and the Health Board was looking to appoint non trainee grade doctors to fill the middle tier gap.</p>	

	<p>Work had been undertaken to improve the induction process and training had been provided to foster confidence in trainees in relation to making decisions in a speciality they were not familiar with. There were plans for extended resident hours to obtain an obstetrics list which should provide an excellent training experience. There were pressures related to staffing and some of the efforts in terms of oversea trainees had not worked out as planned.</p> <p>The Chair questioned whether we were at risk of losing trainees in psychiatry, it was stated there was the potential but no immediate risk for losing trainees had been identified.</p> <p>In terms of critical care, there were issues highlighted in the GMC survey that reflected broader issues in the department. Many of the solutions proposed were part of the generic critical care work which was being focused on in a slightly different way. It was suggested to bring back critical care work to the Quality, Safety and Experience Committee.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the Report and significant development of simulation training be noted</li> <li>b) the priority areas for Undergraduate and Postgraduate Medical Education 2019/2020 be agreed</li> </ul>	<b>SW</b>
<b>UHB 19/09/018</b>	<p><b>DIGITAL HEALTH AND INFORMATION COMMITTEE TERMS OF REFERENCE</b></p> <p>The Director of Corporate Governance introduced the report and confirmed this was a newly formed Committee of the Board which held its first meeting in August where the Terms of Reference had been approved.</p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the Terms of Reference for the newly established Digital and Health Intelligence Committee be approved.</li> </ul>	
<b>UHB 19/09/019</b>	<p><b>QUALITY, SAFETY AND EXPERIENCE COMMITTEE</b></p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the minutes of the Quality, Safety and Experience Committee held in June 2019 be ratified</li> </ul>	
<b>UHB 19/09/020</b>	<p><b>FINANCE COMMITTEE</b></p> <p><b>The Board resolved that:</b></p> <ul style="list-style-type: none"> <li>a) the minutes of the Finance Committee held in July</li> </ul>	

	2019 ratified	
<b>UHB 19/09/021</b>	<b>STRATEGY AND DELIVERY COMMITTEE</b>  <b>The Board resolved that:</b>  a) the minutes of the Strategy and Delivery Committee held in June 2019 be ratified	
<b>UHB 19/09/022</b>	<b>CHARITABLE FUNDS COMMITTEE</b>  <b>The Board resolved that:</b>  a) the minutes of the Charitable Funds Committee held in June 2019 be ratified	
<b>UHB 19/09/023</b>	<b>STAKEHOLDER REFERENCE GROUP</b>  <b>The Board resolved that:</b>  a) the minutes of the Stakeholder Reference Group held in July 2019 be ratified	
<b>UHB 19/09/024</b>	<b>LOCAL PARTNERSHIP FORUM</b>  <b>The Board resolved that:</b>  a) the minutes of the Local Partnership Forum held in June 2019 be ratified	
<b>UHB 19/09/025</b>	<b>EMERGENCY AMBULANCE SERVICES COMMITTEE</b>  <b>The Board resolved that:</b>  a) the minutes of the Emergency Ambulance Services Committee in March and May 2019 be noted	
<b>UHB 19/09/026</b>	<b>ITEMS FOR NOTING AND INFORMATION</b>  <b>NHS WALES COLLABORATIVE LEADERSHIP FORUM MINUTES</b>  <b>The Board resolved that:</b>  a) The minutes of the NHS Wales Collaborative Leadership Forum be noted	
<b>UHB 19/09/027</b>	<b>QUALITY, SAFETY AND EXPERIENCE COMMITTEE CHAIR'S REPORT TO BOARD</b>  <b>The Board resolved that:</b>  b) The report of the Chair of the Quality, Safety and	

	Experience Committee be noted	
<b>UHB 19/09/028</b>	<b>FINANCE COMMITTEE CHAIR'S REPORT TO BOARD</b>  <b>The Board resolved that:</b>  a) The report of the Chair of the Finance Committee be noted.	
<b>UHB 19/09/029</b>	<b>STRATEGY AND DELIVERY COMMITTEE CHAIR'S REPORT TO BOARD</b>  <b>The Board resolved that:</b>  a) The report from of the Chair of the Strategy and Delivery Committee be noted.	
<b>UHB 19/09/030</b>	<b>CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT TO BOARD</b>  <b>The Board resolved that:</b>  a) The report from of the Chair of the Charitable Funds Committee be noted.	
<b>UHB 19/09/031</b>	<b>STAKEHOLDER REFERENCE GROUP CHAIR'S REPORT TO BOARD</b>  <b>The Board resolved that:</b>  a) The report of the Chair of the Stakeholder Reference Group be noted.	
<b>UHB 19/09/032</b>	<b>LOCAL PARTNERSHIP FORUM CHAIR'S REPORT TO BOARD</b>  <b>The Board resolved that:</b>  a) The report of the Chair of the Local Partnership Board be noted.  <b>ANY OTHER BUSINESS</b>  The Chair confirmed that the Board met in private at which the Board discussed a Clinical Negligence claim.  The Chair informed Members that John Antoniazzi, Independent Member, Estates would relinquish his responsibilities with effect from 31 October 2019. He was thanked for his valued contribution to the Board and wished him the best for the future.	

UHB 19/09/033	<b>Date, Time &amp; Venue of Next Board Meeting:</b>  Thursday 28 November 2019, 1.00pm, Barry Memorial Arts Centre, Gladstone Road, Barry CF62 8NA	
---------------	---	--

**ACTION LOG**  
**Following Board Meeting**  
**26 September 2019**

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
<b>Actions Completed</b>					
19/06/009	Patient Safety, Quality & Experience Report	Mental health deaths were due to be a theme at the QSE meeting in October		R Walker	<b>COMPLETED.</b> The QSE held their meeting and this was given full consideration. The QSE can provide assurance to the Board on this issue.
19/03/012	Winter Resilience Programme	Steve Curry, Chief Operating Officer would take the programme back to PCIC	26.09.19	S Curry	<p><b>COMPLETED.</b></p> <p>To be discussed with PCIC Clinical Board</p> <p>Update as at 23.08.19 – It has been agreed that ‘signals from noise’ will now be extended to use data from a number of out of hospital systems including PARIS. This wider system data will inform transformational change. This work is being driven by the signals from noise steering group (inaugural meeting 22.08.19)</p> <p>26.09.19 - This related to the transformation piece with PCIC Out of Hours and the Lightfoot work. This work was in progress and would be monitored through Strategy and Delivery Committee.</p>
19/06/009	Patient Safety, Quality & Experience Report	Mental Health deep dive in relation to themes and trends would be presented at the Special QSE		R Walker	<b>COMPLETED.</b> Presented at QSE October meeting

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
		Meeting			
19/09/009	Patient Safety, Quality & Experience Report	Trends to be included in Board report going forward		R Walker	<b>COMPLETED.</b> In next Board report
19/09/013	CAMHS – Response to mind over matter report including delivery unit report and action plan	Performance measures on CAMHS be analysed in the December QSE Meeting.		S Curry	<b>COMPLETED.</b> This is tracked through Board, Strategy and Delivery Committee and Executive Performance Reviews
19/09/013	CAMHS – Response to Mind Over Matter Report including Delivery Unit Report and Action Plan	Staffing Mix – Was there a way of knowing the referral to assessment target and this to be addressed in November	28/11/2019	S Curry	The target is clear – it is 80% - to be assessed within 28 days. It will be tracked through Executive Performance Reviews and assurance provided through sub committees as agreed.
19/09/006	Board Action Log	19/07/013 – IMTP – Process & Priorities  A presentation on the IMTP was undertaken on an annual basis and the Executive Director of Strategic Planning would check when this would be undertaken again. Independent Member- Trade Union requested if she could be involved.		A Harris	<b>COMPLETED</b> Agenda item.
19/09/016	Strategic Clinical Services Plan	Plan to be reviewed by Management Executives in regard to the conversation with South Glamorgan Community Health Council.		A Harris	<b>COMPLETED</b> Agenda item.
<b>Actions In Progress</b>					
19/07/009	Patient Safety, Quality and Experience Report	(b) Steve Allen, CHC to work with the Health Board in order to help improve signage in relation to Park and Ride	26.09.2019	A Harris/ S Allen	Being picked up by the Wayfinding Group on which the CHC is represented

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
19/01/005	18/119- Relocation of the Links Centre	The Capital Estates and Facilities team is working with PCIC and Mental Health Clinical Boards	26.03.2019	A Harris	CMHT has relocated to the main CRI building. Plans are in place to move the CDAT but due to the needs of the service, the plans will take longer to deliver. Geoff Walsh to provide timeline.
19/03/05	Quality and Safety Experience Report	A further update on the approach to prioritisation and management of maintenance requests be scheduled for six months' time	28.11.2019	A Harris	To be presented to the Board Meeting to be held on 28 <sup>th</sup> November 2019. <i>(Agenda item 7.3)</i>
19/05/010	Community Mental Health Services	A progress report to be provided in six months' time on implementing the new model of care for Community Mental Health Service.	28.11.2019	S Curry	A report will be presented to the Board Meeting to be held on 28 <sup>th</sup> November 2019 <i>(Agenda item 7.7)</i>
19/09/006	Board Action Log	19/07/017 – Welsh Language Policy  There would be further discussions with two Board Champions, Independent Member- Community in relation to equality and Independent Member- University in relation to LGBTQI.	30.01.20	M Driscoll	A proposal will be presented at the Strategy and Delivery Committee in January 2020
19/09/010	Performance Report	Mental Health Performance Measures should be brought back to the next Board meeting and centre on the mental health issues discussed and work through how this could be applied in this particular setting.	28.11.2019	L Richards	To be discussed at the Board Meeting to be held on 28 <sup>th</sup> November 2019. <i>(Agenda item 7.4)</i>
19/09/012	Primary Care Milestones and Delivery Against Them	Reports would be provided to the Board on an annual basis, or if there were exceptions in relation to delivery.	24.09.2020	S Curry	To be added to the work programme for the Board and timetabled for September 2020.
19/09/013	CAMHS – Response to Mind Over Matter Report including Delivery	Staffing Mix – Was there a way of knowing the referral to assessment target and this to be addressed in November	28/11/2019	S Curry	The target is clear – it is 80% - to be assessed within 28 days. It will be tracked through Executive Performance Reviews and assurance provided



MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
	Unit Report and Action Plan				through sub committees as agreed.
19/09/016	Strategic Clinical Services Plan	Executive Directors to reconsider dates of the formal process and when this would begin.	Spring / Summer 2020	A Harris	Continuous engagement ongoing. Consultation, if required to follow in the spring/summer 2020.
<b>Actions referred to Committees of the Board/Board Development</b>					
19/09/006	Board Action Log	19/03/012 – Winter Resilience Programme  This work was in progress and would be monitored through Strategy and Delivery Committee.		S Curry  L Tolley	Progress will be updated through Strategy & Delivery Committee performance update – unscheduled care section.
19/09/012	Primary Care Milestones and Delivery against them	Primary Care Team to present to the Management Executives on future priorities for primary care. This would include delivery milestones and access standards and the Chief Operating Officer would also arrange for this to be presented to the Strategy and Delivery Committee (likely to be in November) be noted.	07.01.2019	S Curry	To be added to the agenda of the January 2020 Strategy and Delivery Agenda
19/09/012	Primary Care Milestones and Delivery Against Them	The proposal for quarterly reports to be considered by the Strategy and Delivery Committee be approved.	7.01.19	S Curry / L Tolley	To be added to the Strategy and Delivery Work plan and then added to the agenda on a quarterly basis
19/09/013	CAMHS – Response to mind over matter report including delivery unit report and action plan	The plan would go to Clinical Boards QSE sub-committee and would be tracked by the Strategy and Delivery Committee who had oversight of the plan and forms part of the Executive Performance Reviews.		S Curry	Performance will be tracked through the performance report provided to the Strategy and Delivery Committee
19/09/017	Annual Medical Education Report	Critical Care work to be brought to the Quality, Safety & Experience Committee	18.02.20	S Walker	QSE Committee - 18 February 2020

<b>Report Title:</b>	<b>Outcome of Engagement on Improving Care for Frail Older People in the Vale of Glamorgan</b>					
<b>Meeting:</b>	UHB Board				<b>Meeting Date:</b>	28.11.19
<b>Status:</b>	<b>For Discussion</b>	✓	<b>For Assurance</b>		<b>For Approval</b>	✓ <b>For Information</b>
<b>Lead Executive:</b>	Executive Director of Strategic Planning					
<b>Report Author (Title):</b>	Director of Operations, Medicine Clinical Board					

## SITUATION

The UHB's Medicine Clinical Board developed a proposal to transform the acute frailty pathway designed to improve outcomes for frail older people in the Vale of Glamorgan, which would result in patients spending less time in hospital, a reduction in the demand for beds and the associated closure of the medical beds currently provided at the Sam Davies ward in Barry Hospital. Following discussion with the South Glamorgan Community Health Council (CHC), the Health Board undertook an eight week programme of engagement September - November 2019 to seek people's views on these proposals.

A report on the public engagement is attached as Annex 1 and sets out the approach to engagement, provides an analysis of the feedback received and summarises key findings. Full and careful consideration has been given to this feedback which includes responses from the Vale of Glamorgan Council and Unison, and a petition to Welsh Government; this report sets out the Health Board's response to the feedback received and makes a recommendation on the way forward.

The South Glamorgan Community Health Council (CHC) has received copies of all the feedback received and will determine its response to the engagement at a CHC Executive Committee meeting on 10<sup>th</sup> December 2019. A final Health Board position will take into account the views of the CHC.

## BACKGROUND

In line with plans set out in the Health Board's Shaping Our Future Wellbeing Strategy, the Health Board has invested significantly over the last four years in primary and community services to increase the support available to keep Wyn living well at home. The focus in this engagement was on the hospital-based elements of Wyn's care and a set of proposals aimed at preventing admission, enabling shorter hospital stays and providing care closer to home. There are three main strands to the proposed model of care: Preventing Hospital Admission; Acute Frailty Assessment; and Discharge to Assess (D2A).

An eight week engagement on this proposal was undertaken from 2 September to 6 November 2019; the approach to engagement was agreed with South Glamorgan Community Health Council (CHC) and reviewed mid-way through the engagement period. The original closing date was extended following agreement to hold an additional public meeting.

## ASSESSMENT

A report on public engagement is attached as **Annex 1** which sets out the approach to engagement, provides a detailed analysis of the feedback received and summarises key findings. A total of 270 responses were received. A public engagement event was held on 23

September, attended by 53 members of the public. A further public engagement meeting, hosted by the CHC, was held on 30<sup>th</sup> October and was attended by 57 members of the public. The proposals were also presented and discussed at a range of stakeholder meetings. In addition to the feedback received directly by the Health Board, a petition organised by Unison and signed by circa 13,000 people, called on Welsh Government to stop the proposal to close the Sam Davies ward and to ensure that Barry Hospital continues to provide health services to the public of Barry and the Vale of Glamorgan.

### **Key Findings from Engagement**

Throughout this engagement, we have heard strong messages about how valued Barry Hospital and the Sam Davies ward are to the community and that we should be putting more services in not taking them out. While many agree with the principles of what we are trying to achieve in terms of preventing admission, shorter hospital stays and care closer to home, people do not believe that the proposed model is the right way of achieving this. There is strong opposition to a closure of the Sam Davies ward and we have received many inspiring comments about the excellence of care on the ward and the strength of the relationships it has built with the local community.

Many respondents point out that Barry is one of the largest towns in Wales and want us to improve provision in Barry Hospital or put more services in, with some querying why the model could not be implemented there instead of at University Hospital Llandough (UHL). Concern about the future of Barry Hospital were expressed, with examples of closures including Sully Hospital and the Neale Kent ward cited as demonstrating a downgrading of service provision in the Vale by the Health Board.

We received many comments expressing concern about the accessibility of UHL for Barry patients and their families who currently access the services provided in Barry Hospital, and generally it was felt that Barry Hospital's location provides better access for the majority of residents in the Vale of Glamorgan. Some respondents highlighted the importance of the role played by visitors and family in supporting the rehabilitation of patients, yet the proposal would mean extra travelling time for many, with less time available to be spent with loved ones. People have concerns about the suitability, reliability and cost of public transport and the difficulty of parking at UHL for visitors, many of whom are themselves elderly.

The feedback demonstrates that a lack confidence in the proposed model, with many questioning whether it recognises the growing, ageing population in the Vale of Glamorgan and arguing that beds cannot be closed until there is evidence that the pathway will work. Concerns have been raised by the public, staff and colleagues in the local authority, primary care and third sector about the capacity of services in the community to support the model and the increased demand this would place on other parts of the care system. The potential impact on social care, GPs and acute hospital beds as services already under severe pressure, were specifically highlighted.

We also received some helpful ideas for the way in which services could be developed in the future. Suggestions included establishing a more integrated health and social care model at Barry Hospital and the introduction of GP involvement in the provision of these services. The importance of engaging with a range of different care and partner agency professionals to shape plans was emphasised as well as the need to involve carers.

Full and careful consideration has been given to this feedback, leading to the development of a set of proposals for taking this work forward which respond to and build on what people have told us in this engagement in the context of the need to improve care for frail older people by adopting nationally recommended models of care.

### **Proposed Way Forward**

We propose to take action to build public confidence in the frailty model and the future of Barry Hospital before proceeding with further consideration of the future of beds in the Sam Davies ward. We will therefore keep the beds on the Sam Davies ward open at this time and continue to introduce key elements of the acute frailty model at UHL to improve outcomes for Vale of Glamorgan patients with complex frailty needs.

Developing services at UHL over the next six months, including the Day Hospital and Elderly Care Assessment Services, an Acute Frailty Service and Discharge to Assess beds will provide us with the opportunity to collect evidence of the impact of the frailty pathway on the demand for beds and on services in the community. We will also embed consultant geriatrician/general interest medicine physician expertise in the already established Community Resource Team in Barry Hospital and grow these services accordingly.

Crucially, we will work with local authority and third sector colleagues to inform the development of a more joined up, integrated approach to meeting the needs of frail older people across health and social care, and across clinical teams who work in primary, community and hospital services. We will use this time to develop a shared understanding of the impact of the model and to assess the availability of resources in the community to support safe early discharge, taking into account the pressures other services are under and the sustainability of funding streams.

Of equal importance is the need to provide clarity on the future of Barry Hospital. Initial work has already commenced on exploring the opportunities offered by the development of Barry Hospital as a Health and Wellbeing Centre, led by the Vale of Glamorgan integrated health and social care team. We will progress this work at pace in tandem with the work on the acute frailty pathway. We work with the local community, staff and other partner organisations to shape what this looks like.

By early 2020, we aim to have developed a clearer and more detailed plan for the development of Barry Hospital as a Health and Wellbeing Centre and we will have undertaken an evidence-based assessment of the impact of introducing a more clinically effective pathway to support patients with acute frailty needs. At this point, we will review the future of beds on the Sam Davies ward and consider the need for further engagement or consultation, if there is a proposal for a change of use or closure of beds.

In the meantime, we will work closely with staff in the Sam Davies ward and in the other parts of the pathway, to keep them informed of progress and involve them in shaping the plans.

**Annex 2** provides more detail on the Health Board's response and proposed action against each of the key themes from feedback received during engagement.

**ASSURANCE** is provided by:

Regular updates on the emerging picture from engagement have been shared and discussed with the UHB Management Executive and at the October Board Development session. The UHB has worked closely with the CHC in designing and running the engagement process, including a mid-way review which resulted in an additional public meeting and extension of the engagement period. All responses and the analysis of feedback have been shared in a timely way with the CHC.

## RECOMMENDATION

The Board is asked to:

- **CONSIDER** the feedback to the engagement set out in Annex 1 and the response to the issues raised set out in Annex 2
- **AGREE** the proposed way forward subject to consideration of the views of the Community Health Council

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1.Reduce health inequalities		6.Have a planned care system where demand and capacity are in balance	✓
2.Deliver outcomes that matter to people	✓	7.Be a great place to work and learn	
3.All take responsibility for improving our health and wellbeing		8.Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4.Offer services that deliver the population health our citizens are entitled to expect	✓	9.Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5.Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✓	10.Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓
------------	--	-----------	---	-------------	---	---------------	---	-------------	---

### Equality and Health Impact Assessment Completed:

Yes. The Assessment was an integral component of the documentation developed to support engagement and has been updated to reflect on feedback received during the engagement.

Trust and integrity

Ymddiriedaeth ac uniondeb

Personal responsibility

Cyfrifoldeb personol

## Annex 1

### Proposals for Improving Care for Frail Older People in the Vale of Glamorgan Report on Public Engagement - November 2019

#### 1. Executive Summary

The Medicine Clinical Board developed a proposal to transform the acute frailty pathway which would result in a reduction in the demand for beds and the associated closure of the medical beds currently provided at the Sam Davies ward in Barry Hospital. Following discussion with the South Glamorgan Community Health Council (CHC), the Health Board undertook an eight week programme of engagement September - November 2019 to seek people's views on proposals aimed at improving care for frail older people in the Vale of Glamorgan.

This report describes the approach to engagement, provides an analysis of the feedback received and summarises key findings. The content of this report will inform the development of a recommended response to the engagement that will be considered at the Health Board meeting on 28<sup>th</sup> November 2019. The CHC has received copies of all the feedback received and will determine its response to the engagement at a CHC Executive Committee meeting on 10<sup>th</sup> December 2019. A final Health Board position will take into account the views of the CHC. The number of responses received is summarised below:

Number of Responses Received	
Type	Number
Feedback Form	27
Email response	63
Other response (e.g. letter)	180
<b>TOTAL</b>	<b>270</b>

The engagement sought people's views on proposals aimed at improving care for frail older people in the Vale of Glamorgan. While the engagement did not ask a specific question about whether or not people supported the proposals, the feedback clearly indicates a great deal of concern about the proposed changes and strong opposition to the proposed closure of the Sam Davies ward. 228 responses either directly stated their opposition to the closure or that the ward should remain open. A number of common themes emerged from the the feedback received in response to the engagement questions and in other formats including emails, letters and comments made at the public and stakeholder events:

#### Current provision at Barry Hospital and the Sam Davies ward:

- Barry Hospital and the Sam Davies ward are highly valued by the community
- The excellence of care on the ward, the support it gives to carers and the strength of the relationships with the local community
- Strong opposition to a closure of the Sam Davies ward



**Concerns about accessing services at Llandough Hospital:**

- Barry Hospital is seen as much more accessible to most Vale residents than Llandough Hospital
- The important role played by visitors and family in supporting rehabilitation of patients, yet the proposal would mean extra travelling time for most, with less time available with loved ones
- Concerns about the suitability, reliability and cost of public transport and the difficulty of using public transport for visitors, many of whom are themselves elderly

**The future of Barry Hospital:**

- Questions about why the model could not be put in Barry Hospital instead of at Llandough, building on the expertise already in the Sam Davies ward
- Concern that this is the beginning of the end of Barry Hospital in the context of a history of other closures e.g. Sully Hospital and Neale Kent ward
- That the Health Board should be improving services and putting more services in, not taking them out of Barry, as one of the largest towns in the country
- The need for the Health Board to be clear about the future of Barry Hospital

**Concerns about the proposed model:**

- While many agree with the principles of what the Health Board is trying to achieve, people have real concerns about the proposed model
- Lack of confidence in the proposed model, questioning whether it recognises the growing, ageing population in the Vale of Glamorgan and arguing that beds cannot be closed until there is evidence that the pathway will work
- Concerns that services in the community do not have the capacity to support the model and that it places increased demand on other parts of the care system
- The potential impact on social care, GPs and acute hospital beds as services which are already under severe pressure

**Comments about the engagement process:**

- Questions about whether the Health Board is listening or has already made a decision
- A view that this is about cuts and is financially driven rather than based on clinical need

**Ideas for what else could be done at Barry Hospital in the future:**

- Establishing a more integrated health and social care model at Barry Hospital
- Introduction of GP involvement in the provision of these services
- Develop more services that support wellbeing and tackle loneliness
- Involve a range of stakeholders in shaping services, including carers, different care professionals, third sector and primary care

The Health Board will need to give careful consideration to the feedback received and the views of the CHC in determining its response to the engagement and agreeing a way forward.

## 2. Introduction

In line with the plans set out in the Health Board's Shaping Our Future Wellbeing Strategy, the Health Board has invested significantly over the last four years in primary and community services to increase the support available to keep people living well at home. To ensure the patient is at the centre of service planning and delivery, a character called Wyn has been created to help illustrate how changes proposed by the Health Board will impact on patients. On this occasion, Wyn's experiences were used to help illustrate the proposal for improving care of frail older people in the Vale of Glamorgan. The focus in this engagement was on the hospital-based elements of Wyn's care and a set of proposals aimed at preventing admission, shorter hospital stays and care closer to home. There are three main strands to the proposed model of care: Preventing Hospital Admission; Acute Frailty Assessment; and Discharge to Assess (D2A). These were described in detail in the Engagement Document.

An eight week engagement on this proposal was undertaken from 2 September to 6 November 2019; the approach to engagement was agreed with the CHC and reviewed mid-way through the engagement period. The original closing date of 1 November was extended following agreement to hold an additional public meeting.

## 3. Background and Approach to Engagement

Proposals to transform the acute frailty pathway were presented at a meeting of the CHC Service Planning Committee on 20 June 2019 to seek early views from the CHC. This led to an agreement to undertake a period of public engagement to ascertain the views of patients, carers and key stakeholders. A first draft Engagement Document and Engagement Plan were discussed with the CHC Medicine Oversight, Scrutiny and Performance Group on 18 July 2019; further questions and comments from the CHC led to re-drafting and internal testing of the proposals in August alongside the development of a suite of resources to support engagement, detailed below. Engagement commenced on 2 September 2019.

### Objectives of the engagement

- **Describe** the vision for an improved pathway of care for frail older people (Wyn)
- **Discuss** the current model of care and the case for change
- **Present** the proposed new model for the hospital-based elements of frailty services
- **Explain** the potential benefits of the proposals for Wyn
- **Ask** you some key questions to inform our thinking
- **Listen** and take into consideration your views and any concerns on the proposed changes

The key bilingual resources produced to support engagement and posted on the UHB [engagement webpage](#) were:



- Engagement Document detailing the proposals and five engagement questions
- Frequently Asked Questions
- Equality and Health Impact Assessment
- Pathway Diagram illustrating Wyn's current and proposed pathways of care

An Engagement Plan describing the key audiences and methods of engagement was agreed with the CHC and is available as Appendix 1. A dedicated email account was created to receive feedback.

The questions included in the Engagement Document were as follows:

1. What are your views on our proposals to improve care for frail older people in the Vale of Glamorgan?
2. Taking into account the information in this Engagement Document and the Frequently Asked Questions, is there anything else we need to consider when taking a decision on the way forward?
3. Is there any more information you would like about these proposals?
4. We would like to know what you think is the most important to frail older people about their experience of care when they become unwell. If applicable, please tick more than one box from the following list:

- Only getting admitted to hospital if absolutely necessary
- Being seen as soon as possible by 'frailty experts'
- Staying in hospital for as short a time as possible and necessary
- Starting therapies earlier in the recovery journey
- No delay in leaving after treatment
- Returning home after a hospital stay with community support to help them recover further and stay safe at home
- Where the hospital care takes place within the Vale of Glamorgan
- The accessibility of the place of care

5. Any other comments?

Details of the engagement, opportunities to learn more and how to share views were circulated widely to stakeholders at the start of the engagement period, with requests for their support in sharing the information within their networks and contacts.

Communications and social media support was also provided. A public engagement workshop was held on 23 September, attended by 53 members of the public. A further public engagement meeting was arranged following discussion with the CHC at the mid way review. The meeting, hosted by the CHC, was held on 30<sup>th</sup> October and was attended by 57 members of the public. Notes of these public events are attached as Appendix 2 and 3. The proposals were also presented and discussed at a range of stakeholder meetings as detailed in the Engagement Plan.

#### 4. Responses to the Engagement

The following feedback was received:

Type of Feedback	Number	Comment
Response form	27	Hard copy and electronic forms including from the following teams/organisations: <ul style="list-style-type: none"> <li>- Unison</li> <li>- Vale Locality/Social Services</li> <li>- Barry Town Council</li> <li>- Glamorgan Voluntary Services</li> </ul>
Email/correspondence received by email	63	Emails including from the following organisations: <ul style="list-style-type: none"> <li>- Bro Taf LMC</li> <li>- Vale of Glamorgan Council</li> <li>- Llandough Community Council</li> <li>- Vale 50+ Forum</li> <li>- Llandough Community Council</li> <li>- Penarth Town Council</li> </ul>
Letter	180	Letters including from the following organisations: <ul style="list-style-type: none"> <li>- Soroptimist International Barry and District</li> </ul>
Public workshop notes	53 attendees	
Public meeting notes	57 attendees	
Stakeholder meeting notes	n/a	Details of meetings where the proposals were presented and discussed are provided in the Engagement Plan
Petition	Circa 13,000 signatures	Petition to Welsh Government

Responses were received through multiple routes, via: engagement email, UHB Chair and Chief Executive, the CHC, politicians, the UHB complaints/compliments team, Welsh Government. Every effort was made to avoid any duplication in counting and analysis.

Comments made at the public engagement workshop and evening meeting were captured, verified by the CHC and analysed. Key points made at a number of stakeholder meetings, as detailed in the engagement plan, were also included in the analysis. It should be noted that everyone was also encouraged to complete individual response forms so there may be an element of duplication in the points

captured in meeting notes and those made in response forms. A full copy of all the feedback received via the forms, emails, letters and meeting notes have been shared with the CHC.

In addition to the feedback received directly by the Health Board, a petition organised by Unison and signed by circa 13,000 people, was presented to Welsh Government on 9 October. Copies were also shared with the Health Board and the CHC on 30 October. The petition called on Welsh Government to stop the proposal to close the Sam Davies ward and to ensure that Barry Hospital continues to provide health services to the public of Barry the largest town in Wales, and the Vale of Glamorgan.

### **Summary of Key Themes Identified from Feedback**

A number of themes were identified when analysing the feedback received via response forms, emails, letters and comments made at the public and stakeholder meetings. These key themes were tested with the CHC at the mid way review and have been used as the basis of analysis of the feedback. Many of the respondents and participants in the public and stakeholder meetings expressed multiple views across their responses.

The key themes are:

- Sam Davies ward/Barry Hospital are highly valued
- Access issues in relation to Llandough Hospital
- Concern for the future of Barry Hospital
- Lack of confidence in the model
- Increased pressure on the rest of the system
- The need to consider other options
- Proposals financially driven not clinically led
- Concerns about the process

The main issues raised under these key themes were as follows:

Sam Davies ward and Barry Hospital are highly valued	Excellence of award winning care; build on their expertise
	Close links with third sector and community groups who support patients and carers and with local nursing homes
Access	Barry Hospital is much more accessible to most Vale residents than UHL
	Visitors/family support are important to rehabilitation so need easy access to their loved ones
	parking difficult at UHL and long distances to walk on site; park and ride unsuitable for some and poorly positioned for Vale residents
	Demographic profile of affected population means many cannot afford public transport or own car and taxis are too expensive
	public transport - poor provision and costly
	Some visitors, many are themselves elderly may have difficulty using public transport or using park and ride
Concern for future of Barry Hospital	As one of the largest towns in Wales, Barry needs services
	This signals the beginning of the end of Barry Hospital; a history of Health Board closing or downgrading services in the Vale, e.g. Sully Hospital, Neale Kent, Day Hospital
	not confident that current staff will be protected in new model
Lack of confidence in the model	This model doesn't recognise the characteristics of the population in Barry/Vale of Glamorgan (growing, ageing, rurality of Vale)
	Lack of infrastructure in the community to support the model: health; physios; pharmacy; care workers; care home beds; adaptations/equipment etc.
	can't close beds until the service is established and there is evidence that the pathway will work (reduced demand for beds, support available in the community, people don't bounce back into hospital)
	Support principles but have concerns
	The principle is care closer to home but services will be further away in this model
	Lack of Social care capacity to support the expectation of community based care
	Lack of primary Care capacity to deal with additional demand
Increased pressure on the rest of the system	Potential negative impact on acute hospital beds already under pressure; unable to transfer patients out of acute beds or pressure to discharge home to soon - need more beds not fewer
	shift of care and workload to social care
	Increased pressure on rest of system, E.G. WAST
	additional workload for GPs
	relies on a model of family support that not everyone has
	extra pressure on family and carers
	extra pressure on third sector services

Consider Other options	Improve/increase services in Barry Hospital
	Put proposed model in Barry Hospital/Sam Davies ward not in UHL
Proposals are financially driven not clinically led	This is about cuts
	Shift of costs to social care/Council
Process	Unhappy with this as an engagement process
	Is the Health Board listening/telling the truth and has the decision already been made?

The following ideas for what else could be done at Barry Hospital in the future were also highlighted in responses:

- Establish a more integrated health and social care model at Barry Hospital; involve Vale Council Social Services and Third Sector in shaping the model
- Introduction of GP involvement in the provision of these services
- Build on model established at Ty Dyfan
- Develop more services that support wellbeing and tackle loneliness
- Involve a range of stakeholders in shaping services including carers, different care professionals, third sector and primary care
- Be clear about the future of Barry Hospital

Other comments:

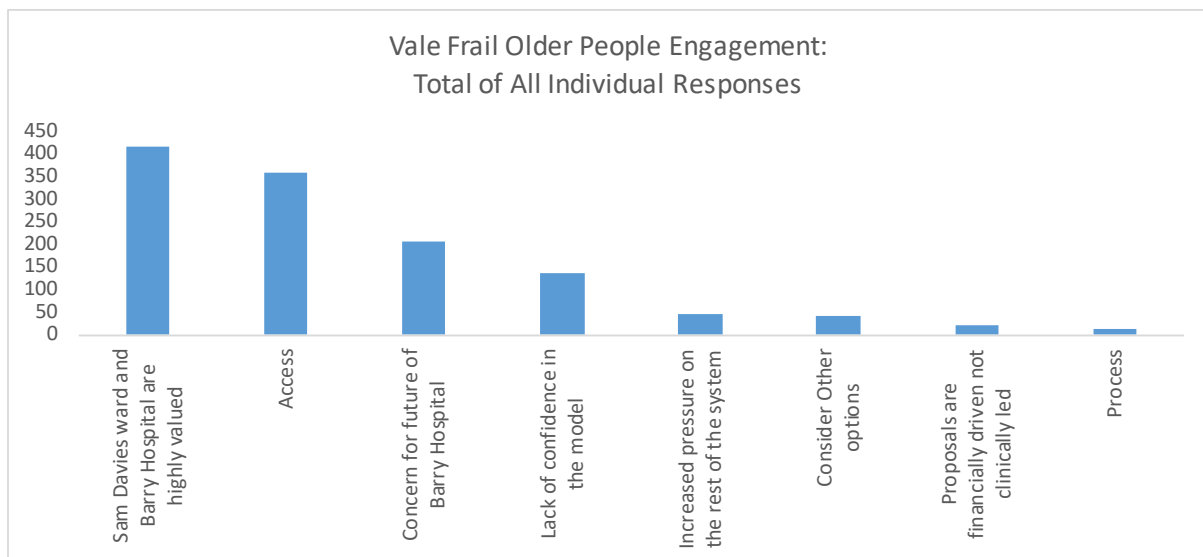
- Work more collaboratively with partner agencies e.g. Fire & Rescue and Police, to support the wider needs of frail older people living in the community and keep them safe at home
- Own experience demonstrates importance of getting people home from hospital more quickly to prevent deconditioning and providing more care in the community to keep people safe at home
- The importance of ensuring the needs of patients with dementia are met
- Questions about how respite provision currently provided on Sam Davies ward would be addressed
- Develop an integrated Acute Frailty Service with Third Sector as partners

## Analysis of Feedback

The nature of the open questions asked in the Engagement Document meant that there was a lot of overlap in the issues people raised under each question. A number of common themes emerged from the responses both to the engagement questions and from the feedback received in other formats including emails, letters and comments made at the public events. The following sections provide an analysis of feedback:

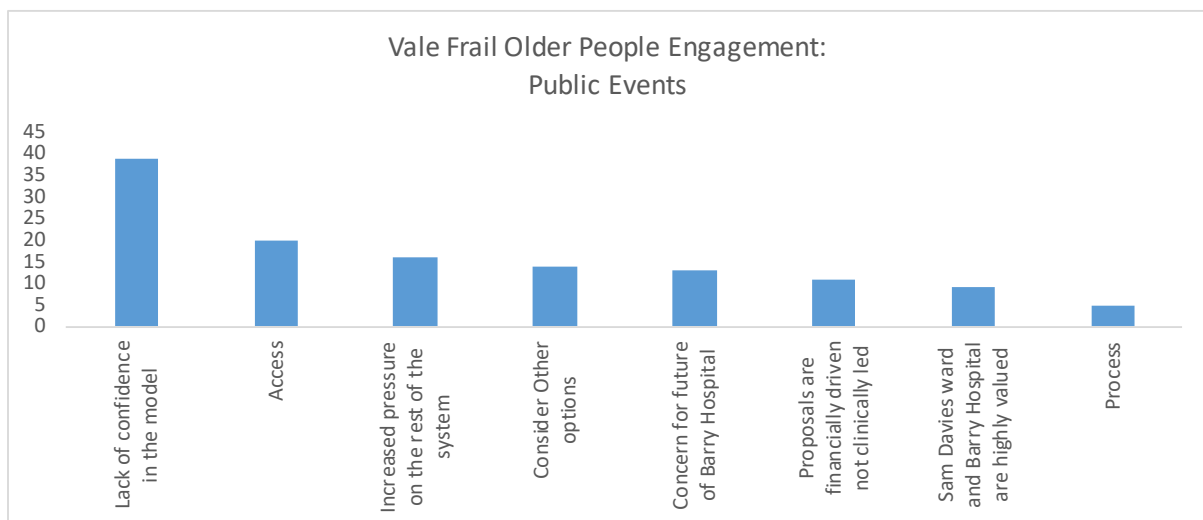
a) From all the responses received via the form, email and letter

Themes	Number of times identified theme was mentioned in responses
Sam Davies ward and Barry Hospital are highly valued	414
Access	357
Concern for future of Barry Hospital	206
Lack of confidence in the model	136
Increased pressure on the rest of the system	46
Consider Other options	40
Proposals are financially driven not clinically led	21
Process	13



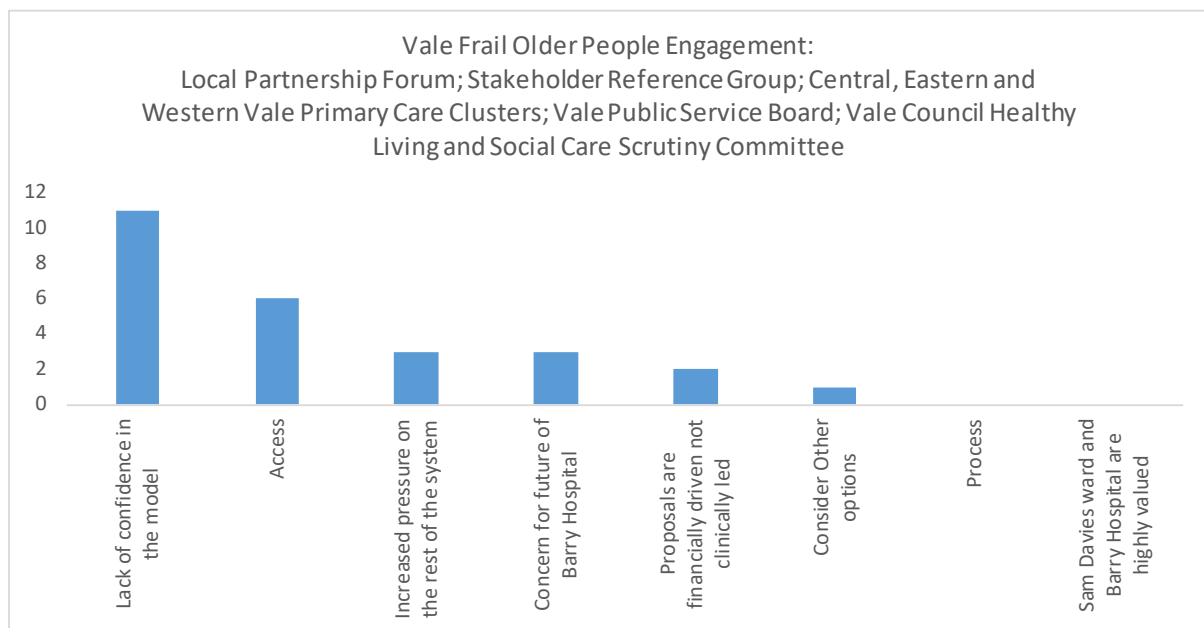
b) From comments made at the two public events

Themes	Number of Comments at public events containing identified theme
Lack of confidence in the model	39
Access	20
Increased pressure on the rest of the system	16
Consider Other options	14
Concern for future of Barry Hospital	13
Proposals are financially driven not clinically led	11
Sam Davies ward and Barry Hospital are highly valued	9
Process	5



c) From comments made at stakeholder meetings

Local Partnership Forum, Stakeholder Reference Group, Central, Eastern and Western Vale Primary Care Clusters, Vale Public Services Board, Vale Council Healthy Living and Social Care Scrutiny Committee	
Themes	Number of Comments containing identified theme
Lack of confidence in the model	11
Access	6
Increased pressure on the rest of the system	3
Concern for future of Barry Hospital	3
Proposals are financially driven not clinically led	2
Consider Other options	1
Process	0
Sam Davies ward and Barry Hospital are highly valued	0

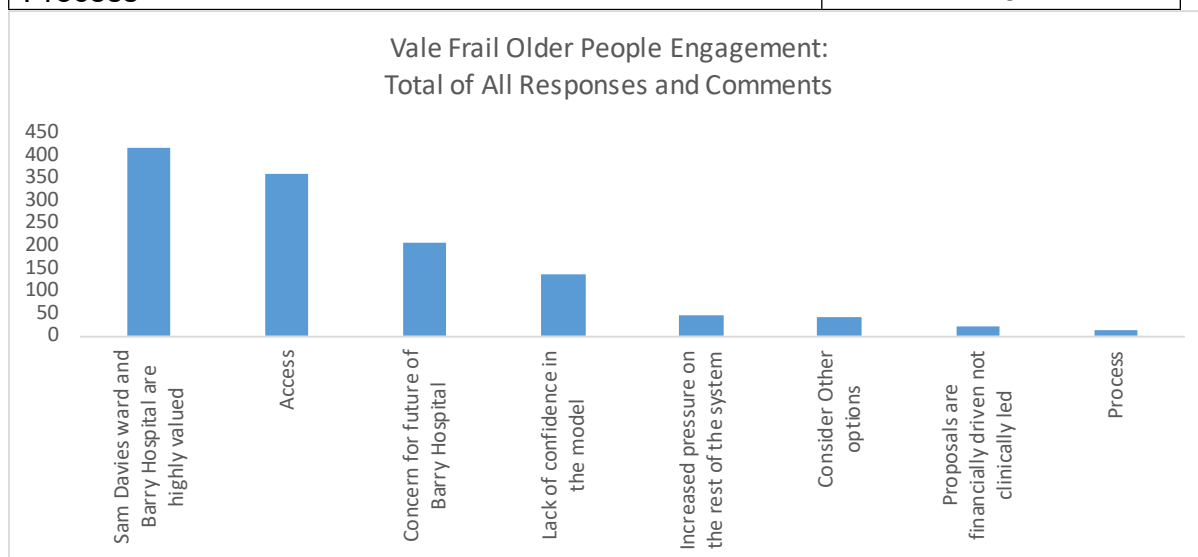




d) From a collation of the all responses above

#### Total of All Responses and Comments

Themes	Number of times identified theme was mentioned in responses
Sam Davies ward and Barry Hospital are highly valued	423
Access	383
Concern for future of Barry Hospital	222
Lack of confidence in the model	186
Increased pressure on the rest of the system	65
Consider Other options	55
Proposals are financially driven not clinically led	34
Process	18



e) From Question 4 on the engagement response form

**Note:** there were only 24 responses to Q.4

Important factor to patients	Total
Where the hospital care takes place within the Vale of Glamorgan	20
Only getting admitted to hospital if absolutely necessary	17
Returning home after a hospital stay with community support to help them recover further and stay safe at home	19
No delay in leaving after treatment	17
Being seen as soon as possible by 'frailty experts'	17
Starting therapies earlier in the recovery journey	16
The accessibility of the pace of care	14
Staying in hospital for as short a time as possible and necessary	16

### **Key Themes from Engagement Feedback and Health Board response/proposed action/mitigation**

The Health Board has carefully considered all the issues and concerns raised through engagement. The following table summarises the key issues raised during through engagement and provides a response including where we have identified further action or mitigation to support implementation of the proposed way forward. More detail on the feedback received and the way it was analysed is provided in Annex 1.

<b>Key Issues and Concerns from Engagement</b>	<b>UHB Response, Action or Mitigation</b>
<p>Sam Davies ward and Barry Hospital are highly valued</p> <ul style="list-style-type: none"> <li>• Excellence of care; build on expertise</li> <li>• Close links with local community</li> </ul>	<p>We have heard very clearly that people have received excellent care on the Sam Davies ward and that it has established strong links with the community which are highly beneficial to patient experience. We propose to take action to build public confidence in the frailty model and the future of Barry Hospital before proceeding with further consideration of the future of beds in the Sam Davies ward. We will therefore keep the beds on the Sam Davies ward open at this time and continue to introduce key elements of the acute frailty model at UHL to improve outcomes for Vale of Glamorgan patients with complex frailty needs.</p> <p>We will build on the knowledge and expertise developed on the Sam Davies ward, to develop a more integrated approach to meeting the needs of frail older people across health and social care and to consider a range of options including the potential re-purposing of beds on the Sam Davies ward. We will work with partners to look at how we maintain and grow community involvement in Barry as a Health and Wellbeing Centre to support improved health and wellbeing outcomes for the local population.</p>
<p>Concerns about accessing services at Llandough Hospital</p>	<p>The nature of acute frailty services and clinical presentation of sick frail older people warrants immediate access to a wide range of complex diagnostics and</p>



NHS  
WALES  
GIG  
CYMRU

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

<ul style="list-style-type: none"> <li>Barry seen as much more accessible</li> <li>Important role of family and visitors in supporting rehabilitation, yet proposal would mean more time travelling and less time with loved ones</li> <li>Concerns about the suitability, reliability and cost of public transport and the difficulty of using public transport for visitors, many of whom are themselves elderly</li> </ul>	<p>prompt access to wider professional groups (other hospital based specialists), that realistically can only be provided within an acute hospital setting.</p> <p>Although introduction of improved acute frailty services should lead to shorter patient stays in UHL, we recognise that members of the public may have concerns about travel and parking at UHL.</p> <p>The Health Board has already taken steps to improve access to UHL with the introduction of a new Park and Ride scheme which is free for the public and staff. This service runs Monday to Friday every 20 minutes starting 6.30am with the last bus leaving UHL at 19.15pm. We have received very positive feedback from patients and staff about the ease of use of the scheme, which drops people right outside the main hospital entrance. However, we recognise that at peak times, travel time can be affected by congestion.</p> <p>Flexible visiting is in place at University Hospital Llandough through 'John's Campaign' and this helps to reduce potential parking issues for Vale of Glamorgan residents who are able avoid usual visiting hours or are not able to access Park and Ride.</p> <p>We will continue to liaise with the Vale of Glamorgan Council to explore opportunities for further Park and Ride and sustainable transport schemes to support residents of the Vale of Glamorgan.</p>
<p>Concern for the future of Barry Hospital</p> <ul style="list-style-type: none"> <li>As one of the largest towns in Wales, Barry needs more services</li> </ul>	<p>We see an exciting future for Barry Hospital as one of our three Health and Wellbeing Centres (H&amp;WBC), providing a wide range of diagnostic and locality health and secondary care outreach services in redeveloped facilities for the Vale of Glamorgan population. Services in each of the H&amp;WBCs will include:</p>



- This signals the beginning of the end of Barry Hospital against a history of closing or downgrading services in the Vale
- Not confident that current staff will be protected in new model

- Tailored diagnostic and clinical support for ambulatory patients (care/ treatment/ tests provided on an outpatient basis)
- point of care testing
- plain film x-ray
- outpatient services
- a range of integrated health and social care services that will be tailored to reflect the specific needs of the locality.
- Continue to develop the expertise and services in the Minor Injuries Unit

Core services proposed for each H&WBC include:

- Ambulatory care for rapid assessment of patients with specific conditions without the need for emergency admission
- Range of point of care testing services and plain film x-ray
- Enhanced enablement services
- Range of outpatient services
- Community Mental Health Teams
- Community Children's Services

We will work with the local community, staff at Barry Hospital and the Sam Davies ward, and other partners to explore opportunities for what this might look like in Barry and what people think will help meet their needs.

In the meantime, we will work closely with staff in the Sam Davies ward and in the other parts of the pathway, to keep them informed of progress and involve them in shaping the plans. We will also embed consultant geriatrician/general interest medicine physician expertise in the already established Community Resource Team in Barry Hospital and grow these services accordingly.



Lack of confidence in the model. Many support the principles but have concerns:

- This model doesn't recognise the growing and ageing population in Barry/ Vale of Glamorgan
- Lack of infrastructure in the community to support the model
- Cannot close beds until the service is established and there is evidence that the pathway will work
- The principle is care closer to home but services will be further away in this model
- Lack of Social care capacity to support the expectation of community based care
- Lack of primary Care capacity to deal with additional demand

We know there will be an increase in the number of older people over 65 in the future according to the Cardiff and the Vale of Glamorgan Population Needs Assessment (2014). The report predicts that demand for services for frail older people will increase by 31% in the Vale over the next 10 years.

With these changes and growing care needs, we need to review, change and improve the type of healthcare we provide to this vulnerable and complex group of patients so we can better support them to leave hospital quicker, retaining their continued independence, confidence and dignity. The current pathway is not sustainable in light of the changes expected in our population and would not deliver appropriate care for the needs of our patients.

The Discharge to Assess and Acute Frailty Assessment service based in UHL will reduce unnecessary total hospital length of stay which in turn reduces clinical deconditioning and loss of mobility/ function in patients. This means that patients are less sick and frail when they are discharged back home and reduces care needs in the community and through primary care.

Previous evidence-based work with the NHS Wales award-winning Community Resource Team model in Cardiff (2010 NHS Award best social care partnership, Cardiff East Locality Team) has demonstrated better patient outcomes, reduced length of stay, reduced admissions and reduced costs for local authority partners in terms of adult social care packages/ placements. Similarly the establishment of an Acute Frailty service at UHW in 2014 has demonstrated reductions in unnecessary hospital admissions and overall length of total hospital stay, as well as improved patient satisfaction. It is highly desirable to establish a similar model in the Vale of Glamorgan to produce equitable services to all residents of Cardiff and the Vale.



	<p>The Elderly Care Assessment Service enables GPs to get specialist advice and treatment for their patients rather than needing an unnecessary and potentially harmful admission to hospital. There is an established 5-day service in Cardiff which needs to be replicated in the Vale.</p> <p>We will continue to engage and work with GPs and colleagues in health and social care services to introduce more services in the community which will support people to stay at home and prevent unnecessary admissions to hospital. The proposed Health and Wellbeing Centre in Barry Hospital and Wellbeing Hubs in the community will provide a range of local services that will support GPs to care for their patients.</p> <p>Acute and community hospitals are rarely appropriate clinical settings for provision of respite care which by default is currently happening.</p>
<p>Increased pressure on the rest of the system</p> <ul style="list-style-type: none"> <li>• Potential negative impact on acute hospital beds already under pressure</li> <li>• shift of care and workload to social care</li> <li>• additional workload for GPs</li> <li>• Increased pressure on rest of system e.g. family, third sector services, ambulance services</li> </ul>	<p>The Discharge to Assess and Acute Frailty Assessment services will reduce total hospital length of stay which in turn reduces clinical deconditioning and immobility.</p> <p>Deconditioning and increased dependency levels increase costs for everyone, including patients, family advocates, the health service and adult social care services. For the latter, this particularly translates into larger and more expensive care packages as well as unnecessary, costly placements in care homes. These costs can potentially be avoided with more timely, tailored intervention via the intermediate care services described below (Discharge to Assess, Elderly Care Assessment Service, Acute Frailty service). This means that patients are less dependent and frail when they are discharged back home and reduces long term care needs in the community setting.</p>



NHS  
WALES  
GIG  
CYMRU

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

	<p>Acute and community hospitals are rarely appropriate clinical settings for provision of respite care, apart from those patients with the most complex and unstable primary health needs, which by default is the current status quo.</p> <p>The Elderly Care Assessment Service enables GPs to get specialist advice and multidisciplinary comprehensive geriatric assessment for their patients rather than needing an admission to hospital.</p> <p>We will continue to work with local authority and third sector colleagues to inform the development of a more joined up, integrated approach to meeting the needs of frail older people like Wyn across health and social care, and across clinical teams who work in primary, community and hospital services. We will develop a shared understanding of the impact of the model and to assess the availability of resources in the community to support safe early discharge, taking into account the pressures other services are under and the sustainability of funding streams.</p> <p>The proposed Health and Wellbeing Centre in Barry Hospital and Wellbeing Hubs in the community will provide a range of local services that will support GPs to care for their patients.</p>
<p>Consider Other Options</p> <ul style="list-style-type: none"> <li>• Put the proposed model in Barry Hospital/Sam Davies ward not in UHL</li> <li>• Improve/increase services in Barry Hospital</li> </ul>	<p>The nature of acute frailty services and clinical presentation of sick frail older people warrants immediate access to a wide range of complex diagnostics and prompt access to wider professional groups (other hospital based specialists), that realistically can only be provided within an acute hospital setting.</p> <p>We see an exciting future for Barry Hospital as described above as one of our three Health and Wellbeing Centres (H&amp;WBC), providing a wide range of</p>





NHS  
WALES  
GIG  
CYMRU

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

	<p>tailored diagnostic and locality health and secondary care outreach services in redeveloped facilities for the Vale of Glamorgan population.</p> <p>We will also embed consultant geriatrician/general interest medicine physician expertise in the already established Community Resource Team in Barry Hospital and grow these services accordingly.</p>
<p>The proposals are financially driven not clinically led</p> <ul style="list-style-type: none"><li>• This is about cuts</li><li>• Shift of costs to social care/local authority</li></ul>	<p>The clinical view is that introducing this acute frailty pathway will lead to improvements in services to assess, treat and rehabilitate patients and a consequent need for fewer and different hospital beds. This assertion will be tested with the introduction of a set of acute frailty services at UHL and further work with partner agencies to develop the whole frailty pathway, before any decision is taken on the number and make-up of beds at Barry Hospital.</p> <p>We will work with the local authority to develop a shared understanding of the impact of the model and to assess the availability of resources in the community to support safe early discharge, taking into account the pressures other services are under and the sustainability of funding streams. There will be potential cost benefits by using our resources more efficiently and effectively, this impacts all stakeholders including patients, their families, the health sector and adult social care services by avoiding unnecessary patient deconditioning, immobility and loss of function, which is currently often the case with the present model of working in the Vale. In acute hospitals patients and clinical teams will often wait for long periods for a transfer to a community bed that further aggravates the deconditioning process when clinical evidence suggests that a more timely intervention and return to home produces better outcomes.</p>



NHS  
WALES  
GIG  
CYMRU

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

#### The Engagement Process

- Unhappy with the engagement process
- Is the Health Board listening/telling the truth and has the decision already been made?

We hope that the proposed next steps demonstrate that this has been a genuine process of engagement to understand people's views and that the Health Board has listened to the feedback received.

By early 2020, we aim to have developed a clearer and more detailed plan for the development of Barry Hospital as a Health and Wellbeing Centre and we will have undertaken an evidence-based assessment of the impact of introducing a more clinically effective pathway to support patients with acute frailty needs. At this point, we will review the future of beds on the Sam Davies ward and consider the need for further engagement or consultation, if there is a proposal for a change of use or closure of beds.



## **Proposals for Improving Care for Frail Older People in the Vale of Glamorgan Engagement Plan Sept - Nov 2019**

### **1. Purpose**

To present a plan to undertake an 8 week engagement on the proposed transformation of the acute frailty pathway resulting in a reduction in the demand for beds and the associated closure of the medicine beds currently provided at the Sam Davies ward in Barry Hospital.

### **2. Objectives of Engagement**

- **Describe** the vision for an improved pathway of care for frail older people (Wyn)
- **Discuss** the current model of care and the case for change
- **Present** the proposed new model for the hospital-based elements of frailty services
- **Explain** the potential benefits of the proposals for Wyn
- **Ask** you some key questions to inform our thinking
- **Listen** and take into consideration your views and any concerns on the proposed changes

### **3. Key Audiences**

The nature of the services we are looking to transform are not exclusively geared towards care of older people, with many of the specialist rehabilitation services provided to all patient age groups (e.g. stroke, orthopaedic), however the majority of service users are older people. In relation to services at Barry Hospital, most patients will be residents of the Vale of Glamorgan.

The engagement process will seek the views of the following:

- Patients and carers currently receiving care
- Staff, specifically those working in the affected services, and their Staff Side representatives
- General Public
- Volunteers working in these services
- Third Sector organisations who work with older people (via Health and Social Care Facilitators and their Networks)
- Over 50s (via Vale 50+ Forum)
- PCIC Community Teams
- Local Partnership Forum
- Stakeholder Reference Group
- Healthcare Professionals' Forum

- Local politicians
- Town and Community Councils
- Local Medical Committee

#### **4. Communication and engagement channels**

A range of communication and engagement channels will be used to enable effective engagement with key stakeholders. These will include:

- Distribution of a bilingual engagement document and set of Frequently Asked Questions to the stakeholders identified above, to include a number of engagement questions and details on how people can share their views
- Presentation to be taken to key stakeholder meetings including the CHC and the UHB statutory advisory groups
- Discussions with current patients and families, using the engagement document and seeking feedback on the engagement questions (to be administered by ward staff and volunteers)
- Distribution of the engagement document to staff, with opportunities for further discussion at team and 1:1 meetings for those directly affected by the proposed changes
- Electronic communication using the Health Board and CHC websites, UHB intranet and social media
- Public engagement workshop
- Public engagement meeting, hosted by CHC
- Meetings with local politicians on request

#### **5. Engagement Questions**

The Engagement Document will seek people's views on the following questions:

1. What are your views on our proposals to improve care for frail older people in the Vale of Glamorgan?
2. Taking into account the information in this Engagement Document and the Frequently Asked Questions, is there anything else we need to consider when taking a decision on the way forward?
3. Is there any more information you would like about these proposals?
4. We would like to know what you think is the most important to frail older patients about their experience of care when they become unwell. If applicable, please tick more than one box from the following list:
  - Only getting admitted to hospital if absolutely necessary
  - Being seen as soon as possible by 'frailty experts'
  - Staying in hospital for as short a time as possible and necessary
  - Starting therapies earlier in the recovery journey
  - No delay in leaving after treatment
  - Returning home after a hospital stay with community support to help them recover further and stay safe at home
  - Where the hospital care takes place within the Vale of Glamorgan
  - The accessibility of the place of care

5. Any other comments?

**6. Timescales and Next Steps**

Engagement will run for 8 weeks from **2 September – 1 November 2019**. A mid-way review meeting will be held with the CHC to consider if any changes need to be made to the engagement approach. A summary of engagement responses will be prepared immediately following the end of engagement to be shared for discussion with the UHB Management Executive and the Community Health Council, to inform decision-making on the next steps including consideration of the potential need for public consultation. The outcome of engagement and proposed way forward will be shared with stakeholders.

## Engagement Activities and Timetable

### INTERNAL ENGAGEMENT AND COMMUNICATION

Stakeholder	Date	Nature of Briefing
Local Partnership Forum - Workforce Partnership Group	7 Aug 10am	Pre-engagement presentation on draft proposals and discussion  Agreement from LPF chairs to circulate engagement documentation to LPF members at start of engagement; not necessary to have further discussion at a meeting
Staff working in the directly affected services and Trade Unions	Number of meetings arranged by Integrated Medicine team	Presentation and discussion; individual engagement meetings
Staff working in Barry Hospital via Barry Hospital User Group	26 Sept 12 noon	Presentation and discussion
Staff working in UHL via Llandough Hospital Management Forum	3 Oct 10am	Presentation and discussion
Volunteers working at Barry Hospital and UHL	Start of engagement	Briefing shared with notification of opportunities to learn more and share views including public workshop  Volunteers to signpost people to engagement document available in Information and Support Centres in Barry Hospital and UHL, and to collect any responses
Healthcare Professionals Forum	Start of engagement	Briefing shared and request for HPF members to respond
General staff	Start of engagement	Briefing shared and notification of opportunities to learn more and share views

<b>EXTERNAL ENGAGEMENT AND COMMUNICATIONS</b>
---

Stakeholder	Date	Nature of Briefing
Elected politicians	Start of engagement	Briefing and notification of opportunities to learn more and share views
Vale Town and Community Councils	Start of engagement	Briefing and notification of opportunities to learn more and share views including public workshop
Over 50s (via 50+ Forum)	Start of engagement	Briefing and notification of opportunities to learn more and share views including public workshop
Third Sector organisations	Start of engagement	Briefing and notification of opportunities to learn more and share views including public workshop via Glamorgan Voluntary Services, Cardiff Third Sector Council and Cardiff and vale action for mental health
Primary Care practioners	Start of engagement	Briefing and notification of opportunities to learn more and share views including public workshop
Bro Taf Local Medical Committee	Start of engagement	Briefing and notification of opportunities to learn more and share views including public workshop
Service Users and Carers	Ongoing	Targeted engagement discussions facilitated by staff
Stakeholder Reference Group	24 July	Pre-engagement testing of draft engagement document and plan Agreement from LPF chairs to circulate engagement documentation to LPF members at start of engagement; not necessary to have further discussion at a meeting
General Public	23 Sept 1.00 – 3.30pm	Public Engagement Workshop
Vale Council Healthy Living and Social Services Scrutiny Committee	17 Sept 5pm	Presentation and discussion



Primary care clinicians (Cluster Lead meetings)		Presentation and discussion
Central Vale Cluster meeting	19 Sept 1.30pm	
Eastern Vale Cluster meeting	24 Sept 1.30pm	
Western Vale Cluster meeting	3 Oct 1pm	
Partner organisations via Regional Partnership Board (RPB) and Public Services Board (PSB)		Presentation and discussion
RPB Strategic Leadership Group	10 Sept 2pm	
Vale PSB	18 Oct 2pm	
CHC Medicine Oversight Scrutiny and Performance Group	4 Oct 10am	Mid Way Review of engagement. Opportunity to share information about responses received, themes emerging, and to identify any amendments or additions to the engagement approach for the second half of the engagement period
General Public	30 Oct 7.00 – 8.30pm	Public meeting, hosted by CHC



**Care of Frail Older People in the Vale of Glamorgan  
Public Engagement Workshop  
23 September 2019, Barry Memo Arts Centre**

**Number of members of the public:** 53

**UHB Presenters:** Len Richards (CEO), Dr John Butler (Consultant Geriatrician), Abigail Harris (Director of Strategic Planning), Charles Janczewski (UHB Interim Chair)

**Also in attendance:** Stephen Allen (Chief Officer, CHC), Daniel Price (Deputy Chief Officer, CHC), other CHC members, UHB clinicians and facilitators

**Comments made in the open forum**

- You could put the model described for UHL in Barry Hospital instead if you put more services in e.g. X-ray, a GP, Day Hospital (that you closed in Barry). There is already a community resource team in Barry Hospital
- I am an ex-nurse. The population of Barry has increased significantly over the years – you should be putting services into Barry Hospital, not taking them out. You are not thinking about the people of Barry
- Don't understand why you need to close a ward in order to bring in early intervention services. You've got this the wrong way round. You could wait to see the impact of the prevention services to see if you need the beds. I don't believe this is driven by clinical priorities, this is about cuts
- There is a danger that care in the community or at home translates to abandoning people. There have been brutal cuts to services due to austerity; the Health Board should refuse to make cuts. It should maintain and improve services in Sam Davies ward
- I don't understand how you can talk about cutting beds when you can't get a bed and wait on a trolley in UHW and UHL
- The plan sounds well and good on paper but it doesn't look the same in reality. When people are sent home, who will look after them? Social care is stretched. Carer jobs are non professionalised. How will you find the staff? We saw with mental health services that people in the community are not well looked after. Will the same happen to older people? Adaptations can take months. Where will people go during this time?
- Getting to UHL is very difficult. The roads around the P&R for UHL are packed in the evening. Hospital transport is not the answer, it is unreliable. Taxis are expensive.
- I am a retired nurse. There was a day hospital at Barry then it went to UHL. Then the Neale Kent ward closed. Previous anecdotal experience has been that when a ward is closed, patients have been 'shipped off' to wherever beds are available. Unfair on patients who have built up a relationship with ward staff. Concern about length of time to get home adaptations undertaken and appropriate care in place
- You want to get people out of hospital quickly, but not everyone is like 'Wyn' and has the family around them
- I am a nurse at UHW. I'm worried about how closure would affect acute care. How can you cut any beds where there is already a bed deficit and a social care deficit. I predict there will be an issue if we are unable to transfer patients out of acute hospital beds to Sam Davies to release capacity
- The D2A scheme is dangerous – people will be sent home without the care in place and it is likely that they'll bounce back to hospital due to a lack of resource in the community to



care for people. There is a lack of care home places too so Sam Davies provides respite beds. Where will this fall in the new model?

- Public transport costs would be high to visit. Families provide the motivation for patients' rehabilitation.
- Sam Davies provides award winning care in an underappreciated service. Staff are being treated appallingly
- You mention a meeting in Barry Hospital on Thursday. Why haven't the Trade Unions been told of this? *(Subsequently clarified that this is the Barry Hospital User Group meeting, not a meeting for Sam Davies ward staff specifically)*
- Will St Barrucs ward follow the same model and close?
- The Royal College of Emergency Medicine says we need extra bed capacity in Wales. There is a huge crisis in the NHS, not enough beds. I go to 'huddle' meetings in UHL and learn about bed capacity. When we go above 85% bed capacity, care is compromised. Medicine wards at UHL are regularly running at 98% capacity
- You need to understand the community aspect that the ward brings, its importance to the community. Groups like the Soroptimists support a huge range of activities. It feels like salami slicing of services at Barry. Will you go out to a public consultation?
- What will happen to patients who need longer term care if beds are at capacity? How are you dealing with population growth and the number of patients who will need both acute care and convalescence? The demography of my area means that people will struggle to pay for public transport and don't have a car to get to UHL. So patients will get fewer visitors at UHL. In mid and west Vale, it is much easier to get to Barry than UHL
- You have spoken for 53 mins, it feels like you are trying to sell something to us and it is not palatable. This is meant to be a consultation but it feels like a one way conversation
- If you have a family member in hospital, you want to use your precious time with that person, not travelling. You are putting care further away but the best care is as close to the family as possible
- You should be looking to create a centre of excellence in Barry and have a vision for Sam Davies ward as a frailty ward
- The carer role is crucial and the public sector should be supporting opportunities for apprenticeships for the care industry
- Where are the Vale Council Social Services department? Your proposals can't possibly happen because we can't get carers in to support people at home. The Vale Council hasn't got the money to support this project.
- What happens if you are suffering with dementia? The care for people with dementia on the Sam Davies ward is wonderful. What will happen to them if the ward closes?
- We had the opportunity at the Healthy Living and Social Care Scrutiny Committee to hear this and we had a discussion at full Council. The Councillors unanimously supported the Sam Davies ward continuing. This is a bed and cost cutting exercise at a time when we have increasing numbers of older people. Medical care needs to increase. Who will fund all the home care required – the Health Board or the Vale Council? This is about shifting costs.
- We all support people going home and spending less time in hospital. But there is a point when they need to stay in hospital for assessment and therapy. There are better ways forward than these proposals. The Sam Davies ward does a good job and it could do more to help rehabilitation. A lot of elderly people don't have family around to help look after them. You should improve Sam Davies, have more medical input. Get people out of acute beds into step down beds. But put more in, not less



- I looked after my husband who had vascular dementia, and when he deteriorated he needed fast access to somewhere like Sam Davies or a Home. It was left to family to cope, when we needed someone like a case manager to help in a crisis
- I'm from the RCN and have come to listen. Where is the infrastructure to implement this model? There are currently not enough social workers, physiotherapists, community pharmacists or carers in place. Also concerned about transport to UHL. Frail older people's visitors may also be frail older people. They may not have the time or energy to be able to visit.
- The example used in the presentation around the person who came from Wenvoe to UHW. Why couldn't the assessment be done at Barry – blood tests, X-rays etc?
- If you live in the western Vale, you have to pass UHL to get to the Park and Ride
- You need to take a holistic view of the patient. The 'Wyn' example has family around but this may not always be the case.
- Social workers are few and far between. Barry has the Vale Community Resource Service on site with a social worker as part of that. The Third Sector are already established in Barry Hospital. The ward has won awards.
- Concerned that voluntary services will end up 'picking up the pieces' if patients are discharged earlier or there is insufficient support in the community.
- I'm from Unison and a resident. You don't make things better by cutting services for the most vulnerable in society. I've waited until the end to speak to hear other views and have noted that no-one has spoken in favour of the proposals. There is a long way to go before you convince people in Barry and the wider Vale that this is anything but a cost saving exercise. Join us on a March on 5 Oct from Barry Hospital to Kings Square to protest to the closure of Sam Davies
- I'm from the Vale 50+ Forum. I am very unhappy with the frailty scoring system you talked about – people should not be classified by a score with the purpose of channelling them through a system. The model of D2A at UHL, then Sam Davies or St Davids or a residential home, all in a short space of time – this is not a proper pathway. Who will do the assessment at home? You could waste a lot of resource on unnecessary assessments.
- The Health Board already has good discharge protocols. Might the specialist units in the hospital be tempted to ignore these and just channel people through this D2A model – this could be an unintended consequence
- The document talks about the first audit at Sam Davies. Why was the D2A system not introduced then as a pilot? Doing the audit twice feels like you've deliberately skewed things to support this model. There is much less precision in planning community services than planning a building – it feels doubtful that this is a viable proposition. It is too lacking in detail and the evidence is poor. You need at least 12 – 18 months of evidence of what is happening at St David's hospital to see if patients are being readmitted. I do agree that people should have short stays in hospital
- Will the next step be closing casualty at Barry? Will the next step be the hospital disintegrating and the land being sold for flats like you did with Sully Hospital? The Barry population is growing yet there is no facility at Barry for emergency help
- Why can't you make Sam Davies ward your pilot for the model? Can it be GP run? Can D2A and the Acute Frailty Pathway be introduced in the Sam Davies ward?
- You don't understand our view of the strategic position of the Sam Davies ward to the Vale. Barry is the largest town in Wales. Your mindset, as shown by the lack of Vale pictures in the skyline in the slides, is that Barry is 'in the sticks'.



- This meeting is at a time when working people can't attend. It is on a wet day and clashes with an important rugby world cup match. You need to hold an evening meeting
- You are not listening to us – we don't want the Sam Davies ward closed

## Round Up and Response Comments from the UHB

Abigail Harris

Assurance that we are genuinely listening. Description of next steps including collation and analysis of all feedback, discussion with the CHC and taking a recommendation to the Board. Clear and consistent messages heard including concerns about:

- bed numbers with a growing population
- pressures on hospitals
- the model proposed being flawed, although a lot of support for the principles of shorter hospital stays and getting people home
- this being a shift of pressure on to community services
- this being a shift pressure to local authority services and social services in particular
- the future of Barry Hospital
- transport and travel – public transport is difficult and expensive and parking is challenging
- this being a proper engagement

Clear message heard that people do not want the Sam Davies ward to close and that the ward, and the Hospital are really valued. Encourage everyone to complete a questionnaire to ensure all views are captured.

Len Richards

- Recognise there is significant disagreement with the proposed model although I think we are on the same page in terms of the principles of what we are trying to achieve. It is how this is delivered that there is disagreement about
- We need intervention early in the pathway for lives to be positively improved
- Current service creaking under the strain of not intervening early enough
- Disparity across the patch - this is an opportunity to rebalance and improve services for frail older people in the Vale
- Your lived experience doesn't give you confidence that the current system works well enough to consider new proposal
- Development of Barry as a Health and Wellbeing Centre is about increasing services at Barry Hospital not decreasing. This will be a facility for the whole of the Vale but it needs remodelling. We need to have an ongoing conversation. We will work with the CHC to look at more opportunities for engagement

John Butler

- Want to assure you that the frailty score is about looking at the population of need and we definitely don't see or treat older people as a number



Charles Janczewski

- We have been listening to what you have told us. I will make sure that the Board pays attention to this feedback

### **Table Discussions following the close of the formal part of the session**

- Agreement of the need to increase access, home first etc. Important to ensure good access to services out of hours
- Did managers get it wrong when Barry Hospital was built if the number of wards has decreased over the years?
- Keen on being involved with further conversations/planning discussions on the future of Barry Hospital
- Feel that the title of the engagement document ought to be clearer about the impact for Sam Davies Ward. Felt that some people may not understand the extent of the consultation and therefore not engage
- Feel that there should be evening engagement sessions arranged
- Concern about financial impact on older people who are moved to a care home at an earlier stage in their pathway – who would pay?
- What is the cost of the new model? And how does it compare to the cost of the current model? Is this a cost cutting exercise?
- Appropriate services should be established in advance of any closure of beds. Concern about the dangers of closing beds before/at the same time as introducing a new clinical model
- Council social services do not have the resources to support this and are looking to make cost savings in the same support services needed to support this model.
- Why in the example, is Wyn from Wenvoe going to UHW when Barry Hospital is closer?
- With the introduction of ambulance paramedics, the multi-disciplinary team at Barry could operate a triage team similar to UHW but not 24 hour.
- Over the years too many wards/services have been lost from Barry e.g. Sully Hospital
- There is a lot of wasted space in Barry Hospital e.g. the old day unit.
- There are too many contractors vans parking at UHW to be able to easily park there. They don't seem to be regulated.
- The infrastructure proposed to support the model is not in place.
- It's not just the elderly frail who need this service (Young onset of dementia).
- There are not enough resources and when they are shifted, Barry Hospital loses out e.g. Sam Davies Ward.
- Physio health professionals could be used in Sam Davies ward.
- Staff are risk adverse at discharge and "must see a Physio first" leads to over prescribing of care (e.g.. double handed visits).
- The proposal needs a change in culture and that will take time.
- The shortage of social workers which take a long time to train and then there is no funding to employee them.
- There needs to be equity of resources across localities. The Vale is the poor relation.
- The Barry Hospital User Group (BUG) meeting on Thursday needs a larger venue and there is confusion over the purpose of the meeting. (The original intention was to outline the SOFW proposal for a Health & Wellbeing Centre at Barry)
- The existing Cariat Centre is a good example of a day hospital.





- The sign posting at UHL is poor, especially the best place for taxi drop off.
- UHL day centre needs its own reception.
- The Day Centre should be able to accept referrals from other professionals not just GPs.
- There have been many attempts to close Barry Hospital in the past. Barry is losing its services e.g. Broad Street clinic.
- There is a low awareness of the additional services moved into Barry Hospital e.g. Paeds Phlebotomy.
- Barry Hospital needs wellbeing services to be developed e.g. a café
- Barry Hospital needs a good quality reception (empathetic and efficient, with life experience and not just a young volunteer)



## **Care of Frail Older People in the Vale of Glamorgan Public Meeting 30 October 2019**

**Number of members of the public:** 57

**UHB Presenters:** Len Richards (CEO), Dr Stuart Walker, Medical Director, Dr John Butler (Consultant Geriatrician)

**Also in attendance:** Malcolm Latham (Chair, CHC), Daniel Price (Deputy Chief Officer, CHC), other CHC members, UHB clinicians and officers

The meeting was arranged by the CHC to provide a further opportunity for people to have their say on the Care of Frail Older People in the Vale of Glamorgan proposals. The Chair noted that the closing date for the proposals has been extended and will close on 6 November 2019.

### **Update from the UHB:**

The meeting provided the opportunity to provide reassurance that the views of the public are being listened to and the strength of feeling for Sam Davies Ward and Barry Hospital has been recognised. Views expressed at this meeting would help inform the considerations in the next part of the process. It has been noted that a fear is that Barry Hospital would be closed and it was emphasised that the hospital has a big part to play in the future of providing services in the Vale of Glamorgan.

Following comments from the previous workshop a short presentation of four slides would be given and the floor opened up for observations and questions. It was emphasised that the UHB were at the meeting to listen and respond where appropriate.

## Open Meeting:

- I have listened and read the reports, still have the impression we are being given a bad pill sugar coated. The ward does not have to close; D2A can be done now. What is the link between the ward closing and provision of care at home, where would the current staff go would they need to reapply for jobs at UHL?. I fear the strategic objective is the closure of Barry of Barry Hospital. Why not be honest and come and tell us it is funding driven? We have experience of other closures like at CRI. How will the closure of Sam Davies benefit patients and would care in the community be provided by private companies? Do not understand and do not accept the proposals

### UHB Response:

- Recognise Barry Hospital has a big part to play in future plans and perhaps this was not clear. But it may look different.
  - People will have a say in the future of Barry Hospital and the UHB would work closely with local community on engagement. We recognise that we need to do more work on what it could look like in the future.
  - The change is on how Frailty services are provided and it is recognised that it is not good to have people in hospital beds that don't need to be there.
  - The current model being discussed is a genuine opportunity to deliver a world class services for patients with complex frailty needs in Cardiff and Vale.
  - The model is the best evidence based way to keep people well and living in their own home
- Evidence based - how can the proposals be evidence based when the new model has only been running 6 months which has not included a winter period and already the UHW is under pressure?

Where is the evidence that there are 23 empty beds at Barry 23 and UHL 21 beds., West wing was noted and the wards were moved not beds closed Why can't Barry be a D2A ward? You should prove that you have empty beds year on year, then you have the evidence on why they are closing.

#### UHB Response:

- West wing wards were stroke, geriatric and frailty and the remodelling of the provision of care meant the acute care was provided in the acute setting and people discharged as quickly as possible. The longer people are in hospital the quicker they become deconditioned.
  - There is a mountain of evidence based information that keeping people in hospital is not right and firmly believe this is the right model to use.
  - Need to get the right multidisciplinary care in place to ensure that people can be discharged.
  - There is evidence in the UK that 20-25% of patients admitted in acute care could be treated at home. 60 - 70% of people treated at home with the right services in the community, social, primary care and community services at 2 weeks do not need a high level of care.
- 
- Nobody is against increase in services to get help for people at home, concerned that if people need care in hospital there would no longer be the capacity to admit them.
  - Feel the people managing the budgets are driving the model and that hospital care is going into the community.
  - The starting point seems to be from need to make cuts not care of patients.
  - Who is going to pick up demand for services, it will be the local councils.

- Local Councils and NHS bodies should be fighting to stop cuts not on who is going to provide services.
- We all want the same thing, the best for people in the Vale. However, evidence has not been provided in any documents on why patients are there (Sam Davies Ward), what is there particular reason for them not being discharged.
- It is coming across that people should think the model is special as clinical reasoning is being used for the changes, but evidence not provided.
- You describe our views as a love for the Sam Davies ward which suggests comments are based on sentimentality and therefore can be discounted. But you haven't provided the evidence for why the ward needs to close
- Discharge pathway not being done properly, discharge planning should start at admission and before going into all this, you need to get process right in hospital and all wards with proper planning.
- 50+ Forum - Old people don't want to be in hospital and don't want to stay in there, it is not their fault they are still in there. There is a lack of co-ordination in Health and Social Care and people can be weeks waiting for home adaption or a package of care to go home.
  - Transport to Llandough difficult, already park and ride in place how will it cope with the additional visitors as there is not enough space for parking now.
  - Barry Hospital has buses that stop directly outside and is part of the community. Lets have services capable of being delivered in hospital be delivered at the Sam Davies Ward.
  - Sam Davies is the preferred place.
- Best care at point of going to hospital, disagree with this as on occasion have had to wait 8 hours before seeing a doctor
  - Increase in population since 1960s when came to Barry, and now there is no medical assessment or anything for people in Barry.

- Would the plan be for the ward to be used for admin if it is closed?
- Union - Role of Union in providing support for pensioners and often support people in crisis. Echo points made by the Health workers, dubious that when services provided in the community they would work. Do need hospital care as well.
  - There seems to be an emphasis on centralising care and moving patients further away. But the emphasis should be on what services can be provided more locally, not on what seems to be a cost cutting exercise.
  - We need services in the local community – the need out there is enormous because of poverty.
  - Much more needs to be done and as Sam Davies provides such excellent care it should not be lost.
- Frail Acute ward was closed at UHW and moved to St David's Hospital as it was stated it was better for patients to be in the community not in hospital, now you are going to move a unit from Barry Hospital to a general hospital setting on an already congested site. Why shut a unit that has expertise?

#### UHB Response:

An Acute Frailty Unit is in operation at UHW and the Acute Frailty Unit at Llandough is due to open on 1 December 2019.

- Volunteer in Community - visits to frail elderly people for over 20 years at home or care/nursing home and hospital (local) and observed over time large number of circumstances where people struggle to cope when partner / family member in UHW or Llandough. They experience lots of difficulty accessing the sites if they don't have own transport, problems with public transport, added costs if they have to use taxis and trying to do the journey every day all take an horrendous toll on them. It would also limit friends visiting who would not make the journey to the larger

hospitals. It affects the health of the carer. This can lead to people ending up in care homes.

- When the patients are back on Sam Davies ward and back in the community you can see the relief for patients and families and services such as ours can offer support.
- Laudable vision and changing long term clinical objective but you say it is about delivering outcomes that matter to people and these are what matters to Barry and the community. Also you want to deliver services nearer to the community and this would be contradicted if Sam Davies moved further away.
- No evidence to show adequate joined up provision in the community and would like to see more like the example of provision at Ty Dyfan.
- Disgusted on what words were put in the report (about the audit of Sam Davies) in February 2019, yet in March 2019 a sister on the ward was presented with an award with the then UHB Chair, Maria Battle, who said that the ward should be looked at and replicated.
- Know of people who have been in UHW 7 weeks and transferred to Llandough for 4 weeks and they did not need medical cover. Why after 5 weeks at home with community care (physiotherapists and occupational therapists) need to go back into hospital as had a urine infection?
- Whilst in hospital patients cannot access other units e.g.. orthotics, memory clinic so have to wait to get back home before can get anything done.
- How many patients discharged into the community have to go back to hospital within 48 hours as they have been charged too early?
- Sam Davies ward is available for patients who are discharged too soon from hospital

- Need to think about sustainable development and need to consider the impact of transporting patients in ambulance for hours on end, it is easier to go to Barry.
- No accident and emergency unit, no maternity no CAMHs and no Mental Health Services, I want services back in Barry not out of Barry
- Age Connect - during role as volunteer I saw increase in calls to say people home from UHW or UHL and no package of care in place
  - Never had call that patients discharged from Barry Hospital without package of care.
- Attended meeting held at Brynhill and when the question was raised about the frail unit at Llandough a local councillor from Llandough, was in attendance, said that no planning permission had been received for it to go to there.
  - If not going to Llandough is it going to St David's or UHW which would cause more transport issues.
- Ex staff Occupational Therapy in Vale Community Resource Service - Shouldn't be divided into staff or residents when asking questions.
  - Lots of experience in getting people home and it has to be at the right time for people. People are very nervous of coping when discharged and how they are going to manage. With the right level of rehabilitation it can reduce the nervousness and take away anxieties and give confidence. Ty Dyfan has been very positive and helps people get home. If patients are rushed home they can be rushed back to hospital.
  - If there needs to be a change make Barry Hospital more rehab based and staffed better with more nurses and therapists
  - Discharge to Access for some people works, but there is a high percentage of coming back in 48 hours.
  - Not enough rehab carers to cope with increase.

- Not enough staff in social services available to help people in the community
- Councillor Bailey - You acknowledge the worries that the hospital will close and you say you don't think that will happen. That is worrying that is only that you don't think it will happen. Barry is Wales' largest town and the ward has received a gold recognition award, this should not be stripped away
- All agree people should be treated as close to home as possible but there is no additional money available to fund.
  - How are GPs going to cope and how are Local Councils going to cope?
- Councillor Thomas - Situation where people are being shanghaied into agreeing with the options in Question 4 (in the response form). No one can disagree with the options and the response questions make it difficult not to agree. So this leads to the view that people support the proposals.
  - No evidence provided.
  - The money that this is going to cost and the hours will come out of Council budget
  - Do not agree that this is a better level of care.
- Member of staff on Sam Davies Ward - Great shame if it is closed down; all the staff love to see people go home. Need to recognised some people cannot go home because they have dementia and are waiting for nursing home places.
- Health Care Support Worker Sam Davies Ward - In practice sounds good but no provision for people that are too frail to go home, will they be left in Llandough waiting for a care home bed? There is a lack of nursing home beds in Barry and will they have to go out of area away from their family, it is a real worry.
- Union and local resident - Did raise at last meeting and going to raise again, the Royal College of Emergency Medicine says we need extra bed capacity in Wales. There is a huge crisis in the NHS, not enough beds. When we go above 85% bed capacity, care



is compromised. Medicine wards at UHL are regularly running at 98% capacity

-Is there evidence on bed occupancy for the last 5 months and how long have people waited to get beds in Llandough or UHW?

- It has been stated that 4,000 extra beds are needed to cope with pressures coming through the front door of the NHS, when you are talking about closing beds

- Jane Hutt AM - Congratulations to everyone for the wonderful evidence and thank you to the Health Board for coming to listen.
  - Concern about role of the CHC, it has been stated that the engagement would go to the Health Board meeting at the end of November but the CHC would not be considering the information and making formal recommendations until 10 December.

#### Health Board and CHC Response:

The Health Board will discuss the engagement at the Board meeting on 28 November but no formal decision would be made until the CHC had submitted their formal recommendation on 10 December.

The CHC explained that they would be in attendance at the Health Board meeting but would not participate in discussions.

Following the submission outcome and / or recommendations of the CHC Executive Meeting 10 December the Health Board will formally respond to the CHC

#### **Closing Comments from the UHB**

Reassurance given that all views would be listened to and considered and would help inform the Health Board decision.

It was confirmed that the Health Board would consider the petition submitted to the Welsh Assembly.

The Health Board firmly believed that the model of care is the right one for frail older people and recognise the concern raised during the engagement process.

The Health Board thanked everyone for attending and participating in the engagement process.

### **CHC Closing Remarks**

The Chair thanked everyone for attending and participating in the conversation, it was reiterated that the closing date for the engagement had been extended to 6 November.

Meeting closed 8:35

Report Title:	INTERIM CHAIR’S REPORT									
Meeting:	CARDIFF AND VALE UHB BOARD MEETING						Meeting Date:	November 2019		
Status:	For Discussion		For Assurance	✓	For Approval	✓	For Information			
Lead Executive:	N/A									
Report Author (Title):	SENIOR EXECUTIVE ASSISTANT TO THE CHAIR									

## SITUATION

At each public Board meeting, the Chair presents a report on key issues to be brought to the attention of the Board since its last meeting. This written report provides an update on the following:

- Relevant meetings and events,
- Where the Chair has been required to affix the Common Seal of the UHB and,
- When Chair's Action has been taken in line with Standing Orders which requires ratification of the Board
- Documents which require Board approval for the Common Seal of the UHB to be used.

## BACKGROUND

This over-arching report highlights the key areas of activity, some of which may be referred to with the business of the Board meeting and also highlights areas of interest to the Board.

### 1. Meeting with Julie Morgan Assembly Member for Cardiff North

On Friday 27<sup>th</sup> September I had an introductory meeting with Julie Morgan Assembly Member for Cardiff North, in her constituency office in Whitchurch.

### 2. Cardiff South West Cluster

Visited the cluster and met with Dr Karen Pardy who provided an update on the work of the cluster which is making significant progress with integrated working and social prescribing.

### 3. Regional Partnership Board (RPB)

Attended the RPB with the key agenda items including:

- Children's Commissioner for Wales attended the meeting with the RPB demonstrating progress being made against the priority to establish integrated services for children with complex needs due to disability, illness and for children and young people with mental health problems and to seek assurance on the likelihood of a number of scenarios occurring in the region.
- Progress with the development of a Regional Outcomes Framework
- Integrated Winter Plans
- Received quarterly reports on Integrated Care Fund, Transformation and Commissioning

- Regional partnerships and research, innovation and improvement hub proposal - presentation

#### **4. South Wales Major Trauma Network Development Event**

On Wednesday 23 October I attended a Major Trauma Development Event held in Cardiff City Stadium, where an overview of the networks requirements, operational delivery and commissioning framework was provided.

#### **5. South Glamorgan Community Health Council**

In October I met with Malcolm Latham, Chair of South Glamorgan Community Health Council. Malcolm Latham was appointed to Chair in April this year, prior to this he was Vice Chair.

#### **6. All Wales Medicine Strategy Committee**

Met with Professor Ceri Phillips, the recently appointed Chair of this committee.

#### **7. Glamorgan Voluntary Services Annual General Meeting**

I recently attended the Glamorgan Voluntary Services (GVS) Annual General Meeting which was held in Llantwit Major. The AGM opening address was given by Councilor Christine Cave, Mayor of the Vale of Glamorgan.

#### **8. Team Wales Event**

Attended the Team Wales event which took place on October at the All Nations Centre.

#### **9. CAV a Coffee – World Menopause Day**

A series of Menopause events are taking place across the UHB and I recently attended an event held in Llandough Hospital. These informal events help to raise awareness of what can be seen as a difficult subject. Encouraging people to talk about the menopause and how it effects individuals in work.

#### **10. Cardiff Public Service Board (PSB)**

Attended the Cardiff PSB which was held in Her Majesty's Prison, Cardiff. The meeting was hosted by Helen Ryder, Governor of the prison and included a tour of the facility. Key agenda items focused on two presentations (delivered by Fiona Kinghorn) on "Health Inequalities in Cardiff and the Vale of Glamorgan" and "Move More; Eat Well: Strategic Priorities for Cardiff and the Vale of Glamorgan"

#### **11. Frail and Older People Public Meeting**

On 30<sup>th</sup> October I attended a public meeting hosted by the Community Health Council as part of the engagement on proposals for Frail Older People's services in the Vale of Glamorgan.

## **12. Llantwit Major Town Council Meeting**

On Thursday 31<sup>st</sup> October I attended along with Lisa Dunsford, Primary, Community and Intermediate Care (PCIC) Director of Operations a Llantwit Major Town Council evening Meeting. This is part of an ongoing series of engagement conversations with different community groups and organisations to talk about the UHB's vision, developments, challenges and successes. An opportunity for the public to ask questions, or share their experiences of our services.

## **13. Annual Volunteers "Thank you" Event**

On Friday 1<sup>st</sup> November I spoke at the Annual Volunteers "Thank you" event, which was held in the Sports and Social Club, UHW. This event is held to express our appreciation for the commitment and loyalty that all volunteers and Third Sector organisations provide in supporting patients, service users and staff across our local hospitals and in the community.

## **14. Community Mental Health Team Visit**

On Monday 4<sup>th</sup> November I visited the Community Mental Health Team based Barry Community Hospital and was accompanied by Councillor Susan Elsmore (Independent Member).

## **15. Glamorgan Voluntary Services (GVS) Visit**

On 6<sup>th</sup> November I visited the Glamorgan Voluntary Services based in Llantwit Major. GVS is an independent charity and has voluntary and community organisations active in the Vale of Glamorgan. They help to improve the quality of life of people and communities by supporting volunteers, volunteering opportunities and voluntary groups.

## **16. National Primary Care Conference**

Attended the 4<sup>th</sup> National Primary Care Conference held in Newport. This year's theme was Clusters, Past, Present and Future

## **17. Nursing and Midwifery Conference**

Attended the Cardiff and Vale UHB Nursing and Midwifery Conference held in City Hall Cardiff.

## **18. Fixing the Common Seal / Chair's Action and other signed documents**

### **a) Affixing the UHB Common Seal**

This section details the action that the Chair has taken on behalf of the Board since the last meeting. The Board is requested to ratify these decisions in accordance with Standing Orders.

The UHB Common Seal has been applied to 7 documents in accordance with requirements. A record of the sealing of these documents was entered into the Register kept for this purpose and has been signed in accordance with Section 8 of the Standing Orders.

	<b>Documents to be sealed/approved</b>	<b>Background Information</b>
	<b>200 Fairwater</b>	Purchase of small part of Car Park not included transaction (£10k).

### **Documents requiring retrospective approval for the use of the seal**

<b>Seal No.</b>	<b>Description of documents sealed</b>	<b>Background Information</b>
920	<b>Commitment Of The Host Institution for ERC Calls 2020</b>	Pharmaco-Invasive Strategy for Deferred Stenting During ST Elevation Myocardial Infarction to Salvage Myocardium Utilising Index of Microcirculatory-Resistance (IMR) as a Tool to identify high risk patients with failed Microvascular Reperfusion
921	<b>Llandough Hospital – Section 106 Agreement.</b>	Development of land (All Wales Cystic Fibrosis Centre) at University Hospital Llandough and Cardiff and Vale University Health Board
922	<b>Call Off Contract for National Supply Chain Partner for Development of a Health and Wellbeing Centre at CRI</b>	Between Cardiff and Vale University Health Board and Wilmott Dixon Holdings Limited.
923	<b>Call Off Contract for National Project Manager for Development of a Health and Wellbeing Centre at CRI</b>	Between Cardiff and Vale University Health Board and Gleeds Management Services Limited
924	<b>Lease of the Star Centre, Splott, Cardiff</b>	Between County Council of the City and County of Cardiff and Cardiff and Vale University Health Board
925	<b>Lease for Ground Floor Premises, The Chapel, Whitchurch Hospital, Park Rd, Whitchurch, Cardiff</b>	Between Cardiff and Vale University Local Health Board and Trustees for Whitchurch Hospital Bowls Club
926	<b>Lease Relating to Temporary Portakabin, Whitchurch Hospital</b>	Between Cardiff and Vale University Local Health Board and Trustees for Whitchurch Hospital Bowls Club

### **b) Signed Legal Documents –**

The following legal documents have been signed:

Date Signed	Description of Document	Background Information
26.09.2019	Call off Contract. Software Licence and Support Agreement between Synbiotix Solutions Limited and Cardiff University Health Board	Catering Information System.
29.10.2019	Heads of Terms & Conditions For New Tenancy	West Services Building, Ely and Cardiff County Council.
08.11.2019	Tenancy at Will, South Glamorgan Estates Limited and Cardiff and Vale University Health Board	Premises at Ivor House, Bridge St, Cardiff

### c) Chair's Action

Chair's Action was taken on four occasions in relation to:

<b>19/09/2019</b>	Claim approval over £1 million
<b>27/09/2019</b>	Outsourcing of Surgical Procedures
<b>21/10/2019</b>	Purchasing of Twenty One SLE6000 Infant Ventilator Systems
<b>21/10/2019</b>	National Eye Care Procurement

### ASSURANCE AND RECOMMENDATION:

**ASSURANCE** is provided by:

- d) Discussion at the Governance Co-ordinating Group
- e) Discussions with the Director of Corporate Governance

The Board is recommended to:

- f) **NOTE** the report
- g) **APPROVE** that the Common Seal can be affixed to documents detailed in paragraph 11a
- h) **ENDORSE** the affixing of the Common Seal for documents in paragraph 11b
- i) **APPROVE** the Chairs Actions and signing of legal documents

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
-------------------------------	---	--	--



2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	
<b>Five Ways of Working (Sustainable Development Principles) considered</b> <i>Please tick as relevant, click <a href="#">here</a> for more information</i>			
Prevention		Long term	
		Integration	
		Collaboration	X
		Involvement	X
<b>Equality and Health Impact Assessment Completed:</b>	Not Applicable		

<b>Report Title:</b>	<b>CHIEF EXECUTIVE'S REPORT</b>					
<b>Meeting:</b>	CARDIFF AND VALE UHB BOARD MEETING			<b>Meeting Date:</b>	28.11.2019	
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	<b>For Information</b>
<b>Lead Executive:</b>	<b>CHIEF EXECUTIVE</b>					
<b>Report Author (Title):</b>	<b>EXECUTIVE ASSISTANT TO THE CHIEF EXECUTIVE</b>					

## SITUATION

At each public Board meeting, the Chief Executive presents a report on key issues which have arisen since its last meeting. The purpose of this Chief Executive report is to keep the Board up to date with important matters which may affect the organisation.

A number of issues raised within this report may also feature in more detail in Executive Directors' reports as part of the Board's business.

## REPORT

### BACKGROUND

This is the eleventh written report being presented and, where appropriate, has been informed by updates provided by members of the Executive Team.

### ASSESSMENT

## GOVERNANCE AND ASSURANCE

### 1 Research and Development Conference

On 15 October, our Research and Development Department held another successful conference celebrating the valuable work that has been undertaken by staff within the department.

The conference is always a great opportunity to see the breadth and depth of research that takes place across the large research portfolio here at Cardiff and Vale, and this event was no different with a range of really interesting presentations throughout the day, on research activity taking place across our clinical boards.

### 2 Vale of Glamorgan Healthy Travel Charter

In April this year, I had the pleasure of signing the Cardiff Healthy Travel Charter on behalf of the UHB to sign the organisation up to fourteen ambitious actions to promote active travel as well as the use of public transport and ultra-low emission vehicle use. Much of this work has been spearheaded by our Local Public Health Team and lead by Dr Tom

Porter, a Consultant in Public Health medicine, who for his efforts has received commendation from the Future Generations Commissioner.

On 18 October, eight leading public sector organisations which work in the Vale of Glamorgan signed a Healthy Travel Charter committing themselves to supporting and encouraging their staff and visitors to travel in a sustainable way to and from their sites.

Between us, the organisations will commit to reducing the proportion of journeys commuting to and from work made by car, and increasing the proportion of vehicles used during the day which are plug-in hybrid or pure electric.

Organisations which signed the charter at a launch event at the Vale of Glamorgan Council Civic Offices were: Vale of Glamorgan Council, Cardiff and Vale University Health Board, Cardiff Airport, South Wales Fire and Rescue Service, South Wales Police, HM Prison and Probation Services, Welsh Government and Welsh Ambulance NHS Trust.

By working together with a view to the long-term, public sector organisations across the Vale aim to increase the proportion of journeys made to and from workplaces which are sustainable, reducing the impact on the environment and health of people in the Vale for current and future generations. The public sector in the Vale employs over one in four working adults, over 15,000 people.

### **3 Wales Major Trauma Network Briefing Session**

On 23 October, some of our Board members, Exec Team, Jan and I attended a Wales Major Trauma Network briefing session.

You can access the full presentation from the session [here](#).

### **4 Double Recognition at National Diabetes Awards**

On 17 October we gained national recognition at the 2019 Quality in Care Diabetes Awards for the work that we are doing around Diabetes in Children and Young People.

The Noah's Ark Children's Hospital for Wales won the Children, Young People and Emerging Adults category, for the innovative quality improvement work they have undertaken in collaboration with colleagues in primary care to improve the early stages of care in diagnosis of Type 1 Diabetes in Children and Young People, which the judges highlighted as being an example for other service providers to follow.

Highly commended in the same category was our Department of Paediatric Diabetes, for the emotional wellbeing support they are delivering to young people with Type 1 Diabetes through engaging with them through sport, which has enormous appeal and the potential for widespread uptake even among the most hard-to-reach individuals.

Both of these initiatives are fantastic examples of how we can enhance the care that we offer our patients being innovative and challenging the way that we already do things.

## 5 Celebrating our Volunteers

On 1 November, I attended our annual Volunteers Thank You Celebration Event. Around 200 Health Board and Health Charity Volunteers attended the event along with third sector staff, which was extremely uplifting.

I heard a number of inspiring stories on the day, but was particularly struck by Ethan Prosser who volunteers on our Library Trolley Service and Luke Morgan from the Make a Smile Project for the difference their volunteering makes to them and our patients.

I would like to thank all of our volunteers and third sector partners for giving up their time, and making a real difference in improving the experiences of patients in our care. My thanks are also due to our Volunteer Services Team for their dedication and commitment to providing these opportunities for our volunteers, which makes a huge difference to the services that we provide.

## 6 Welsh Health Specialised Services Committee (WHSSC)

The Committee's last meeting took place on 12 November 2019.

The agenda and papers can be accessed via the following link:  
<http://www.whssc.wales.nhs.uk/2018-19-whssc-joint-committee>

## 7 Cardiff and Vale UHB's Nursing and Midwifery Conference

On Friday 8 November, I had the pleasure of speaking at the UHB's annual Nursing and Midwifery Conference. The conference was attended by over 400 staff. It was an excellent conference and celebrated the contribution of Nurses and Midwives to our Health System.

**ASSURANCE** is provided by:

The Executive Team contributing to the development of information contained in this report.

### RECOMMENDATION:

The Board is asked to **NOTE** the report

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1.Reduce health inequalities	✓	6.Have a planned care system where demand and capacity are in balance	✓
2.Deliver outcomes that matter to people	✓	7.Be a great place to work and learn	✓
3.All take responsibility for improving our health and wellbeing	✓	8.Work better together with partners to deliver care and support across care	✓

									sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	✓								9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✓								10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	✓
<b>Five Ways of Working (Sustainable Development Principles) considered</b> <i>Please tick as relevant, click <a href="#">here</a> for more information</i>										
Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓	
<b>Equality and Health Impact Assessment Completed:</b>		Not Applicable								

<b>REPORT TITLE:</b>	<b>PATIENT SAFETY QUALITY AND EXPERIENCE REPORT – V4</b>					
<b>MEETING:</b>	Board Meeting			<b>MEETING DATE:</b>	28.11.19	
<b>STATUS:</b>	<b>For Discussion</b>		<b>For Assurance</b>	✓ <b>For Approval</b>		<b>For Information</b>
<b>LEAD EXECUTIVE:</b>	Executive Nurse Director					
<b>REPORT AUTHOR (TITLE):</b>	Assistant Director, Patient Safety and Quality – 029 2184 6117 Assistant Director, Patient Experience – 029 2184 6108					
<b>PURPOSE OF REPORT:</b>						

## SITUATION:

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from September to October 2019.

## REPORT:

### BACKGROUND:

The development of an integrated Patient Safety Quality and Experience report, presents an opportunity for greater triangulation and analysis of information. It enables Clinical Boards and the Corporate Teams to identify areas of good practice but also to identify emerging trends and issues that require action in order to improve safety and quality of services.

The UHB has a wide range of data which provides a level of assurance on the safety and quality of services, as well as on the experience of patients and families. This report provides an analysis of information drawn from the reporting of patient safety incidents, Serious Incidents (SIs) and Never Events, as well as concerns raised by patients and families and feedback from national and local patient surveys as well as national audit and the output from mortality and morbidity processes. Themes emerging from internal and external inspections of clinical areas also provide a very valuable level of assurance in relation to the quality and safety of clinical services.

Where available, benchmarking data with peers is provided. Assurance in relation to the action that is being taken to address areas for improvement is also described.

### ASSESSMENT

**Still birth and neonatal deaths** - The 2018 MBACE-UK Perinatal Mortality Surveillance Report provides information on still births or neonatal deaths (up to 28 days old) from January to December 2017. For the past two years Cardiff and Vale UHB have reported perinatal mortality (the time, usually a few weeks immediately before and after birth) at over 5% higher than the national rate, this figure has been stabilised to take into account the size of the unit and adjusted

to account for key factors that increase the risk of perinatal death including socio- economic deprivation. The 2017 performance was anticipated as a result of robust monitoring and reporting and work has been undertaken to improve the UHB performance. Since 2017, the implementation of Gap and Grow and the Safer Pregnancy messages has been introduced with the result that the Health Board has observed a significant drop in perinatal mortality with sustained improvements in 2018 which we expect to be reflected in the 2020 MBRACE report.

**Ophthalmology** - At present, demand for ophthalmology surgical services is exceeding capacity and the UHB is currently pursuing both out-sourcing and in-sourcing arrangements to ensure that patients are seen within appropriate prescribed timeframes. We are ensuring that the lessons from a previous serious incident involving an in-sourced company are being used to strengthen the governance around future arrangements. A high volume of current concerns relate to the waiting times and cancellation of follow up Ophthalmology Appointments and this trend is on an increasing trajectory which we hope to see will improve with the measures being put in place.

**The National Hip Fracture Database (NHFD)** 2018 National report was published in November 2018. A detailed report of the results and actions were reported through the Quality Safety and Experience Committee in February 2019. The report detailed an adjusted mortality rate of 8.5%. As a result of the higher mortality rates a detailed review of all elements of care provision in the Hip Fracture pathway is being undertaken. A reduction in crude mortality has been noted over the past 12 months since and the crude annual mortality rate in August 2019 was 6.6%.

**Assessment Unit at University Hospital of Wales** - the Board has previously been and advised of an unannounced visit by HIW in March 2019, in which a number of immediate assurance issues were identified. Despite a number of measures being put in place to address the issues identified, this is an area that remains under pressure and will require continued monitoring from a quality and safety perspective. **RECOMMENDATION:**

The Board is asked to:

- **CONSIDER** the content of this report.
- **NOTE** the areas of current concern and **AGREE** that the current actions being taken are sufficient.

#### SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1.Reduce health inequalities		6.Have a planned care system where demand and capacity are in balance	
2.Deliver outcomes that matter to people		7.Be a great place to work and learn	
3.All take responsibility for improving our health and wellbeing		8.Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.Offer services that deliver the population health our citizens are		9.Reduce harm, waste and variation sustainably making best use of the	



entitled to expect				resources available to us			
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time				10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives			
Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click <a href="#">here</a> for more information							
Sustainable development principle: 5 ways of working	Prevention	Long term	Integration	Collaboration	Involvement		
<b>EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:</b>	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.						



## PATIENT SAFETY QUALITY AND EXPERIENCE REPORT

### September - October 2019

#### Serious patient safety incidents (SIs reportable to Welsh Government)

#### How are we doing?

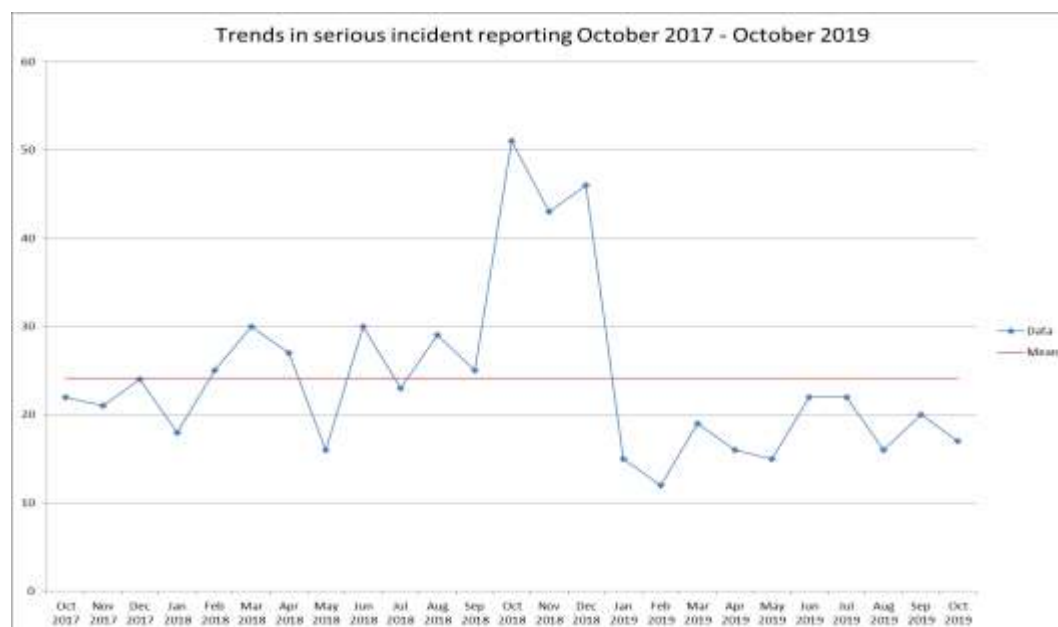
Serious Incidents		
Clinical Board	Number	Description
Children & Women	1	Stillbirth.
	1	Neonatal death following breech delivery
	1	A baby was transferred to the Children's Hospital for Wales. Concern has been raised regarding whether the response to an abnormal coagulation result following transfer was timely and appropriate.
Clinical Diagnostics and Therapeutics	1 2	Information governance breach. Retrospective SIs reported to WG following the settlement of 2 historical high value claims
Executive & Corporate Services	1	Multi-agency working following the death of a teenage boy who lived in the Vale of Glamorgan.
	2	Procedural Response to Unexpected Death in Childhood (PRUDICs)
Medicine	1	Delay in the referral to and the reporting of a histology results in the Dermatology setting.
	5	Healthcare acquired pressure damage.
	2	Falls where the patient sustained significant injury.
Mental Health	4	Adolescents aged 16 and 17 years admitted to Hafan Y Coed overnight whilst awaiting input from Child and Adolescent Mental

	6	Health services.  There have been 6 unexpected deaths of patients known to Mental Health and Substance Misuse services,
<b>Specialist</b>	1 1 1 1	Pressure damage Patient fall Death of a patient awaiting cardiothoracic surgery. A significant medication error
<b>Surgery</b>	1 2 1 1	Pressure damage Patient falls Delay in operating on an Ophthalmology patient. Potential wrong site surgery. This has been reported and managed as a Never Event until investigation determines the full circumstances.
<b>TOTAL</b>	<b>37</b>	

<b>No Surprises</b>		
<b>Clinical Board</b>	<b>Number</b>	<b>Description</b>
<b>Miscellaneous</b>	1	Public Health Wales advised the Health Board that they were investigating an outbreak of Legionnaires disease in the Barry area.
	1	The UHB participated in a multi-agency counterterrorism meeting.
<b>Medicine</b>	1	The sad death of a nurse in a road traffic accident following a twilight shift at UHW.
<b>Mental Health</b>	1	Alternative accommodation for the Links Community Mental Health Team had to be sourced following damage caused by recent heavy rainfall.
<b>Primary, Community &amp; Intermediate Care</b>	1	Unexpected death of a prisoner at HMP Cardiff. The gentleman's death will be subject to scrutiny by the Prison and Probation Ombudsman and HM Coroner.

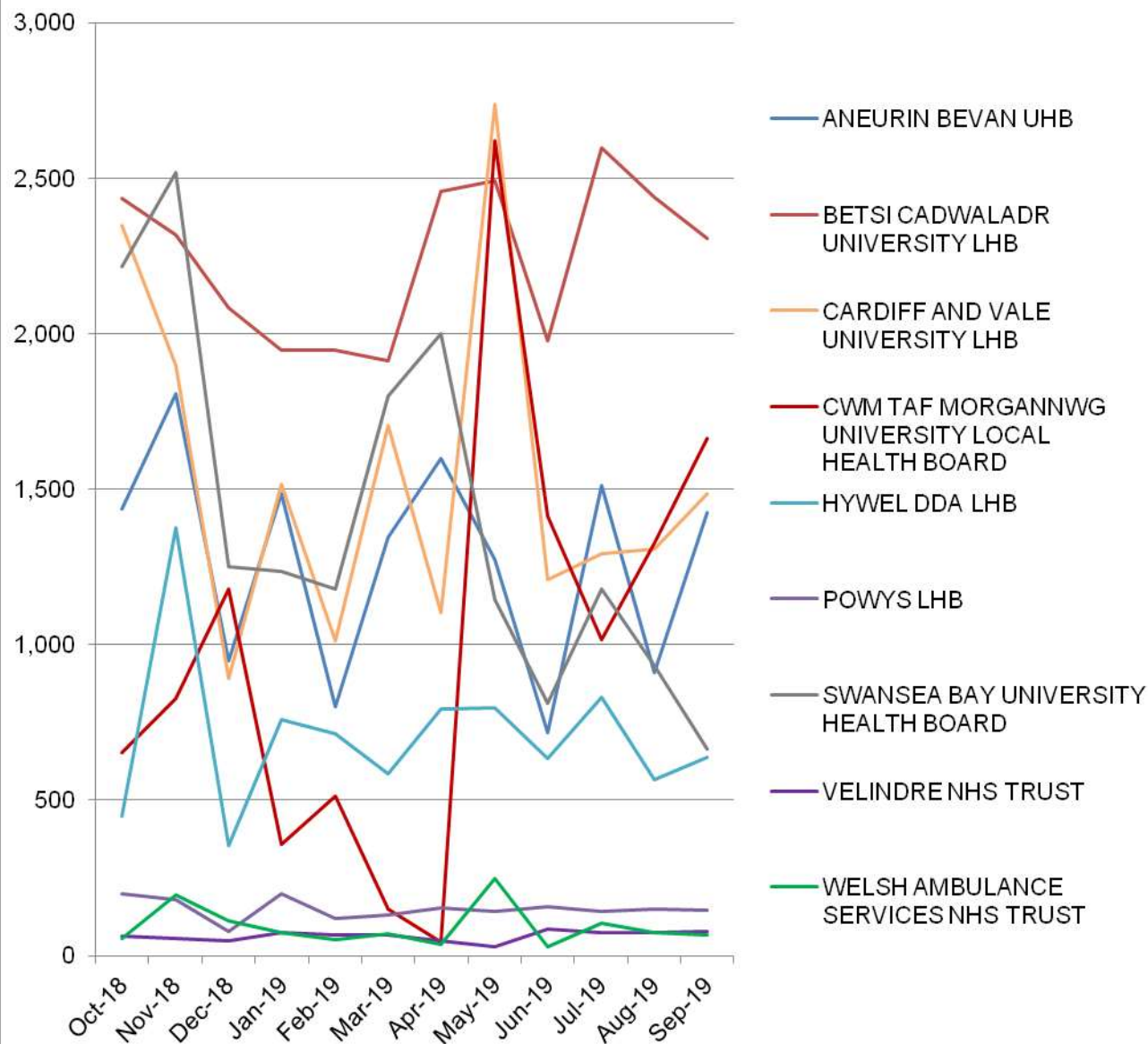
<b>TOTAL</b>	<b>5</b>	
--------------	----------	--

A detailed report on Serious Incident and Never events was presented to the October 2019 Quality, Safety and Experience (QSE) Committee. Trends in incident reporting over the last two years show a decreasing trajectory. This is largely due to changes in the guidance for reporting pressure damage. The UHB will continue to monitor this trend.



The latest available data from The National Reporting and Learning System (NRLS) indicates that there has been a 7% increase in reporting of incidents from October 2017 –March 2018 when compared with the same period from 2018-2019. In addition the NRLS has confirmed that on average 50% of our reports were submitted within 39 days after the reported incident date. This is an area for improvement as the target is to submit data to the NRLS as soon as possible after it is reported or at least every month and performance in the 2017-2018 period was better with 50% of incidents reported after 34 days. The average median time in England is 22 days.

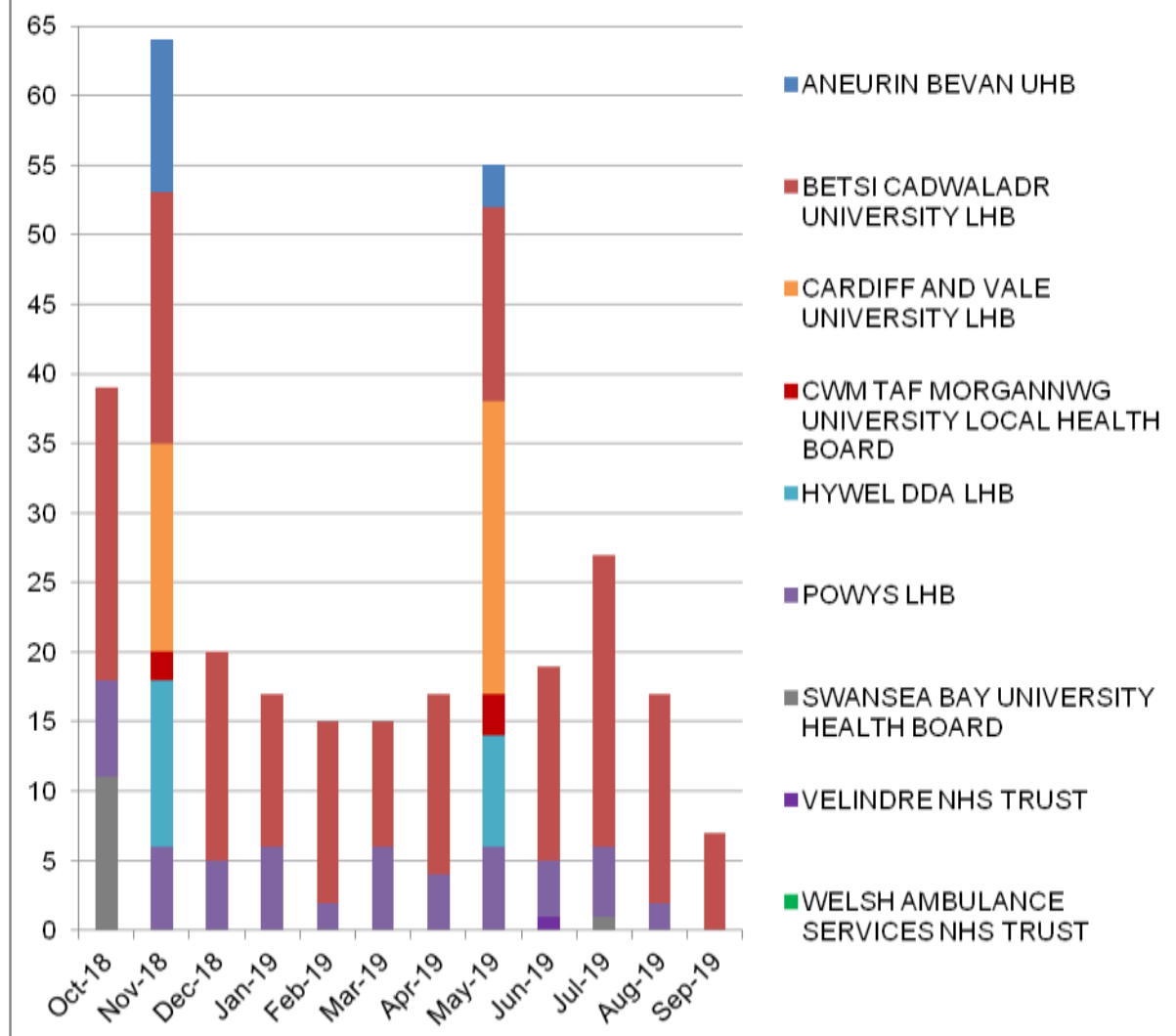
## Number of Patient Safety Incidents Reported by Health Boards in Wales Oct 2018 to Sep 2019



The Board will note that in terms of trends in reporting, the UHB reports more patient safety incidents to the NRLS than smaller organisations in Wales, is in approximately the same reporting range as Aneurin Bevan and Swansea Bay UHBs but reports significantly less than Betsi Cadwalader UHB (BCUHB). Further work will be undertaken to try and understand the profile of incident reporting in BCUHB so that the UHB can determine whether there are areas of under-reporting that may need to be addressed.

The number of patient safety incidents recorded as causing severe harm across Wales are demonstrated in the following diagram:

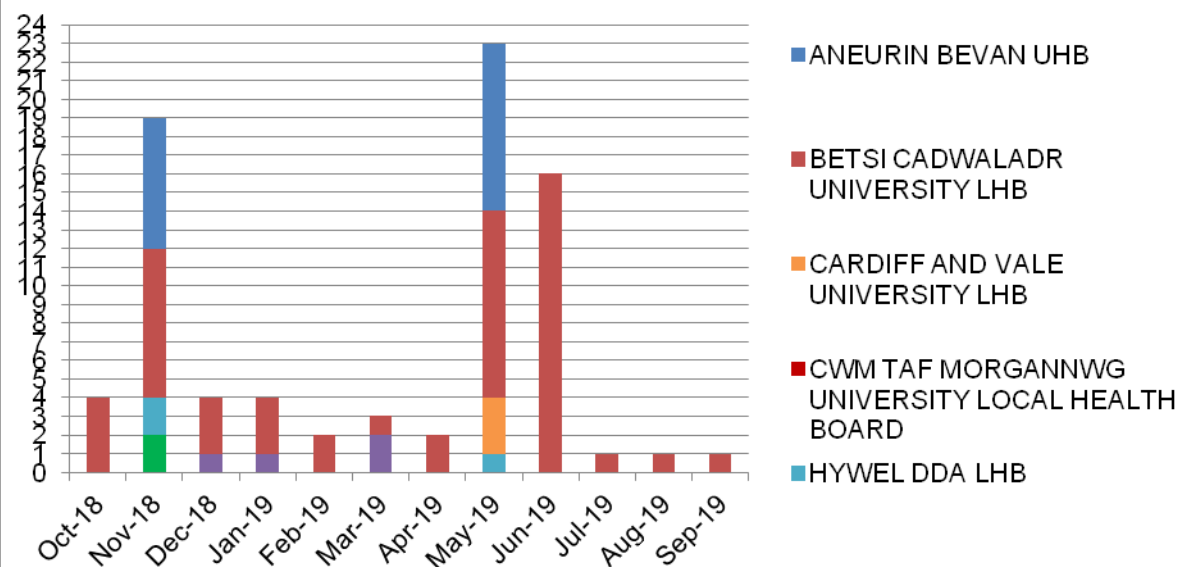
## Severe Harm Reported as Patient Safety Incidents by Health Board Oct 2018 to Sep 2019



Again, it would appear that the UHB reports considerably less than BCUHB for this category of incident, but more overall than Aneurin Bevan UHB or Swansea Bay UHB.

The number of deaths reported as patient safety incidents across Wales is represented in the following diagram:

## Deaths Reported as Patient Safety Incidents by Health Board Oct 2018 to Sep 2019



Within the UHB, there is a quality assurance process that takes place before each NRLS upload. This is to determine that any incident that is recorded as having caused the death of a patient is factually accurate. It is clear from the graph that the UHB reports less deaths as a result of a patient safety incident than other organisations of comparable size. The UHB will continue to monitor this and also take action to try and determine the types of incidents reported as causing deaths in other UHBs across Wales.

### Emerging themes and trends

#### Stillbirth and Neonatal deaths

The Board will note two serious incidents following a still birth and a neonatal death, both of which are currently under investigation to determine whether there were issues of concern in the care which may have contributed to the outcome. The QSE Committee is monitoring Maternity Services and has received detailed reports to the June 2019 Committee meeting which provided assurance in relation to Cardiff and Vale UHB assurance framework that was developed following publication of the Review of Maternity Services at Cwm Taf Health Board in April 2019. A progress update was received at the September 2019 Committee. This provided assurance that governance arrangements have been strengthened as recommended. Multi professional meetings have been held and case presentations will be circulated to Obstetric and Midwifery staff(who were not in attendance. The Obstetric department has a robust Clinical Audit plan. Audit leads are exploring opportunities to develop Multi professional Audit days with Neonatal staff and Anaesthetics in attendance.



With regards to **consultant on call for the labour ward**, interviews took place in September and the UHB successfully recruited 4 additional Consultant Obstetricians. Antenatal ward rounds will be mandated in their job plans.

In September 2018 the QSE Committee received assurance in relation to the reduction of perinatal mortality rates for the UHB as published within MBRRACE-UK Perinatal Mortality Surveillance Report for UK Perinatal Deaths for Births from January to December 2016.

The 2018 MBRRACE-UK Perinatal Mortality Surveillance Report provides information on still births or neonatal deaths (up to 28 days old) from January to December 2017. For the past two years Cardiff and Vale UHB have reported perinatal mortality at over 5% higher than the national rate, this figure has been stabilised to take into account the size of the unit and adjusted to account for key factors that increase the risk of perinatal death including socio- economic deprivation. The 2017 performance was anticipated as a result of robust monitoring and reporting and work has been undertaken to improve the UHB performance. Since 2017 the implementation of Gap and Grow and the Safer Pregnancy messages has been introduced with the result the Health Board has observed a significant drop in perinatal mortality with sustained improvements in 2018 which we expect to be reflected in the 2020 MBRRACE report.

The crude perinatal mortality rate for 2017 (the number of deaths divided by the total births) remained the same as the previous year with MBRRACE reflecting adjusted neonatal deaths at over 5% higher than the national average. Adjusting for birth weight of under 500g and excluding neonatal cases babies with congenital abnormalities that are not conducive to survival the neonatal mortality rate is closer to 2.8 / 1000 live births but this remains higher than the national average.

### **Deaths in patients known to mental health and substance misuse services**

With regards to the deaths of patients known to mental health services, the Mental Health Clinical Board provided a detailed update to the Quality, Safety and Experience Committee in October 2019.

The requirement for mental health services is growing year on year with an anticipated 60,000 plus referrals this year and a predicted rise to 100,000 by 2021. 14,000 of these referrals are for people with suspected serious mental illness. There are about 5000 service users on permanent mental health service caseloads, with approximately 100,000 clinical contacts in CMHTs annually. There are in excess of 1000 referrals to primary mental health services on a monthly basis.

Mental Health services are diverse. The primary care liaison teams together with third sector partners have increased the level of support in primary care settings by 700% in 7 years. Adult Liaison services provided mental health support in the Emergency Unit and to general wards including the poisons unit. There is a Liaison Psychiatry service for older People (LOPOP) providing support to wards and in the Medical emergency assessment units. Mental Health services work closely with police and ambulance to triage and support each other with decisions about the care of patients with apparent mental health problems. New funding has been identified for Cardiff University Liaison and for mental Health Prison in-

reach services. The CHLT cover all nursing and residential homes in C&VUHB and the service also covers all parts of the justice system.

There is growing complexity and risk within the mental health service. . Traditional psychosis and severe mood disorder services now face further complexity related to serious Post Traumatic Stress Disorder (PTSD) and non PTSD trauma and substance misuse. There has been an increase in acuity and challenging behaviour related to mental illness in in-patient settings. These factors introduce the challenge of identifying escalating risk behavior amongst large caseloads. Staff have to determine what is a chronic risk and what is an escalating risk and this involve complex clinical decision making.

The National Confidential Inquiry into Suicide and Safety in Mental Health 2018 Identified the suicide rate within Cardiff was 12.6 per 100,000 in 2014/16, this figure is higher than the rest of Wales with the exception of Powys. The primary psychiatric diagnosis in patient suicide is 41% affective disorder, 15% patients diagnosed with Schizophrenia and other delusional disorders and 16% alcohol or drug dependence/ misuse. The figures are comparable to UK figures and primary diagnosis rates in England. Suicide rates in Wales for patients under the care of mental health services are lower than those across the UK, while suicides within 3 months of discharge were slightly higher in Wales than England and UK figures (this data is not available by region)

The UHB has invested in high risk areas and this includes:

- 100% increase in funding for First Episode Psychosis services – still only seeing half of expected population
- The identification of a lead for Emotionally Unstable Personality Disorder transition and trauma – to work across transitional age ranges
- The establishment of a Recovery College and Co-production – this is more likely to improve hope & capability for the future
- High Intensity Psychological Therapies delivery – 6000 pa and rising
- Investment in Dual Diagnosis Substance Misuse/MH services
- Identification of a MH Lead for the regional Suicide and Self Harm delivery group for Talk to Me 2
- Appointment of a Consultant Nurse for Complex Clinical Risk
- Agreement to host the sub regional Suicide and Self Harm worker in the UHB

There are a number of other initiatives underway which were reported in detail to the QSE Committee.

The Clinical Board has a well-established process for the review and investigation of all deaths in patients known to mental health services. There is a weekly sentinels meeting attended by a multi-disciplinary team including the patient safety team which reviews and discusses all new reported cases. A decision on the level of investigation required is agreed and this may involve an MDT review of the care of the patients undertaking a notes review or it may involve a full Root cause Analysis investigation in line with the UHB Serious Incident process. . All concluded investigations are discussed at the bi-monthly lessons learned group and actions are followed through to conclusion. Directorates have responsibility for implementing the necessary improvements and some lessons learned include

reminding staff of their responsibilities in relation to good record keeping practice, staff training in risk assessment, falls prevention and management and the need for multi-agency communication.

The QSE Committee was advised of the need by mental health services to appropriately balance the 'risk v recovery'. This means that it is always necessary to balance positive risk taking that encourages recovery, re-ablement and personal responsibility with the risk of suicide and self-harm.

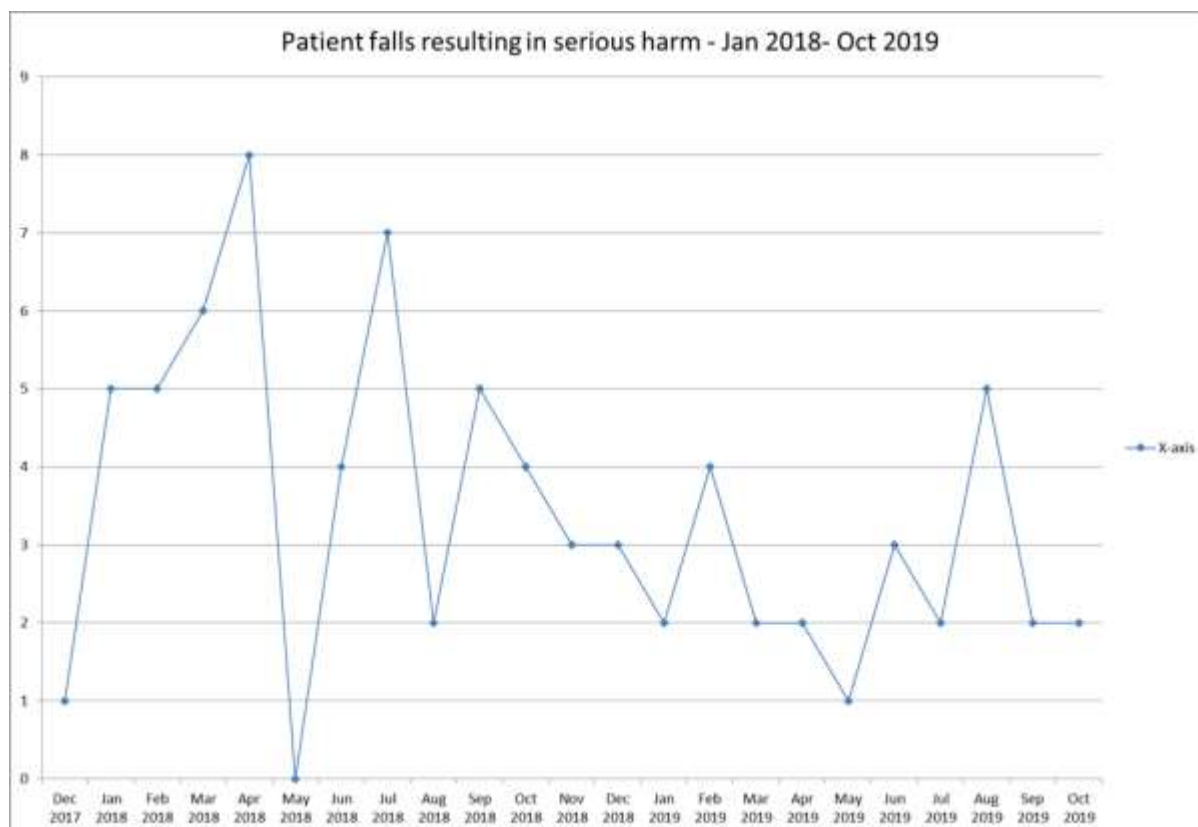
### **Ophthalmology waiting times**

At present, demand for ophthalmology surgical services is exceeding capacity and the UHB is currently pursuing both out-sourcing and in-sourcing arrangements to ensure that patients are seen within appropriate prescribed timeframes. We are ensuring that the lessons from a previous serious incident involving an in-sourced company are being used to strengthen the governance around future arrangements. The outcome of the investigation of this previous incident is close to completion and will be reported in detail to the February 2020 QSE Committee.

### **Falls and fractured neck of femur**

The National Hip Fracture Database (NHFD) 2018 National report was published in November 2018. A detailed report of the results and actions were reported through the Quality Safety and Experience Committee in February 2019. The report detailed an adjusted mortality rate of 8.5%. As a result of the higher mortality rates a detailed review of all elements of care provision in the Hip Fracture pathway is being undertaken. A reduction in crude mortality has been noted over the past 12 months since and the crude annual mortality rate in August 2019 was 6.6%.

The NHFD 2018 report identified that 7.6% of hip fractures were sustained as an inpatient. Since January 2019 the Health Board has participated in the National Audit of Inpatient Falls aligned to the NHFD allowing the Health Board to collect data on the immediate post falls management. The number of hip fractures sustained as an inpatient has dropped significantly since the beginning of the year and the crude annual rate of 4.9% was recorded in August 2019.



There has been an overall reduction in the number of falls which cause serious harm over the last two years. The Board has previously been advised of the actions being taken on the prevention and management of falls across the UJHB healthcare system.

## Outcomes of internal and external inspection processes

### External inspections

Since the last report to Board, HIW have undertaken unannounced visits to the Stroke Rehabilitation Centre (SRC) at University Hospital, Llandough and also to wards 4 and 5 at Rookwood Hospital. An immediate assurance issue in relation to the checking of resuscitation trollies on SRC has been addressed and an internal safety notice issued across the organisation. Feedback, otherwise in both areas was very positive. An improvement plan to address the recommendations following the visit to SRC has been submitted and accepted by HIW. The UHB is currently awaiting the draft report in relation to Rookwood Hospital.

The UHB continues to work with HIW in relation to the national review of Maternity Services and for the review of Surgical pathways. Unannounced visits are anticipated in the coming weeks as part of these reviews.

**Assessment Unit at University Hospital of Wales** - the Board has previously been and advised of an unannounced visit by HIW in March 2019, in which a number of immediate assurance issues were identified. Despite a number of measures being put in place to address the issues identified, this is an area that remains under pressure and will require continued monitoring from a quality and safety perspective.

## Patient Experience

The All Wales Framework for Assuring Service User Experience describes four quadrants which group together a wide range of feedback including **real time**, **retrospective**, **proactive/reactive** and **balancing**. The UHB employs a wide variety of methods across the four quadrants in order to gain the views of service users so that this rich, qualitative information can be considered and used to improve services.

Feedback mechanisms include kiosks, on line surveys, patient, carer and staff stories, paper surveys including the national survey and bespoke ones. We also meet with some of seldom heard people to listen to their experiences.

In September and October we completed 3560 surveys as part of our routine monthly survey work.

**We had 789** surveys completions on our kiosks.



We had **24474** responses. using our Happy or Not Machines

We also have ongoing reviews of patient experience and carer experience of patients with Learning disabilities who have used our service.

The patient satisfaction score for the 2 months is **94%** in UHL and UHW.

Our inpatient and outpatient surveys have been telling us some key information. These surveys have been designed to ascertain feedback supporting the Health Board strategy, providing information that we could learn from and importantly act upon.

Recent inpatient surveys told us:

- 60% of our patients surveyed as an inpatient had discussed their discharge plan with staff.
- 62% of our patients always felt involved in decisions about their care.
- 73% of our patients felt that they were always listened to.
- 91% of our patients surveyed felt that they were always well cared for.

As reported in the last Board report, an area that was identified as needing improvement was:

***Question 8. If able, have staff encouraged you to get out of bed and move around?***

In September and October we saw a slight increase in that 75% of patients answered always or usually to this question. We will continue to monitor this.

When asked what was good about their experience, 77% responded 'Staff'. Of the **positive** comments left, the vast majority related to the staff and the care received:

- All round fantastic hospital best I've ever been to, staff, care, everything. First class. Thank you.

- Good care.
- You were great.
- Great hospital, thanks so much.
- Very caring staff.

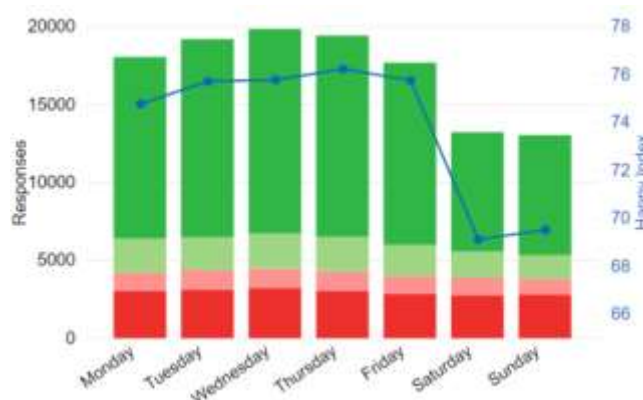
We have recently undertaken a review of the Happy or Not data and analysis has provided some interesting data. We have collected over 120,000 responses via our **Happy or Not machines**.



The amount of feedback has increased significantly each year.

### What has it told us?

Patient satisfaction consistently decreases on Saturdays and Sundays. Satisfaction drops between 8pm-11pm. We need to further explore why this is consistently the feedback at these times and these days in all sites.



Analysis of the open feedback demonstrates issues for each site

#### Children's Hospital

- Wait time and parking were key themes being mentioned by unhappy patients

#### UHL

- Café/coffee shop opening times and parking were key themes at UHL

#### UHW

- Toilets and general cleanliness were the key themes here

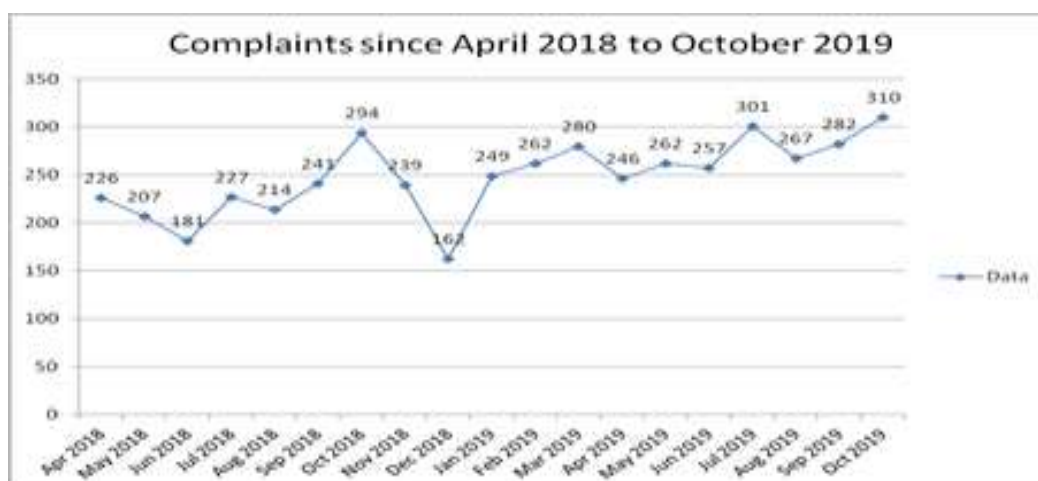
These comments have been shared with the estates department and we will continue to monitor the feedback.



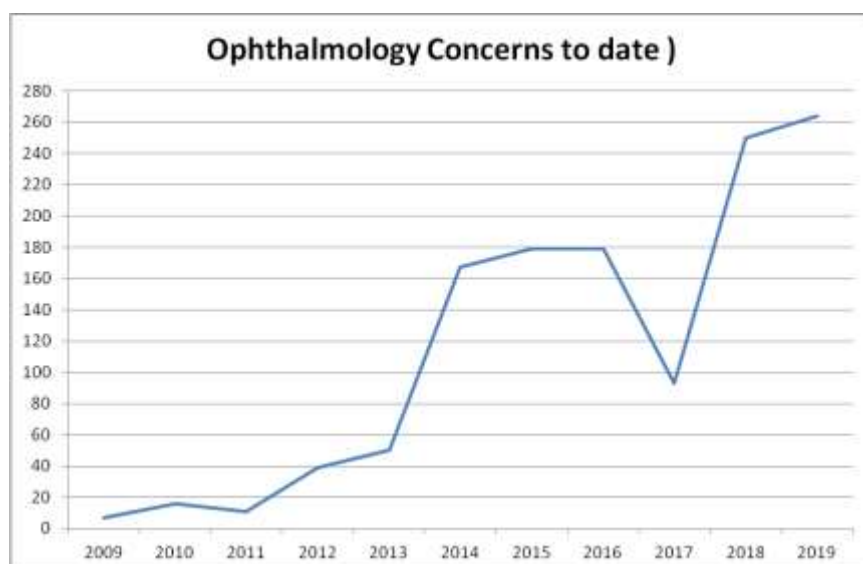
From March 2019, 3 smiley touch single question kiosks were placed in the Emergency Unit at UHW we have collected over 45, 000 responses and a slight increase in patient satisfaction has been noted.

## Concerns

Concerns data continues to demonstrate an increasing trend. The graph below demonstrates the sustained increase since April 2018. Whilst this may be attributable in part to our increased awareness raising in relation to how to raise concerns



A high volume of concerns relate to the waiting times and cancellation of follow up Ophthalmology Appointments. The chart below demonstrates the increase. As discussed earlier in the paper, there is currently discussion in the Clinical Board and Executive team regarding a sustainable resolution which will probably involve the in-sourcing and out-sourcing of services.



The themes remain consistently about communication, and cancellations of appointments



It is pleasing to note that during September and October we closed **85%** of our concerns within 30 working days.

### Compliments

During the period 1<sup>st</sup> September 2018 to 31<sup>st</sup> October 2019, the Health Board received 290 compliments. Medicine Clinical Board continues to receive the highest number of compliments (109), in particular for the Emergency Unit.

### What are we doing?

Here are some examples of action taken in relation to concerns:

You Said	We Did
Concerns were raised that letters sent from Eye Clinic should be sent in large print for ease of reading by people with a sight problem.	The Unit is arranging for eye clinic letters to be printed in a font and size which is suitable for visually impaired patients.
Concerns were raised about lack of communication when a patient was undergoing a radiology investigation.	The patients experience has been shared anonymously with staff to explain how vulnerable the person felt.

<b>Report Title:</b>	<b>PERFORMANCE REPORT</b>						
<b>Meeting:</b>	Board Meeting					<b>Meeting Date:</b>	28/11/2019
<b>Status:</b>	<b>For Discussion</b>	X	<b>For Assurance</b>	X	<b>For Approval</b>	<b>For Information</b>	X
<b>Lead Executive:</b>	Director of Digital and Intelligence						
<b>Report Author (Title):</b>	Members of the Performance and Information Department (tel 029 20745602)						

## SITUATION

The Performance Report sets out the UHB's performance against Welsh Government (WG) Delivery Framework and other priority targets for the first quarter of 2019/20 where the data is available and provides more detail on actions being taken to improve performance in areas of concern.

## BACKGROUND

The UHB is presently compliant with 23 of the 70 performance measures (August 2019 = 23/70), and is making satisfactory progress towards delivering a further 21 (August = 21).

The UHB's performance in meeting the expected standards is summarised in the table below:

Policy Objective	Green	Amber	Red	Score
Delivering for our population	10	7	4	13.5/21
Delivering our service priorities	2	2	3	3/7
Delivering sustainably	10	9	15	14.5/34
Improving culture	1	3	4	2.5/8
Total	23	21	26	33.5/70

## ASSESSMENT

Section 2 provides commentary on the following areas of performance which have been prioritised by the Board and the actions being taken to drive improvement. These are:

- Mortality
- Mental Health Measures
- Unscheduled care
- Primary care services
- Stroke
- Cancer
- Elective access
- Outpatient Follow Ups
- Finance

Commentary and assessment on the latest quality and safety indicators is provided in a separate report from the Director of Nursing.

The corporate scorecard is included as a separate appendix.

**ASSURANCE is provided by:**

- the UHB's level of compliance with the national delivery and outcomes framework and ability to deliver our Integrated Medium Term Plan for 2019-22, noting there are a number of new measures and standards introduced.

**RECOMMENDATION**

The Board is asked to:

- CONSIDER the UHB's current level of performance and the actions being taken where the level of performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale

**Shaping our Future Wellbeing Strategic Objectives**

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✓	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

**Five Ways of Working (Sustainable Development Principles) considered**

*Please tick as relevant, click [here](#) for more information*

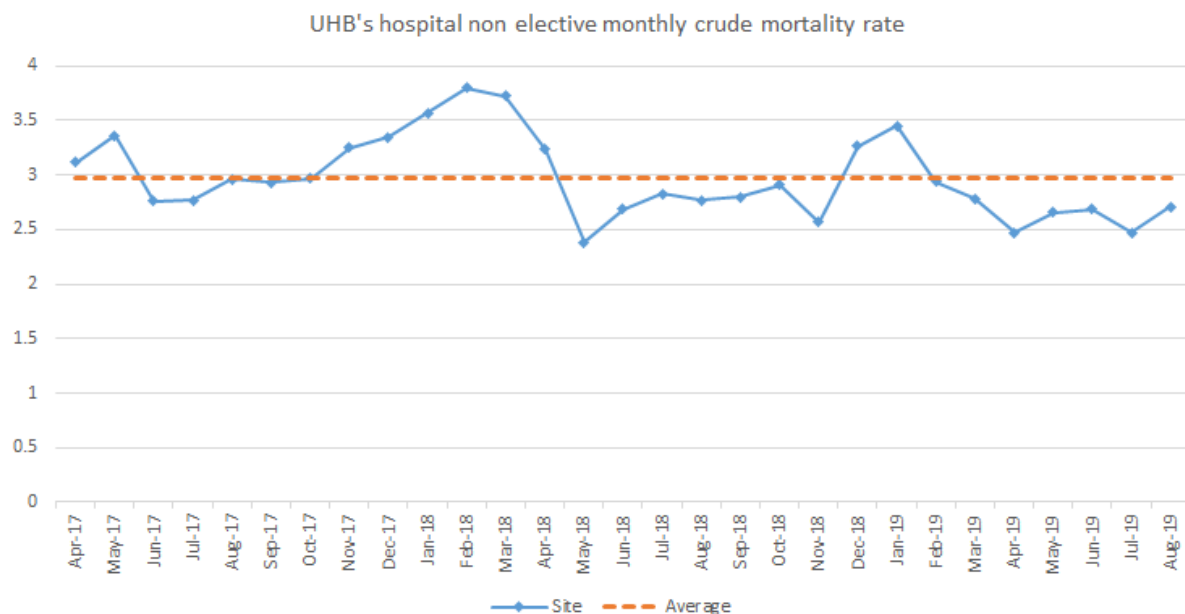
Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓
<b>Equality and Health Impact Assessment Completed:</b>		Not Applicable							

## ASSESSMENT

### 1) MORTALITY

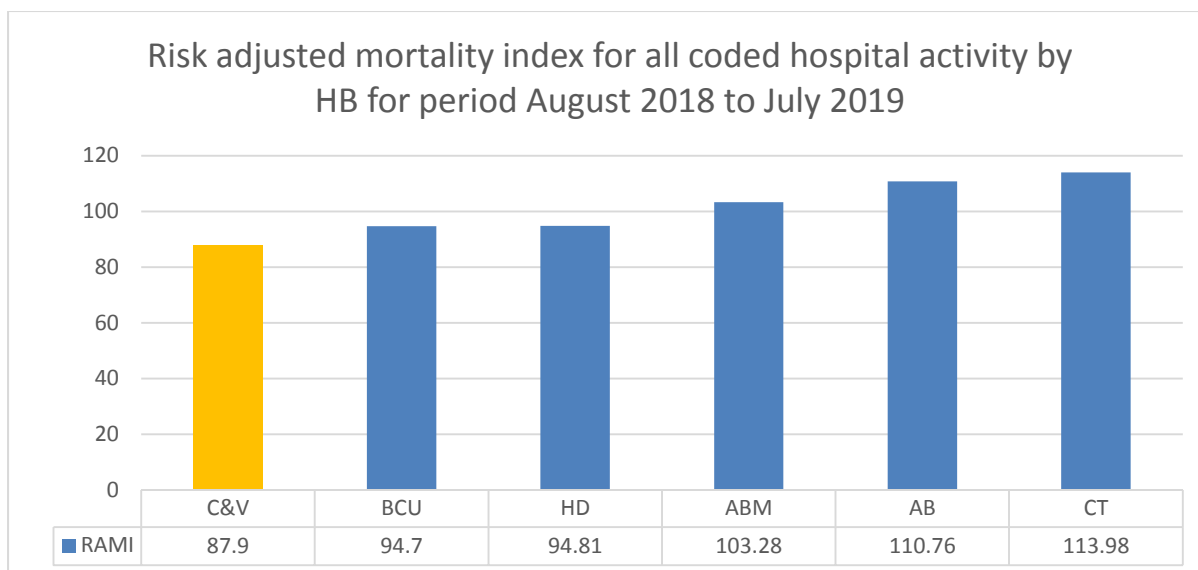
#### How are we doing?

The UHB's crude mortality rate for non-elective admissions across all of the UHB's hospitals has continued to reduce. Since April 2019 the rate has fluctuated between 2.4% to 2.7%, below previous levels of the same periods demonstrating a sustained improvement.



#### How do we compare with our peers?

The UHB's performance is in line with the performance attained by our peer group of 24 acute teaching hospitals in the UK outside of London, and better than that attained by our Welsh Health Board peers.



## Risks

Hospital mortality is an important indicator for measuring the UHB's effectiveness in providing safe, clinically effective services and for the early identification of harm occurring.

## What are we doing?

Mortality & Morbidity forms a central element of the monthly departmental Audit each directorate carries out. Trends are analysed and discussed supported by individual reviews of cases by clinical teams.

The UHB continues to deliver on all recommendations made by Professor Stephen Palmer in his report on managing mortality in NHS Wales in July 2014. National case mix dependent audits are undertaken and lessons learnt.

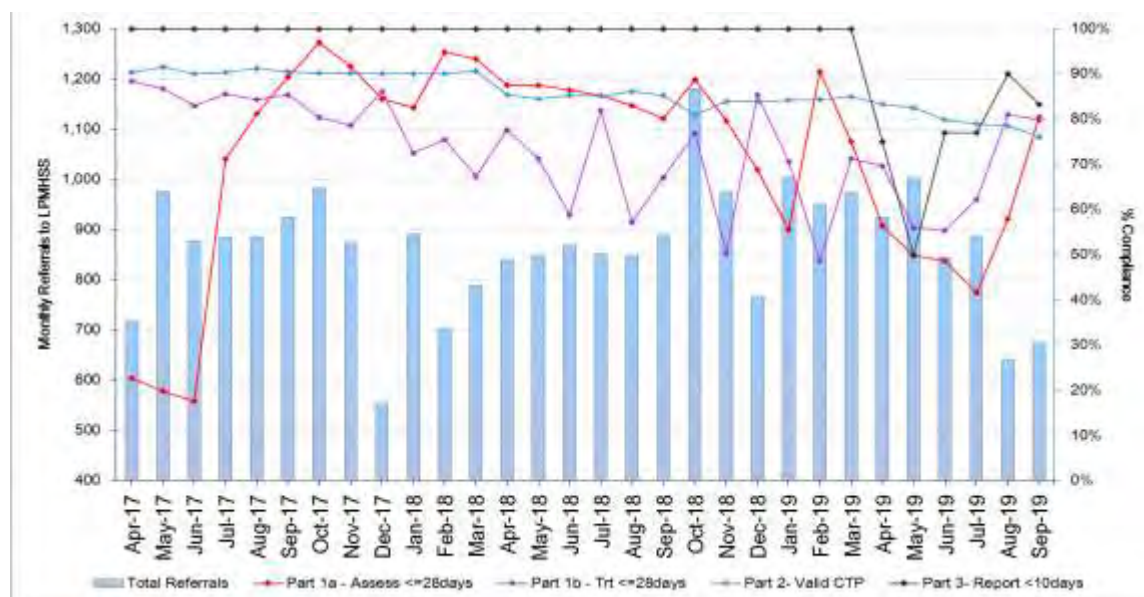
## 2. MENTAL HEALTH

### How are we doing?

At the last Board, the Chief Operating Officer reported a number of data reporting issues for the MH measures. This has arisen out of system issues, changes to local protocols for community health teams and a rise in volume for referrals rendering manual reporting unreliable. The Chief Operating Officer reported that work would be undertaken to address this in conjunction with the Health Board's Information Department and the Wales Delivery Unit (DU). This work has progressed and is almost complete. The new reporting position, validated by the Wales Delivery Unit, will be reflected in this report and all reporting changes will be complete by the next Board report.

Following a period of rising demand for adult primary mental health services up to July 2019, the volumes of referrals have reduced in August (640) and September (675). The presence of MH Liaison Workers in the GP surgeries appears to be helping to improve the quality of referrals and reduce overall volumes although the long term impact remains to be fully assessed.

The proportion of service users receiving an assessment within 28 days met the Welsh Government target of 80% in September 2019 (up from 57.9% in August and our highest level since February 2019)).



In respect of part 1b, the service met the Welsh Government standard of 80% of service users receiving a therapeutic intervention subsequent to their assessment within 28 days

Part 2 of the measures sets out an expectation that mental health service users should have a valid Community Treatment Plan completed at the end of each month. The UHB performance for September 2019 was 76% (August 2019: 78%) against the Welsh Government's minimum standard of 90%.

Part 3 – the requirement for an assessment outcome letter of a re-referral assessment within 10 days.

Due to an increase in Part 3 referrals this requires an electronic solution from a manual data collection method. PARIS are working to establish a reliable process for recording follow up letters which clinicians and administrators to clinical teams can understand and work with.

Action to Resolve – Data collection method agreed with PARIS and the DU who are satisfied with the reliability. Implementation commenced in August 2019 and showed that the Health Board is compliant with the Mental Health measure. There is a lag in this new feed to the information department. Therefore, the corrected position will be reflected in the performance report before the next Board.

Part 4 provision of an advocacy service for patients continues to be met.

### **How do we compare with our peers?**

Due to data quality issues referred to elsewhere which have been the subject of review by Wales Delivery Unit, reliable comparable data is not available for this performance report.

### **What are the main areas of risk?**

The main risk to providing an accessible responsive service is maintaining the performance levels at periods of high demand. Although we have seen a reduction in referral volumes since the introduction of enhanced primary care MH liaison support in GP surgeries, this may not be a long term impact, though, as the pilot project for this now UHB wide service saw referral numbers climb near to their original level within a year.

### **What actions are we taking?**

In respect of Part 1 the UHB is seeking to accelerate the increased use and ability of Primary Care services as the first point of contact Mental Health provision, by right sizing the capacity of the service in order to balance assessment and intervention and manage the variation and rising levels of demand.

For children's services, there has been successful recruitment to all vacancies within the team, with new staff members now in post. This has supported an increase in capacity to better support meeting the demand. Additional short term capacity through the recruitment of agency staffing has been implemented, with the expectation of significantly reducing the waiting list over the next two month period.

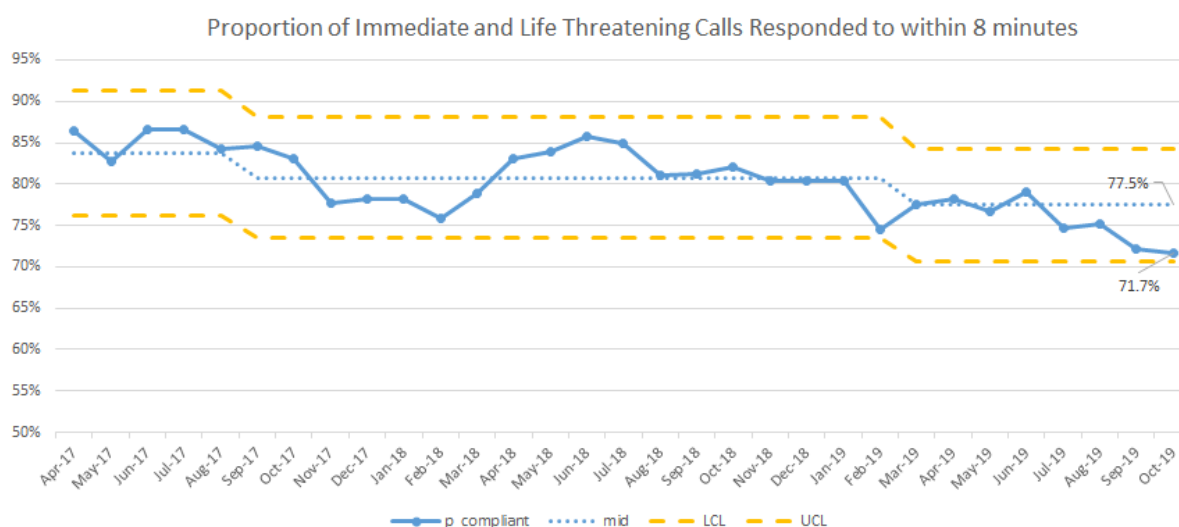
The service is currently working with Healios as a partner to increase clinical capacity through the delivery of assessment and intervention on a digital platform, it is expected that this service offer will go live at the end of November/beginning of December. Significant work is underway with the team to better plan and monitor capacity in line with demand, as well improve data quality both in terms of recording and reporting of information.



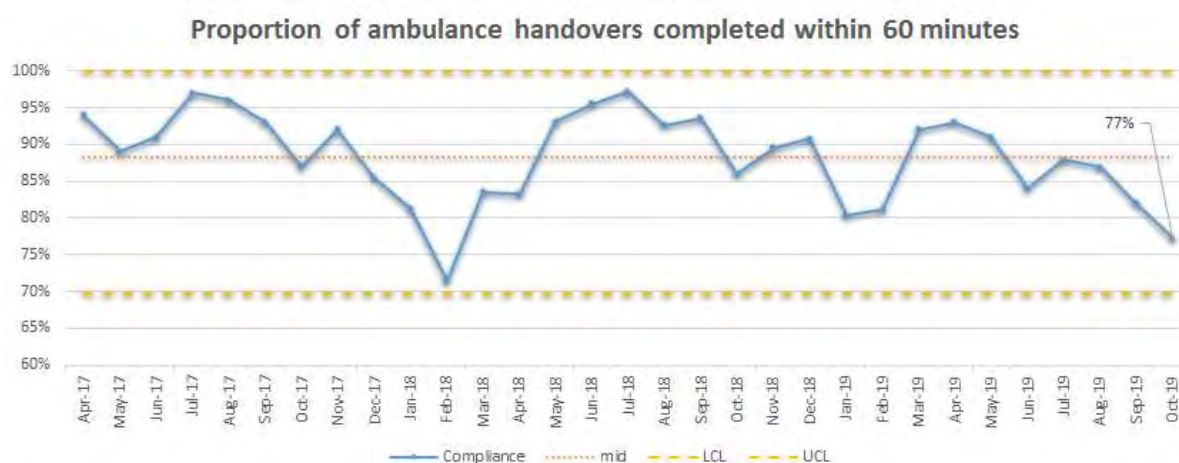
### 3) UNSCHEDULED CARE

#### WAST 8 Minutes Response

The Health Board commissions the Welsh Ambulance Service Trust to provide responsive, high quality services to patients. Whilst the proportion of patients with a potentially immediate or life threatening condition within Cardiff and the Vale to whom the Ambulance Service responded within 8 minutes has fallen in the past 6 months by 6%, performance remains above the Welsh Government target of 65%. October's performance was 72%.



In respect of ambulance handovers, performance has not changed significantly for 3 years, fluctuating around a mean of 88% of patients being handed over within 60 minutes. The WG minimum standard is 100% within 60 minutes.

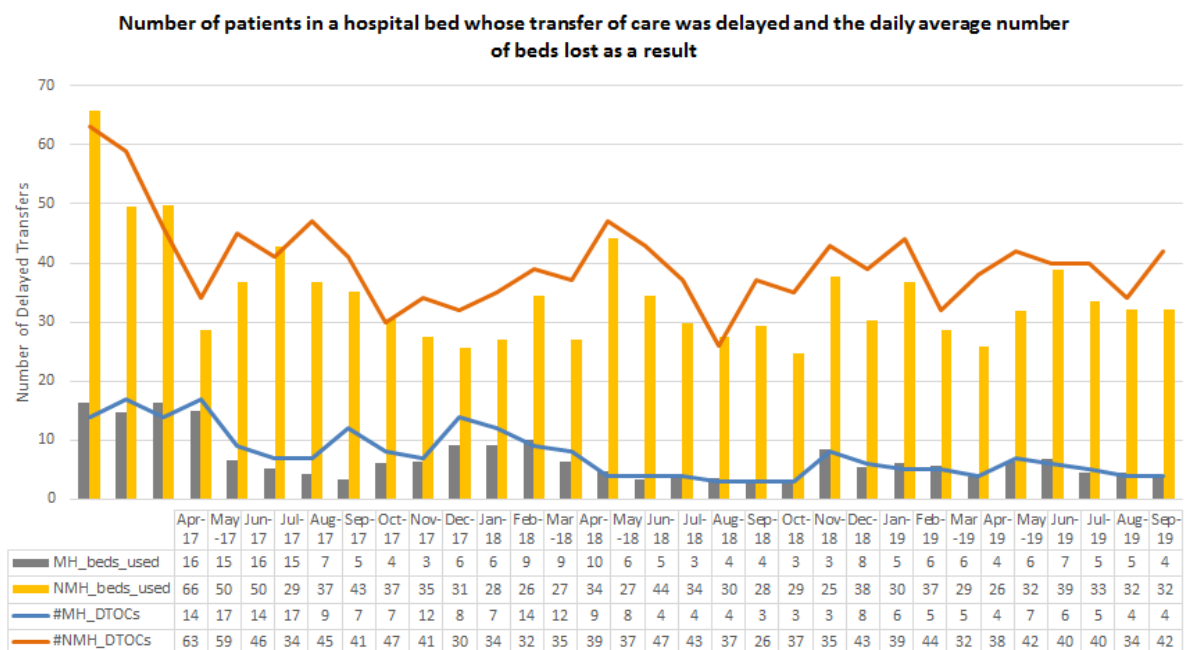


The proportion of patients admitted, discharged or transferred within 4 hours was 82% in October, in line with the mean performance. Whilst this was a reduction on the performance for the same period last year our performance overall remains strong compared with other Health Boards in Wales. The WG standard is 95%.



The number of patients waiting in excess of 12 hours was 173 in the month of October. The WG's expected standard is that no patient should wait in excess of 12 hours. In keeping with Welsh Government guidance and the reporting in other Health Board's, these figures continue to exclude patients where there has been clinical justification for the patient requiring extended periods of care and observation within the Emergency Department footprint.

**Delayed Transfers of Care:** The total number of patients whose care was delayed was 46 in September 2019, an increase of 8 from August (38).



- This increase is in part reflective of increased system wide demand and reduction in Social Worker capacity due to sickness levels and vacancies. The Local Authority are aware and have taken measures in an attempt to increase capacity and changed systems to support reduction in delays in anticipation of moving flow forward.

- Domiciliary Care capacity for most people continues to be available within reasonable time scales. However, Patients with more complex needs often continue to wait long periods before a provider able to support their needs is found.
- Within the Vale Local Authority area there has been a significant improvement in timely discharge for those Patients requiring care in their own home. This is in part as a result of the implementation of a Single Point of Access via Vale Community Resource Team (VCRS) and improved Domiciliary Care brokerage arrangements, which has resulted in reduction of DTOC delays associated to community arrangement delays.
- Cardiff LA have now implemented a similar model although it is in the very early stages and impact yet to be felt within the unscheduled care system.
- EMI Nursing Home capacity and therefore the choice of suitable care homes for Patients and their families continues to be challenging. The Cognitive Impairment Pathway work continues to progress and support the issues associated with Care Home placements, improve the Patient experience and help expedite discharge.

### How do we compare with our peers?

The latest performance data available indicates that UHB ranked first for three out of the four measures in comparison to its peers for the recorded unscheduled care access measures in September 2019. In relation to the measure ranked second, it is important to note that ambulance delays over 1 hour have been reported in total volume and are not relative to the overall conveyance volume. For example, C&V has one of the highest conveyance volumes in Wales.

	Target	AB	BC	C&V	CTM	HD	SB	C&V Rank	Month
% Red calls WAST respond to within 8 mins	65%	68.3%	69.0%	72.2%	68.1%	68.5%	66.7%	1/6	Sep-19
Patients waiting > 1hr for a handover	0	932	895	357	329	406	778	2/6	Sep-19
% of patients waiting less than 4 hrs in EU	95%	72.3%	71.7%	82.1%	71.3%	80.3%	71.4%	1/6	Sep-19
No.patients waiting > 12 hrs in EU	0	697	1973	139	912	910	939	1/6	Sep-19

### What are the main areas of risk?

Demand continues to rise with the volume of patients attending our Emergency Departments up 4% year-to-date, representing on average an additional 500 patients presenting per month. What is of particular concern, is that the vast majority of the increased attendances at ED are categorised as 'majors' patients (as opposed to minor injuries). This is relevant in terms of the majors stream of patients being those who are more likely to require a bed.

## What actions are we taking?

We continue to work with our partners across health, social care and the voluntary sector focusing on:

- Right place, right time - Improved access to Urgent and Emergency care
- Every Day Counts – Timely decision making and access to diagnostics and therapies
- Get Me Home - Alternative services in the community to reduce long hospital stays.

Programmes of work include the rollout of 'Red to Green' on wards; continuing to maximise our core Community Resource Team capacity; and 'Get me home plus'. A number of pathway improvement initiatives are being taken forward as part of the Length of Stay improvement programme of work, most recently in respiratory and trauma and orthopaedics. This work is being informed and supported by an increased use of data and business intelligence.

In addition to these improvements, a detailed Winter Plan has been developed to support the management of unscheduled care pressures throughout this period. A series of initiatives will commence from November onwards to create additional capacity within the Health system.

#### 4) PRIMARY CARE

##### GENERAL MEDICAL SERVICES

###### How are we doing?

The UHB is presently engaged with Welsh Government and other Health Boards in Wales to develop a standard approach to reporting risk in relation to General Medical Services (GMS). The UHB's present status in respect of three of the key metrics that are expected to be adopted, are reported on below:

- a) **Sustainability applications:** The UHB currently has zero active applications from GPs to support with the sustainability of their services and there are no lists presently closed to new registrations.
- b) **Contract terminations:** There have been no contract terminations
- c) **Directly managed GP services:** The UHB presently has no directly managed primary medical care services

There are presently no closed lists.

###### How do we compare with our peers?

Data to inform the all Wales position in respect of GMS is presently under development.

###### What are the main areas of risk?

Primary care is essential to delivery of the organisation's strategy and strategic objectives, affecting all dimensions of health and care. Owing to a number of factors, the UHB is facing challenges in recruiting and retaining sufficient numbers of General Medical Practitioners to meet the demands of a growing, aging population, who have increasingly complex clinical needs from some fairly antiquated estate.

###### What actions are we taking?

Further to initiatives previously described, developments over the past 2 months, include:

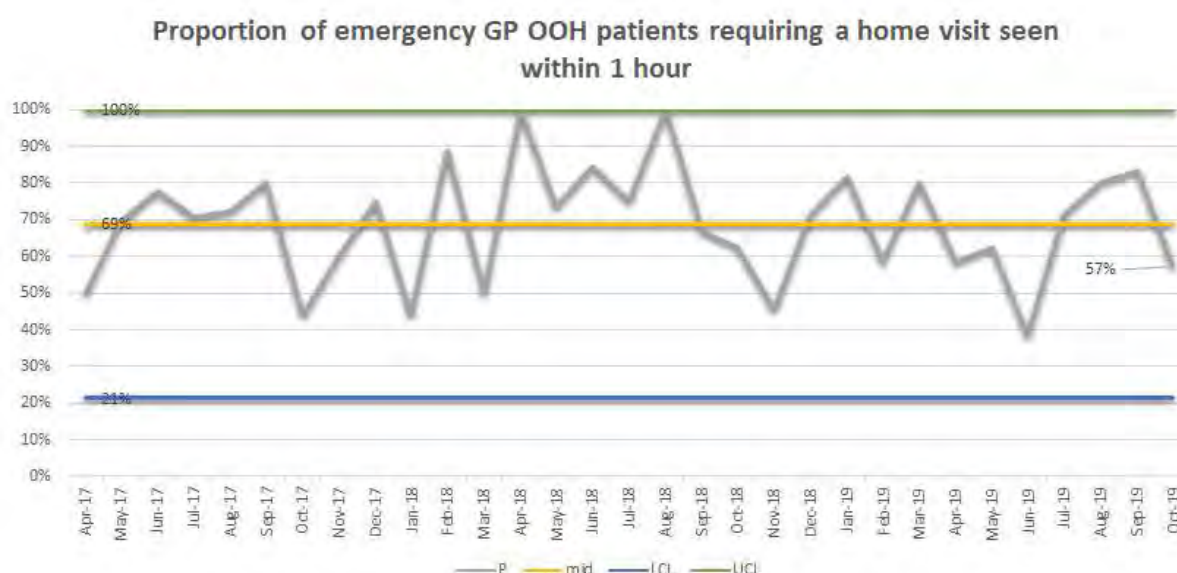
- Supporting GP practices to interpret GMS contract changes
- Providing GP practices with the opportunity to undertake training in Quality Improvement methodology in line with GMS contract changes and introduction of QAIF (Quality Assurance & Improvement Framework)

## URGENT OUT OF HOURS SERVICES (OOH)

### How are we doing?

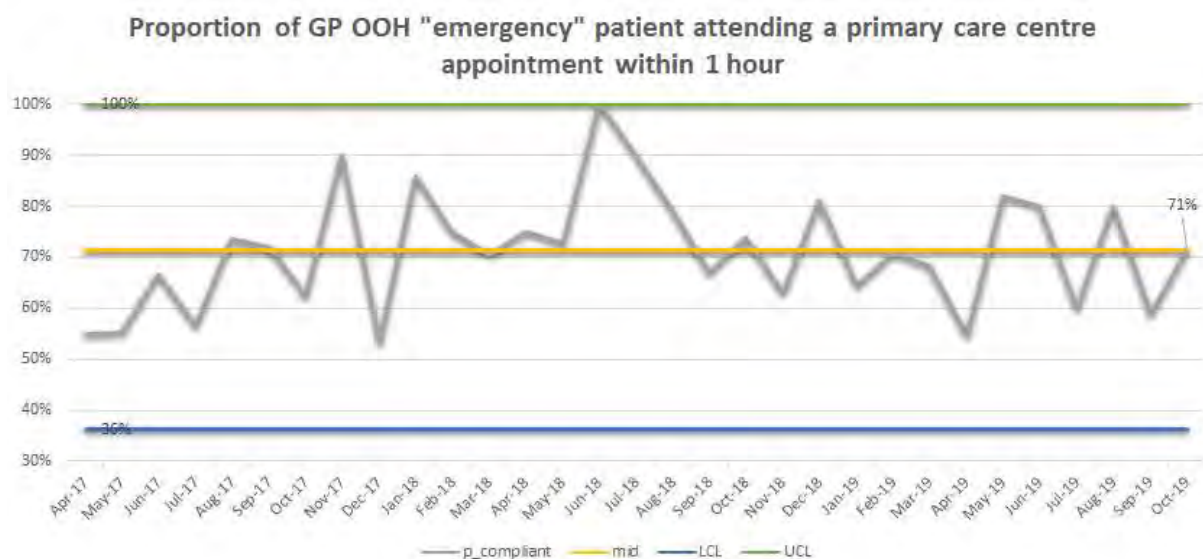
The Welsh Government have introduced a new suite of indicators for 2019/20 and extended the scope of the measures to include patients accessing primary care through the 111 service. In October the UHB was compliant with 6 of the 14 measures, and within 10% of the compliance standard (marked as amber) for a further 3.

As per the chart below the proportion of home visits for patients prioritised as “emergency” which were provided within 1 hour continued to fluctuate wildly over the course of the year between limits of 38% and 100%, reflecting the large variation in demand on this service, both in terms of very small volumes and location. The discrete performance in October was 57% relative to a median performance of 69% and the Welsh Government’s delivery standard of 75%.



The proportion of primary care centre appointments provided within 1 hour for those prioritised as “emergency” also remains stationary at a median of 71%, with discrete performance for October at 71%.





## How do we compare with our peers?

There is no available comparative data from some Health Boards, but from the available data, C&V UHB is performing well regarding home visits within 1 hour, exceeding the target and less well regarding a primary care consultation within 1 hour.

		Target	AB	BC	C&V	CTM	HD	SB	C&V Rank	Month
Proportion of GP OOH patients triaged as emergency receiving:	a home visit within 1 hour	90.0%	No Data	93.8%	96.9%	95.5%	No Data	No Data	2/6	Sep-19
	a primary care centre consult within 1 hour	90.0%	No Data	75.0%	58.8%	87.7%	No Data	No Data	3/6	Sep-19

## What are the main areas of risk?

The three areas of concern are:

- An ability to provide home visits within 60 minutes for all areas of Cardiff and Vale when considering the geographical area covered and the variation in average travel times across our dense urban areas.
- The ability to attract staff onto the roster at peak periods and certain times of the week and the subsequent reliance on bank staff, who provide less certainty as to their availability.
- Ensuring that the triaged clinicians are using a standardised approach to what constitutes a P1, P2, P3 home visit or PCC appointment and what impact an incorrect prioritisation can have on the system.

## What actions are we taking?

The workforce plan is in the final stages, with a number of the new extended roles have been piloted and implemented on a smaller scale. It is promising to note that shift fill rates are increasing, predominantly due to the workforce skill mix changing, and the further introduction of Clinical Practitioners and Minor Illness clinicians.

A plan for Winter has been developed aligned to the workforce and service plan and the



service's demand and capacity modelling. Bids for Welsh Government badged funding having been submitted to try new roles this year. A presentation of the workforce plan is being presented to QUEST in two weeks. Using CPD events to help ensure that triaged clinicians are using a standardised approach to categorising a home or PCC appointment.

## 5) STROKE

### How are we doing?

The Sentinel Stroke National Audit Programme (SSNAP) measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland.

Our SSNAP score is back to a Level B in the latest published data. This is an improvement from Level C previously.

Performance against the four measures of Welsh Government focus remains variable and our challenge remains to achieve target and consistency in delivery, particularly for the 4 hours direct admission.

WG benchmarking standard		IMTP trajectory	UHB in Oct-19
4 Hour QIM	60%	47.3%	43.8%
12 Hour QIM	94%	96.6%	98.0%
24 Hour QIM	83%	78.9%	81.6%
45 Minute QIM	90%	24.4%	33.3%

### How do we compare with our peers?

C&V UHB compares well with other Welsh Health Boards for Direct Admission to an Acute Stroke Unit within 24 hours, and is hitting its target of 55.5% for direct admissions within 4 hours.

Indicator	Target	AB	BC	C&V	CTM	HD	SB	C&V Rank	Month
Direct admission to Acute Stroke Ward within 4 hours	55.5%	40.0%	59.3%	56.3%	31.6%	63.0%	41.8%	3/6	Aug-19
Assessed by Stroke Consultant within 24 hours	84.0%	100.0%	75.9%	81.1%	68.7%	92.9%	94.6%	4/6	Aug-19

### What are the main areas of risk?

- Maintaining thrombolysis procedural and educational standards for all staff to keep rates high and door to needle times minimised.
- Consultant assessment as early as possible in the stroke pathway – guiding correct admission to A6 South and to offer specialist senior assessment as early as possible in a patient's admission
- Direct admission of stroke patients within 4 hours of arrival – challenges in maintaining bed capacity on A6, urgently identifying correct patients for admission to the stroke pathway and minimising use of stroke beds for outliers

## What actions are we taking?

Through our Stroke Operational Group, two actions have been agreed to support further improvement in performance.

- The first is ring-fencing of 4 x Stroke beds on our acute stroke ward in UHW. The plan is to trial this for a four week period commencing in September.
- The second change is related to the medical model – and an increase specifically in consultant cover at the front door as part of the Code Stroke team and on our acute stroke ward to improve timeliness of senior decision making. This is being introduced in a phased approach through September to November.

## 6) CANCER

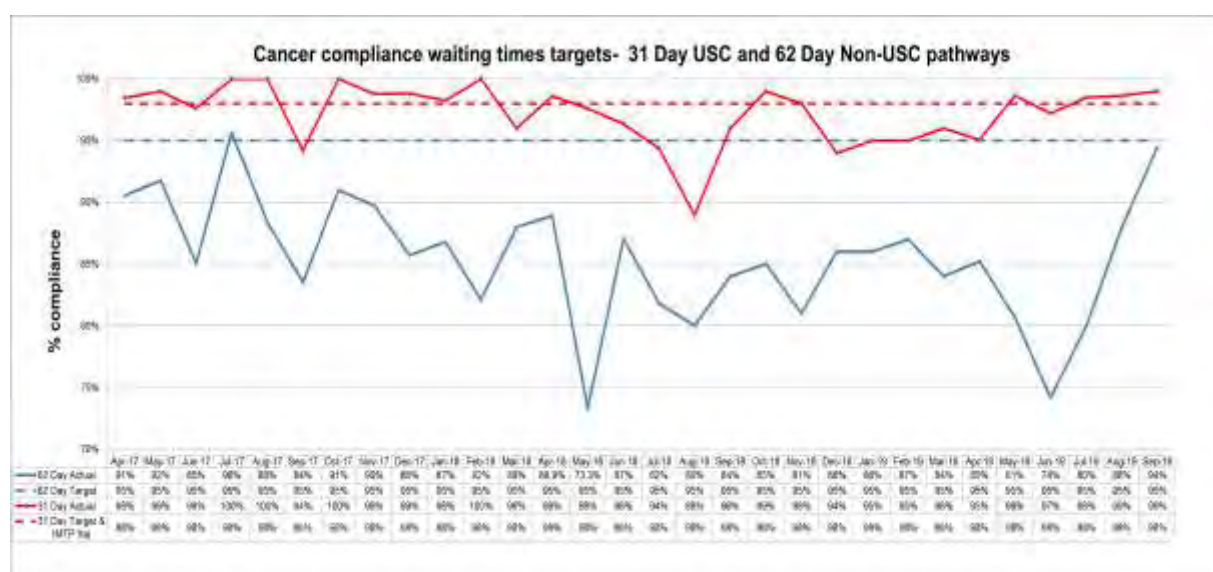
### How are we doing?

During September 2019 96% of cancer patients who were referred by their GP as urgent with suspected cancer, commenced treatment within 62 days of their referral, against a minimum expected standard of 95%.

99% of patients who were not on an “urgent suspected cancer” pathway commenced treatment within 31 days of the requirement for treatment being agreed with them. The UHB met the minimum expected standard of 98%.

Following significant challenges related to increased demand earlier in the year, a revised plan to reverse an adverse impact on cancer performance was put in place. Both urgent and non urgent suspected cancer performance measures have shown improvement in recent months. Cancer breach rules are, as such that there is a lag between the patient breaching and their treatment event. For this reason a more gradual improvement up to the months of July and August has been accentuated in September. Performance will normalise to a lower but still improved position over October/November.

Monthly performance against the 31 and 62 day standards is shown below:



### What are the main areas of risk?

- Increased demand and insufficient capacity in a number of key tumour site services.
- Challenges in redesigning complex cancer pathways – including urology and lower GI.
- Meeting the requirements for the new single cancer pathway.

## What actions are we taking?

The ongoing scrutiny of tracking and expediting arrangements continue to support (and mitigate risks to) improvements. As reported last month we have extended this approach to the monitoring of the cohort of patients within the 51-62 wait days which has reduced from >125 at the end of August to circa <30 patients at the end of October. A brief spike has occurred due to administrative validation required which will be resolved in early November.

The other element to our recovery plan remains the focus on balancing demand and capacity on a sustainable basis, particularly in tumour sites where demand increases have compounded pre-existing process and capacity constraints – urology and GI specifically.

Single cancer Pathway: The UHB continues with implementation of its SCP project plan. Of note, we have received funding for this year and next (£400K per annum) from Welsh Government to support implementation. The Health Board has prioritised this to help reduce the demand and capacity diagnostic gap (radiology and endoscopy) and in supporting development of an IT and Business Intelligence System that supports the SCP and national data requirements.

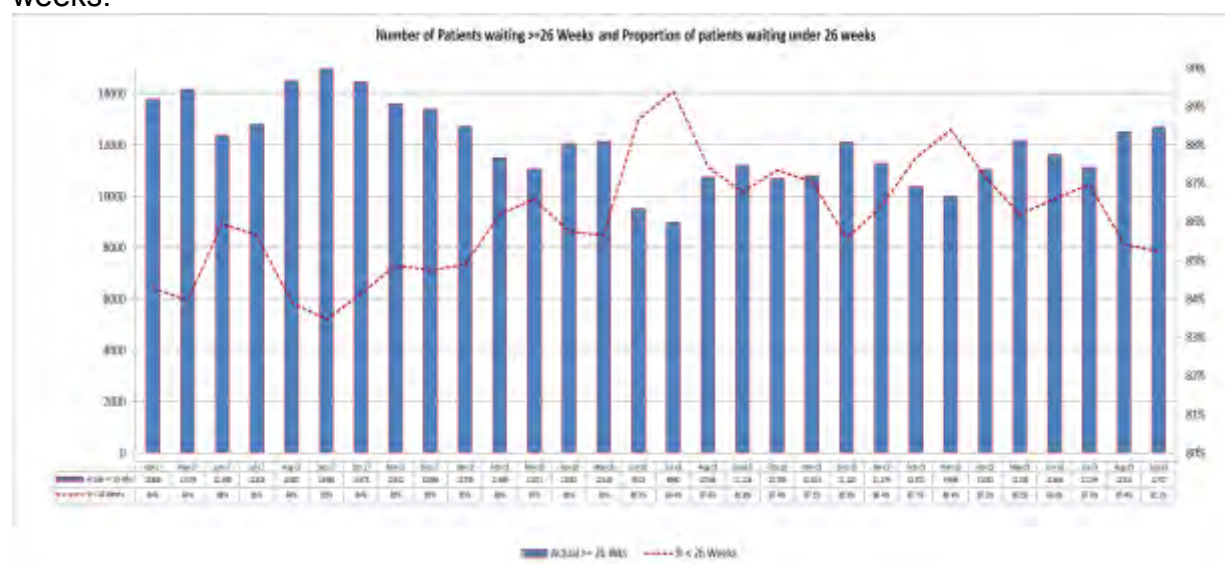
No percentage compliance target has been set yet but the expectation is for continuous improvement in 2019/20. Our shadow reporting arrangements are now in place and this shows a reported position of 81% with adjustments in September.

## 7) ELECTIVE ACCESS

### How are we doing?

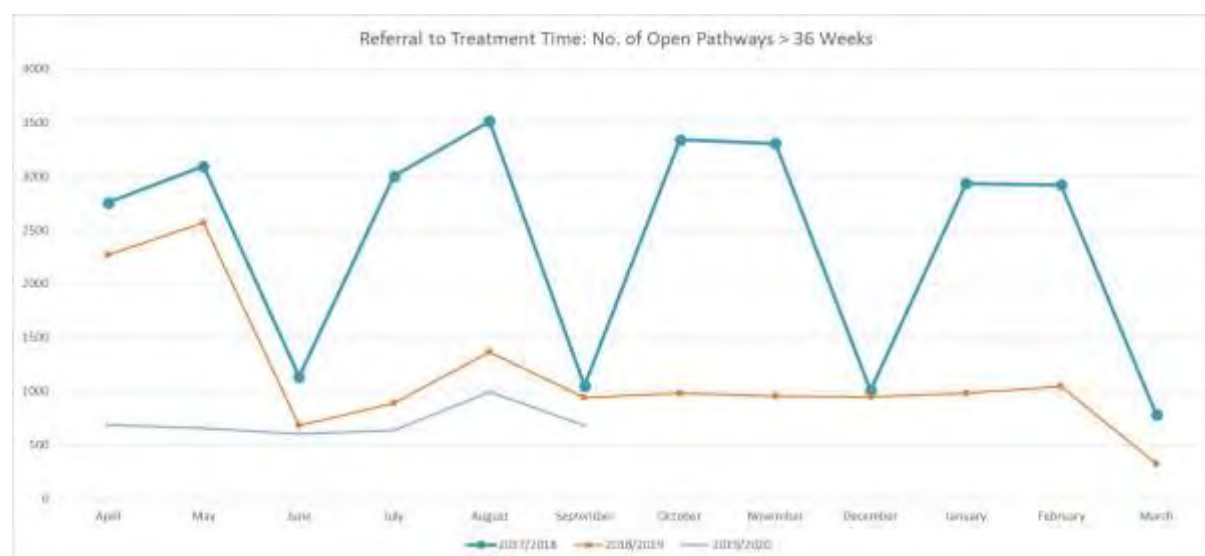
The Welsh Government has set a target that 95% of most patients referred for consultant-led elective care should be treated within 26 weeks from date of receipt of referral, with the remaining 5% seen within 36 weeks.

At the end of September 2019, 85.2% of patients in the UHB were waiting under 26 weeks.

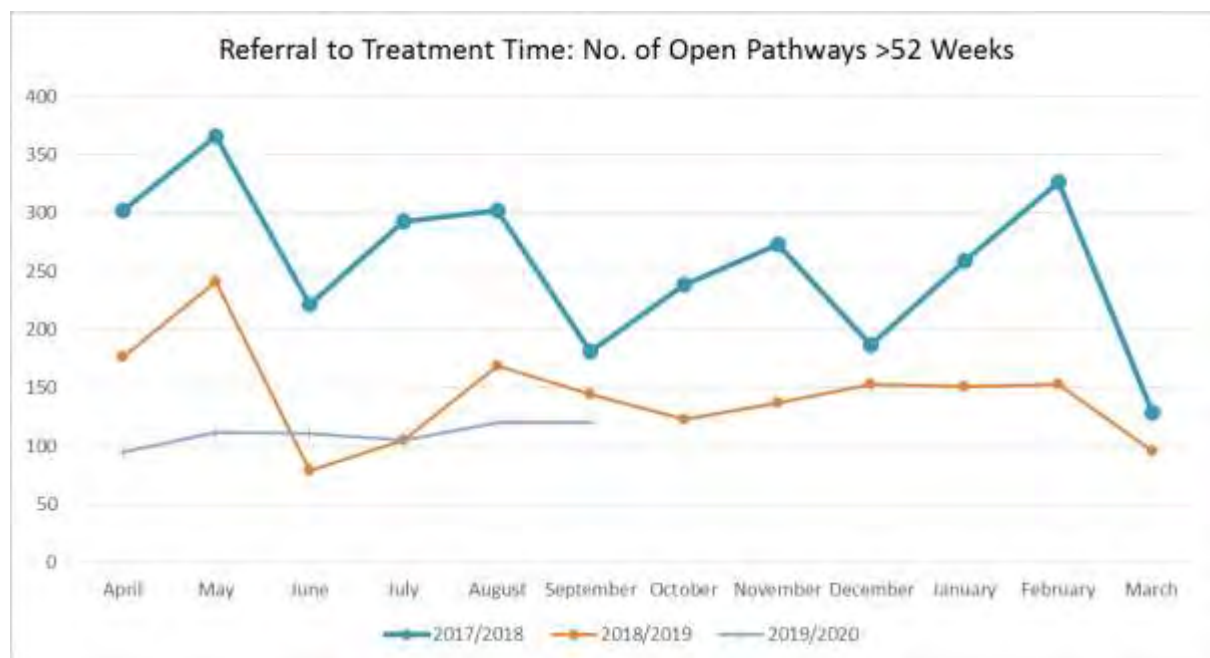


The number of patients waiting in excess of 36 weeks elective care was 683 for September 2019. This is 133 higher than the IMTP trajectory submitted to WG.

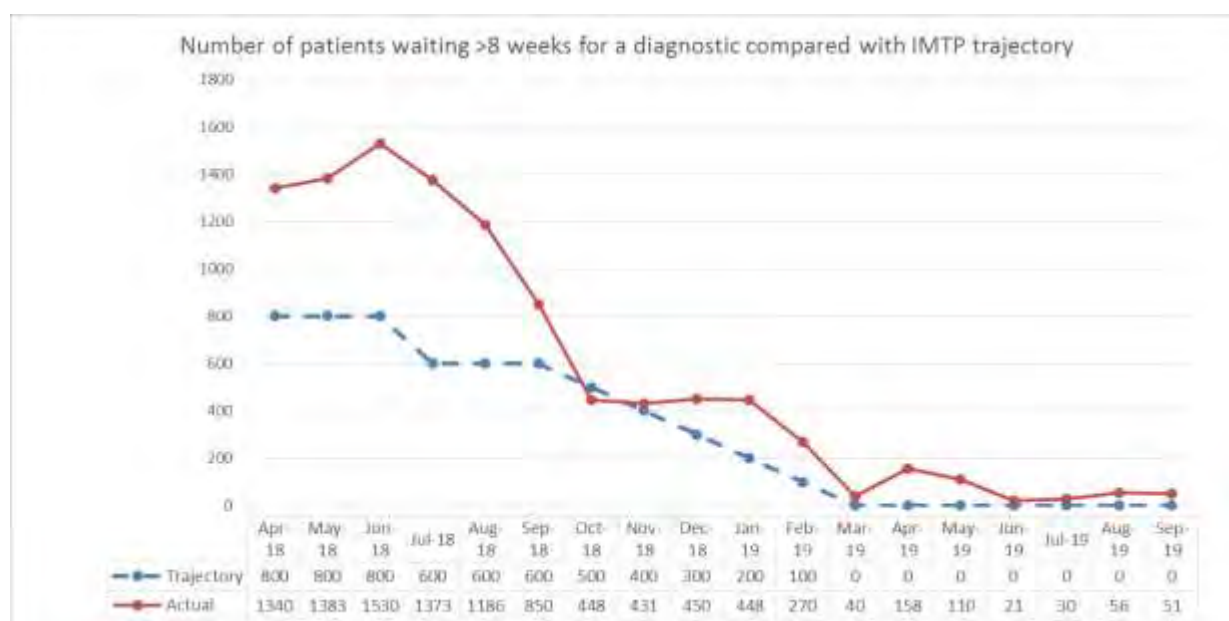
While the September position is a slight decrease since the start of the year, it is a 27% reduction on the September position last year. This is in contrast to the All Wales position which is showing an increase in the year on year over 36 week wait position.



At the end of September 2019 the UHB had 120 patients waiting >52 weeks. As the Health Board has reduced high volumes of long waits, the remaining > 36 week specialties include specialist and complex work where there is a concentration of the longest waits i.e. over 52 weeks. Almost all of these patients are within orthopaedics spinal surgery.



The Health Board saw a small increase in the number of patients waiting greater than 8 weeks for a diagnostic test from 40 in March 2019 to 51 in September 2019, against a revised target of 0. Our plan remains to clear greater than 8 week diagnostic waits.





## How do we compare with our peers?

The All-Wales waiting time position at the end of August 2019 is shown below.

Indicator	Target	Month	Wales	SB	AB	BC	C&V	CTaf	Hdda	Powys	C&V Rank
% of patients waiting less than 26 weeks (RTT)	95%	Aug-19	85.7%	86.4%	88.9%	80.4%	85.4%	85.8%	87.8%	98.8%	6/7
Number of patients waiting > 36 weeks (RTT)	0	Aug-19	19,100	3262	1507	9890	995	2940	506	0	3/7
Number of patients waiting > 14 weeks for therapies	0	Aug-19	460	1	0	0	5	25	424	5	4/7
Number of patients > 8 weeks for diagnostic	0	Aug-19	5091	344	190	2957	56	1181	345	18	2/7

## What are the main areas of risk?

When the treatment of patients is delayed for non-clinical reasons, there is a potential for harm.

The corporate organisational risk is that of failing to achieve the IMTP targets set by WG.

As with Health Boards and Trust across the UK Cardiff & Vale UHB is experiencing significant challenges related to changes in pensionable taxation – particularly for consultant staff. This national issue is currently being looked at, but in the meantime the Health Board has been unable to commission additional consultant capacity in the way it had previously done so. The CEO provides a monthly update to Welsh Government on the activity and performance impact of this. It is anticipated that this will continue to have a material impact on performance in the remainder of this year.

## What actions are we taking?

We manage the risk relating to long waiting patients specifically by our adoption of the good practice recommended by the Delivery Unit in their all Wales review in 2017, their report to Cardiff UHB in November 2018 and CHC reports also, which recommended a series of actions the UHB needed to take to improve its management of this issue. Clinical Boards adhere to the good practice guidelines and this is monitored by the UHB centrally.

Implementation of speciality specific delivery plans remains the key action in delivery of RTT and diagnostics. In specific areas such as Spinal Surgery where we have a particular demand and capacity challenge, we have made Consultant appointments. Two additional Spinal Surgeons commence working for the UHB in January 2020.

There are national programmes of work under the Planned Care Programme Board focussing on identifying best practice and supporting sustainable approaches to the management of elective care. The UHB partakes in these forums and works with other Health Boards in a series of sub groups reporting to the Planned Care Programme Board.

## 8) OUTPATIENT FOLLOW UPS

### How are we doing?

Historically, Cardiff & Vale has reported the highest historical Follow-Up volumes across NHS Wales and our single biggest challenge has been the recording and accuracy of follow-up data, largely driven by information and data systems issues.

Over recent years the UHB has made the largest improvement in its position across Wales largely through system led validation working closely with clinicians to determine a set of rules and guidelines which have greatly improved the accuracy of data. However we still have more to do to improve both in our systems and in our ways of working as too many of our specialties remain working using traditional models of outpatient follow ups which are increasingly outdated.

Welsh Government announced in June 2019 a number of targets for follow-up outpatients for 2019/20, described below. The baseline for improvement is March 2019.

As at the 30<sup>th</sup> September 2019, there were:

- 41,143 had no target date identified – a small increase from the March 2019. This equates to 82% against a target of 95% by the end of December 2019.
- 234,649 open pathways where the patient may be requiring a follow up appointment, a <1% reduction on March 2019. Our target for delivery by 31 March 2020 is 199,640.
- 76,652 patients recorded as delayed over 100% - 2% reduction compared to March 2019. Our target for delivery by 31 March 2020 is 66,739.

### How do we compare with peers?

Data reported on a national basis only relates to a limited number of specialties being monitored as part of the Planned Care programme. From our latest reported position, this table shows the scale of the performance improvement required by each Health Board in terms of total volumes and delays over 100%.

Target is 15% reduction from March 2019 position												
		Target	AB	BC	C&V	HD	Powys	CTM		SB	C&V Rank	Month
No. waiting for a follow-up appointment	Target	130839	172330	199640	29175	7298						
	Actual	154091	203737	236351	43405	8169	107739	134363				Aug-19
	% reduction to achieve target	18%	18%	18%	49%	12%					2/5	
No. waiting for a follow-up appointment delayed by over 100%	Target	7372	45404	66739	19036	379						
	Actual	10192	55307	79599	29379	467	19257	25758				Aug-19
	% reduction to achieve target	38%	22%	19%	54%	23%					1/5	

In the peer comparison C&V's position increased by 2%, however all LHBs have experienced increases in the *No. waiting for a follow-up appointment delayed by over 100%* measure ranging from 2% to 15%.

## What actions are we taking?

The UHB still has a number of data quality issues to address and is using a number of analytical approaches alongside improved functionality within digital applications in an effort to overcome these.

Our work is focused on improving patient access, experience and outcomes through transforming the way outpatient consultations are delivered, rethinking the location (closer to home) and enhancing the role of patients in supporting them in managing their own conditions. An important element of this work is reliant on enhancing current digital technology and systems and adopting new and innovative technology platforms including Patient Knows Best (PKB).

We have recently received approval from WG to support additional system led validation and have established a senior group to coordinate delivery against the 2019/20 targets and to focus on accelerating service transformation initiatives.

Our Outpatient Follow up Improvement Programme has identified a series of initiatives which we expect to make a material difference in our position by the end of December 2019. The UHB remains committed to delivery of the Welsh Government targets by 31<sup>st</sup> March 2020.

## 9) FINANCE

### How are we doing?

The UHB's 2019/20 operational plan includes a balanced financial plan.

This is dependent upon managing the following key challenges:

- delivering a £26.095m savings target;
- the management of operational cost pressures and financial risks within delegated budgets.

The UHB has a full savings programme in place and the delivery of this is key to the success of the plan. The UHB is reporting an overspend of £2.385m against this plan for the 7 months to the end of October 2019.

### Background

The Health Board agreed and submitted its 2019/20 – 2021/22 IMTP to Welsh Government by the end of January 2019 for its consideration. Approval of this plan was received by Welsh Government in March 2019. The financial plan aims to deliver a break even position for each year during the period of this plan.

### Reported month 7 position

At month 7, the UHB is reporting an overspend of £2.385m against plan which represents an improvement of £0.140m on the position reported at the end of September.

The UHB plans to recover this year to date deficit and deliver a break even position by the year end. This will take concerted effort and will require the delivery of the remedial actions that have been identified. The position is expected to show sustained improvements in the last five months of the year towards a break even position.

### Income and Expenditure Analysis

#### Summary Financial Position for the period ended 31<sup>st</sup> October 2019

Income/Pay/Non Pay	In Month			Cumulative Year to Date		
	Budget	Actual	Variance (Fav)/Adv	Budget	Actual	Variance (Fav)/Adv
	£m	£m	£m	£m	£m	£m
Income	(115.962)	(115.988)	(0.026)	(830.561)	(832.937)	0.009
Pay	54.706	54.645	(0.061)	374.234	372.983	(1.251)
Non Pay	62.009	61.955	(0.053)	456.327	459.955	3.628
Variance to Plan £m	0.753	0.613	(0.140)	0.000	0.000	2.385

## Progress against savings targets

The UHBs £31.245m savings target has been reduced by £5.150m to reflect the release of £2.1m relating to the UHBs remaining investment reserve and a further £3.050m to reflect an operational underspend on WEQAS. The target is now £26.095m. At month 7 the UHB had fully identified schemes to deliver against the £26.095m in year savings target.

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Unidentified) £m
Total £m	26.095	26.095	0.000

## Underlying deficit position

The underlying deficit position brought forward into 2018/19 was £36.3m. Successful delivery of the 2019/20 plan will reduce this to £4m by the year end. At month 7 there is a £6.6m shortfall against the recurrent savings plan.

## Creditor payment compliance

Non-NHS Creditor payment compliance was 96.8% for the 7 months to the end of June, achieving the 95% 30 day target.

## Remain within Capital expenditure resource limit

The UHB had an approved annual capital resource limit of £42.139m at the end of October. Capital expenditure for the first 7 months of the year was £19.579m against a plan of £19.920m.

## Cash

The UHB has a forecast year end cash surplus of £0.677m. The UHB cash balance at the end of October was £4.233m.

## What are our key areas of risk?

The key challenge for the UHB is now managing operational service pressures within delegated budgets.

## What actions are we taking to improve?

**Managing operational pressures** – Clinical Boards have identified recovery measures to deliver an improved financial position. In addition the UHB will need to carefully manage its corporate risks and opportunities. This work is ongoing and will continue until the UHB has assurances on the delivery of the financial plan.

## RECOMMENDATION:

The Board is asked to **CONSIDER** UHB current performance and the actions being taken to improve performance.

Cardiff and Vale University Health Board - Performance Dashboard - October 2019											
Measure	n	Mar-17	Mar-18	RAG rating	Mar-19	RAG rating	Oct-19	RAG rating	Latest Trend	Target	Time period
Purpose: For Our Population											
Strategic Objectives: All take responsibility for improving our health and wellbeing											
Uptake of influenza vaccination among high risk groups	1	>65: 68.5%, @risk: 48.1%, staff:52.9%	>65: 70.8%, @risk: 49%, staff:64.7%	A	>65: 70%, @risk: 44%, pregnant women 77.2%, staff:60.7%	A	>65: 44%, @risk: 14%, pregnant women 21.9%, staff:33.7%	A	↔	Green: Community: 75%, staff 60%; Amber (improvement on 16/17) - profile FYO >65: 70%, @risk: 52%, staff:50%	>65 & Staff as at Oct 19 Pregnant Women as at March 19
the 6 in 1 vaccine by age 1 & who received 2 doses of the MMR vaccine by age 5	2	81.2%	5 in1 : 94.7%, MMR2: 87.5%	A	6 in1 : 94.1%, MMR2: 91.2%	A	6 in1 : 94.0%, MMR2: 92.7%	A	↑	Target: 95%, amber = IMTP trajectory of 95% and 88.5%	Q1 19/20
Proportion of adults obese or overweight	3	54%	52%, Age std 54%	G	56%	R	56%	R	↔	reduction on previous year (54% 2012/13, 2013/14)	NSW 2016-18
% of adults consuming > 14 units of alcohol p. Wk (New measure)	4	42%	23% Age std 23%		21%	G	21%	G	↔	New measure - previous results relates to consumption above recommended units	NSW 2016-18
Proportion of adults meeting physical activity guidelines	5	60%	60% Age std 59%	A	58%	A	58%	A	↔	Target continuous reduction in % of adults who reported being physically active for more than 150 mins in the previous week	NSW 2016-18
% of C&V resident smokers who make a quit attempt via smoking cessation services - target 5%	6	0.7% to Q2	0.85% to Q2 17/18	R	1.2%	R	0.5%	R	↔	WG target 5% over course of full year	Q1 2019-2020
% C&V residents who are CO validated as successfully quitting at 4 weeks - measured annually - target 40%	7	67.0%	55.3% Q2 17/18	G	50.4%	A	59.0%	G	↑	Tier 1 target 40%,	Q1 2019-2020
Rate of conceptions among females under 18	8	Cardiff 27.5 per 1000, Vale 15.8 per 1000	Cardiff 27.5 per 1000, Vale 19 per 1000	A	Cardiff 21.2 per 1000, Vale 13.6 per 1000	G	Cardiff 21.2 per 1000, Vale 13.6 per 1000	G	↔	reduction on previous year	2017 (Annual)
Strategic Objectives: Deliver outcomes that matter to people											
Crude Hospital Mortality Rate for people aged less than 75	9	0.60%	0.62%	G	0.59%	G	0.53%	G	↑	12 Month Improvement Target (18/19 was 0.59, 12M to Jun-18 :0.6%)	12 months to Aug-19
Emergency crude mortality rate (12 mth)	10	3.05%	3.05%	G	2.81%	G	2.75%	G	↑	Reduction in CMR (12M to June-18 = 3.08%)	12 months to Aug-19
Demonstrable reduction in the mortality rate for stroke, heart attack and fractured neck of femur patients (30 day post event, 12 mth) - based on primary ICD-10 code	11	stroke 11.2%, heart attack 3.7%, #NOF 6.1%	stroke 12.5%, heart attack 3.8%, #NOF 8.1%	A	stroke 12.2%, heart attack 4.8%, #NOF 8.6%	A	stroke 11.9%, heart attack 4.2%, #NOF 8.7%	A	↔	Demonstrable reduction in rolling 12 month rate (2017/18: 12.8%,8.7%, 7.2%)	12Mths to July-19
% Universal mortality reviews undertaken within 28 days of a death	12		71%		78%	R	76%	R	↓	NEW MEASURE from April-17 - Target is 95%, IMTP trajectory= 83%	Sep-19
National Patient experience survey	13	87%	87%	A	97%	G	95% UHL, 94% UHW	G	↔	% of pts responding who rated overall experience of care as 8/10 or above (Green 90%)	National patient experience report Aug-19
Proportion of formal complaints responded to within 30 working days	15	43%	74%	A	74% (78% for 2018/19)	A	88% (78% for 2018/19)	A	↓	Green: 80%, Amber sustainable improvement from 40-50% range	Monthly in performance up to 31/7/19



Cardiff and Vale University Health Board - Performance Dashboard - October 2019												
	Measure	n	Mar-17	Mar-18	RAG rating	Mar-19	RAG rating	Oct-19	RAG rating	Latest Trend	Target	Time period
	Strategic Objectives: Reduce health inequalities											
Reduce health inequalities	Life expectancy at birth	16	80.8	Cdf- F: 82.6, M:78.4, V- F: 83.5, M: 78.8	G	Cdf- F: 82.7, M:78.5, V- F: 83.4, M: 78.9	G	Cdf- F: 82.7, M:78.5, V- F: 83.4, M: 78.9	G	↔	Continuous Improvement (June-18 figures updated)	2015-17
	Reduce infant mortality for population	17	3.9 per 1,000 live births	2.8 per 1,000 live births	G	3.8 per 1,000 live births	G	3.8 per 1,000 live births	G	↔	reduction on 2015 rate (3.9)	ONS (2017)
	% live births with a birth weight of less than 2500g	18	5.90%	5.98%	G	6.10%	A	6.6%	A	↔	12 mth cumulative reduction on previous year (5.9%)	Aug-19
	Rate of hospital admissions with any mention of intentional self harm for children and young people per 1000 popn (New measure)	19	387	3.5	G	3.4	G	3.4	G	↔	Annual reduction from 3.6 in 16/17, 3.87 in 15/16 & 4.33 in 14/15	Year 17/18
	Reduction in the number of emergency hospital admissions for basket of 8 chronic conditions per 100k popn	20	1089	1020	A	1036	A	1113	R	↓	reduction against same 12 month period of previous year (1021)	12M to Jul-19
	Reduction in the number of emergency hospital readmissions within a year for basket of 8 chronic conditions	21	196	202	A	176	G	187	G	↔	reduction against June-May 2018 =202	12M to Jul-19
	Emergency admission for hip fractures (age-standardised, 65+ per 100,000 people) (Revised Populations applied)	22	554.8	583.7	A	547	A	571	A	↔	reduction on previous year (545 per 100,000 conf limit+/-54)	12 months to May-19

Cardiff and Vale University Health Board - Performance Dashboard - October 2019											
Measure	n	Mar-17	Mar-18	RAG rating	Mar-19	RAG rating	Oct-19	RAG rating	Latest Trend	Target	Time period
Purpose: Our Service Priorities											
Strategic Objectives: Offer services that deliver the population health our citizens are entitled to expect											
Delivery of the 31 day (Non- USC) and 62 day (USC) cancer access standards	23	97% NUSC, 83% USC	98.3% NUSC, 86.8% USC	R	96% NUSC, 84% USC	R	99% NUSC, 94% USC	R	↑	Green Tier 1: 98 % NUSC, 95% USC, Amber IMTP trajectory Q3 = 98% & 92%	Sep-19
Primary care contractor professionals assurance status	24	Satisfactory	Managerial Intervention Required	A	2 contract terminations · 0 new sustainability applications · 4 temporary list closures	G	0 contract terminations · 0 new sustainability applications · 0 temporary list closures	G	↔	Present internal assessment of C&V GP sustainability position - text relates to Q1 2019/20 events	as at 31/10/19
% GP Practices offering appointments between 17:00 and 18:30 on 5 days a week	25	88%	88%	G	88%	A	94%	G	↔	Improvement target (2017 - 88%)	2018
% people (aged 16+) who found it difficult to make a convenient GP appointment	26						45%	R	↓	New measure: Annual reduction on 41.6% in 2017/18	2018/19
% HB population regularly accessing (within 2 years) NHS primary dental care	27						56%			New measure - quarterly improvement trend - baseline 56.1% in Dec-18	Dec-18
Dementia Bundle: Diagnosis rates, Access & training	28	Diagnosis: 58% Access: 98%, Training: 30%	Diagnosis: 63% Access: 99%, Training: 32%	G	Diagnosis: 63% Access: 99%, Training: 23%	R	Diagnosis: 63% Access: 97%, Training: 23%	R	↔	Target: Diagnosis improvement in proportion >65years diagnosed with dementia, Access attain 95% memory patients seen within 14 weeks, Trainingimprovement in %GP practices that completed MH DES in dementia care	Diagnosis Yr 17/18, Access: Oct-19, Training Year 17/18
% of people over 65 who are discharged from hospital and referred to a care home and not their usual place of residence	29	3.00%	3.30%	A	3.37%	A	3.14%	A	↔	Demonstrable reduction in rolling 12 month rate (2017: 3.29) - Amber remain in SPC limits (p_mean = 3.09, UCL 4.2%)	12 months to Sep-19
Sustained compliance against four acute stroke bundles	30	1: 40%, 2: 96%, 3: 64%, 4: 79%	1: 23%, 2: 90%, 3: 60%, 4: 92%	R	1: 42%, 2: 96%, 3: 64%, 4: 90%	A	1: 54%, 2: 92%, 3: 78%, 4: 92%	A	↔	Amber: Continuous improvement Green: UHB IMTP trajectory	Monthly performance in May-19

Cardiff and Vale University Health Board - Performance Dashboard - October 2019											
Measure	n	Mar-17	Mar-18	RAG rating	Mar-19	RAG rating	Oct-19	RAG rating	Latest Trend	Target	Time period
Purpose: Sustainability											
Strategic Objectives: Offer services that deliver the population health our citizens are entitled to expect											
Number of new serious incidents & % assured within agreed timescale	31	206 serious incidents, 39 no surprises	240 Sis, 31 no surprises - 52% assured in timescale	A	336 Sis, 27 no surprises -27% assured in timescale	R	301 Sis, 37 no surprises - 44% assured in timescale	R	↑	No. of Sis: reduction in year (231 Sis in17/18, 336 Sis in 18/19) , Timeliness for assurance : 90%	No. of Sis: 12M to Aug-19, Timeliness Jun-19
% patients with a positive screening for sepsis in both inpatients and emergency A&E who have received all 6 elements of the 'sepsis six' bundle within 1 hour.	32	64.9%	Jan-18: 55%, YTD 66%	A	18/19: 79%	G	76% Inpatient, 47% emergency	A	↔	Continuous improvement target (last 12 months 67%, 18/19: 79%)	April-Sep 2019
Reduction in number of patients who had a potentially preventable Hospital Acquired Thrombosis (VTE) up to 90 days post discharge	33		10 potentially preventable, 0 to be reviewed		5 potentially preventable	G	5 potentially preventable	G	↔	rolling 12 mth reduction in preventable HATs post level 2 Root Cause Analysis	Nov18-Oct'19
% of nutrition score completed and appropriate action taken within 24 hours of admission	34	94%	95%	G	95%	G	95%	G	↑	Green: 95%, Amber 90%	Oct-19
Patient environment: Credits 4 cleaning scores for high risk areas	35	Very high risk: 98.1% High risk: 97.0% Significant risk: 96.7%	Very high risk: 98.2% High risk: 96.7% Significant risk: 96.8%	G	Very high risk: 98% High risk: 97% Significant risk: 95%	G	Very high risk: 99% High risk: 98% Significant risk: 95%	G	↑	Very high risk: 98% High risk: 95% Significant risk: 85%	Monthly snapshot for Oct 19
% compliance with Hand Hygiene (WHO 5 moments)	36	94%	94%	R	96%	A	93%	A	↔	Green: 100%, Amber:>95%	Monthly snapshot for October 19
Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA ), working towards a zero tolerance	37	13.7 C difficile cases; 10.6 S. aurea cases	115 C difficile cases; 140 S. aurea cases; 316 E. coli cases	R	107 C difficile cases; 171 S. aurea cases; 335 E. coli cases	R	57 C difficile cases; 48 S. aurea cases; 235 E. coli cases	A	↔	WG target: tbc (M5 18/19: c-diff:50, s-aureas: 66, e-coli:156)	Apr 19 to Oct 19
Reduction in the number of healthcare acquired pressure ulcers	38	M10 = 577 MA(12) = 55	M10 = 1119 MA(12) =107	R	Data quality issue identified		Data quality issue identified			10% reduction on previous year (2015/16 avg = 34.4, target = mthly average of 31) {source:FOC}	
Financial balance: remain within revenue resource limits	39	£29.717m deficit at M11	£25.502m deficit at M11	R	£9.873m deficit at month 12. £0.027m favourable variance against plan	R	£2.385m deficit at month 7.	R	↔	2019/20 Break-Even	M7 2019-20
Reduction in Underlying deficit	39a				£36.3m assessed underlying deficit position at month 12	R	£6.6m shortfall against the recurrent savings plan target at month 7 (see below).	R	↔	If 2019/20 plan achieved reduce underlying deficit to £4.0m	M7 2019-20
Delivery of recurrent £16.345m 2% devolved target	39b				Fully Identified Savings Plan	G	£16.345m in year schemes identified at Month 7. £ 2.1m shortfall against recurrent schemes.	R	↔	£16.345m	M7 2019-20
Delivery of £10.0m recurrent/non recurrent corporate target	39c					G	£9.750m in year schemes identified at month 7. £4.5m shortfall against recurrent schemes	R	↔	£10.0m	M7 2019-20

# Cardiff and Vale University Health Board - Performance Dashboard - October 2019

Measure	n	Mar-17	Mar-18	RAG rating	Mar-19	RAG rating	Oct-19	RAG rating	Latest Trend	Target	Time period
Remain within capital resource limits.	40				Expenditure at the end of the Year was £48.413m against a plan of £48.486m.	G	Expenditure at the end of October was £19.579m against a plan of £19.920m.	G	↔	Approved planned expenditure £40.030m	M7 2019-20
Creditor payments compliance 30 day Non NHS	40a				Cumulative 95.0% in March	G	Cumulative 96.8% in October	G	↑	95% of invoices paid within 30 days	M7 2019-20
Remain within Cash Limit	40b				Cash surplus of £1.219m	G	Forecast cash surplus of £ 0.677 m	G	↔	To remain within Cash Limit	M5 2019-20
Maintain Positive Cash Balance	40c				Cash balance = £1.219m	G	Cash balance = £4.233m	G	↔	To Maintain Positive Cash Balance	End of August
Number of procedures undertaken that are on the UHB's "Interventions not normally undertaken" list for procedures of limited clinical effectiveness	41	5528	5197	A	6861	A	6699	A	↔	NEW INNU list adopted from August 2018: 12 month rolling reduction (Aug17-Jul18 : 6798)	12mth to 31/7/19
Reducing outpatient did not attend rates for New and Follow Up appointments	42	N 10.2%, 11.8%	N:10.1%, FU 12.2%	R	N:9.6%, FU 10.7%	A	N:9.7%, FU 10.5%	A	↔	12 month rolling reduction- 16/17 New DNA 10.2%, FU 11.9%	12mths to Oct-19
Increasing in-session theatre utilisation (adopting Newton measure)	43	72%	75%	A	75%	A	79%	A	↔	Newton consulting set standards: green >= 85%, amber 67%-85%, red <=67%	Oct-19
Uptake of ERAS across whole HB.	44	Programme has stalled	Refresh being planned as part of TTC	R	Case for acceleration submitted for transformation funding	A	£750k funding secured, resources being attained	A	↑	Self assessment based on roll out plan agreed with WG	Sep-19
Ensure that the data completeness standards are adhered to within 1 month of the episode end date	45	95.8% within 30 days	94.9%	A	97.3%	G	96.1%	G	↑	95% within 30 days	Sep-19
<b>Strategic Objectives: Have a planned care system where demand and capacity are in balance</b>											
Number of procedures postponed either on the day or day before for specified non clinical reasons	46	28%	37%	R	2070	A	2006	R	↔	WG target: 5% reduction on 2018/19 figure = 1967 , amber continual improvement	12 Mths to 31/7/19
Part 1 Local Primary care Mental Health Support Services (% assessed within 28 days & therapy started within 28days)	47	78% (assessment), 86% (therapy)	83% (assessment), 79% (therapy)	A	75% (assessment), 71% (therapy)	R	80% (assessment), 80% (therapy)	G	↑	80% within 28 days for assessment, 80% within following 28 days for therapy	Monthly snapshot for September-19
Part 2 Coordination of care and treatment Planning for secondary Mental Health Users (% of users with a care and treatment plan)	48	91.0%	90.1%	G	85.0%	A	76.0%	R	↓	90% - NB data quality issues	Monthly snapshot for September-19
Part 3 % of former users of secondary mental health services who are assessed under part 3 of the measure, who received their outcome assessment report within 10 days	49	100%	100%	G	100%	G	data quality issues	R	↓	Green: 100%, Amber: Continuous improvement as new standard	
Part4 Mental Health Advocacy (Provision of an advocate to all eligible requesting users)	50	100%	100%	G	100%	G	100%	G	↔	100%	Sep-19
% of children waiting less than 26 weeks to start ADHD / ASD neurodevelopment assessment	51				76%	R	54%	R	↓	New target- target 80%	Sep-19
% patients waiting less than 26 weeks to start a psychological therapy	52		29%	R	21%	R	81%	G	↓	New target- target 80%	Sep-19

# Cardiff and Vale University Health Board - Performance Dashboard - October 2019

Measure	n	Mar-17	Mar-18	RAG rating	Mar-19	RAG rating	Oct-19	RAG rating	Latest Trend	Target	Time period
% of high risk (R1) ophthalmology patients waiting 25% beyond their target date for an OP appointment	53				51%	R	59%	R	↔	New target- target 95%	Monthly snapshot for Oct-19
Number of patients waiting for a follow up & no. delayed by >100%	54				#: 235,000 delayed >100%: 78,000	R	#: 234,649 delayed >100%: 76,652	R	↑	Targets: 15% redn in total no.= 196,640. 15% redn on nop. Delayed >100%. Target: 66,739	Snapshot at Oct-19
95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks	55	83% <26 weeks, 2720pts > 36 wks	84% <26 weeks, 2921pts > 36 wks	A	86% <26 weeks, 327pts > 36 wks	A	85% <26 weeks, 683pts > 36 wks	R	↓	95% <26 wks, 0 > 36 wks: Amber: Achieve quarterly IMTP milestone	Snapshot at Oct-19
<b>Strategic Objectives: Have an unplanned (emergency) care system that provides the right care, in the right place, first time</b>											
Attainment of the primary care out of hours service standards	56	6 Green, 6 Amber, 5 Red	8 Green, 1 Amber, 8 Red	R	6 Green, 4 Amber, 7 Red	R	6 Green, 3 Amber, 5 Red	A	↔	Number of standards where the UHB is compliantn.b. Standards changed in March 19	Monthly performance in Oct-19
Deliver the 70% Cat A 8 minute response times all Wales target on a rolling 12 month basis and sustain the 65% Health Board target on a monthly basis	57	82%	82%, 83% for 12 mths	G	78%, 81% for 12 mths	G	71.7%, 76.7% for 12 mths	G	↓	70%	Upto Oct-19
95% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge	58	84%	75%	R	84%	R	82%	R	↓	WG target: 95%,	Monthly performance in Oct-19
Eradication of over 12 hour waits within all hospital emergency care facilities	59	59	290	R	34 in month, 301 in Q4	R	173 Oct, 139 in Sept	R	↓	WG target: 0, IMTP trajectory: 175 for Q4	to Oct-19
% critical care bed days lost due to delayed transfers of care	60				6.30%	R	11.00%	R	↑	Quarter on quarter improvement & <=5%	Jul to Sep-19

Cardiff and Vale University Health Board - Performance Dashboard - October 2019											
Measure	n	Mar-17	Mar-18	RAG rating	Mar-19	RAG rating	Oct-19	RAG rating	Latest Trend	Target	Time period
Purpose: Culture											
Strategic Objectives: Be a great place to work and learn											
Percentage of staff (excluding medical) undertaking PADR (Performance Appraisal Development Review)	61	58%	59%	R	55%	R	54%	R	↔	Green: >85%, Amber 68-84%, Red <68%	Sep-19
Medical Staff – percentage of staff undertaking Performance Appraisal	62	74.4%	77.0%	A	74%	R	80%	R	↓	Green: 85%, Amber: increase from Mar-18 position of 77%	Q1 2019/20
% staff who would be happy with care by their organisation oif friend / relative needed treatment	63				79%		79%			Improvement on the 2018 79% baseline	2018 Survey
Overall measure for organisational climate / engagement	64	3.64/5	3.64/5	A	3.85/5	A	3.85/5	A	↑	Bi-Annual	2018 Survey
Achieve annual local sickness and absence workforce target	65	4.86%	5.12%	R	5.11%	R	4.97%	R	↑	12 month rolling reduction from 5.12% Mar-18,	Sep-19
Retain platinum corporate health standard	66	Achieved	Achieved	G	Achieved	G	Achieved	G	↔	Re-assessed as meeting standard	2017/18
Strategic Objectives: Work better together with partners to deliver care and support across care sectors, making best use of our people and technology											
Ambulance handover times: % within 15 and 60 minutes	67	15 mins: 49%, 60 mins: 90%	15 mins: 31%, 60 mins: 71%	R	15 mins: 50%, 60 mins: 92%	R	15 mins: 33%, 60 mins: 87%	R	↔	15 mins: 60%, 60 mins: 100% (Amber: IMTP trajectory for 60 mins requires c. 94%)	Monthly performance in Aug-19
No. of Delayed transfers of care – mental health (all ages) and non mental health (75 years and over)	68	29 NMH, 17 MH	32 NMH, 14 MH	A	32 NMH, 5 MH	A	42 NMH, 4 MH	A	↓	IMTP trajectory is 7 MH, 28 NMH	Monthly snapshot for Sep-19
Progress in Delivering Strategic Programme	69	Slippage on aspects due to changing financial posn	Transformation programme accelerating	A	2nd transformation bid to accelerate progress submitted	A	Putting resources in place - recruitment is progressing	A	↔	Sustained improvement	Assessment at Oct-19

<b>Report Title:</b>	<b>Transformation Update</b>						
<b>Meeting:</b>	<b>Board</b>				<b>Meeting Date:</b>	28 November 2019	
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>	✓	<b>For Approval</b>		<b>For Information</b>
<b>Lead Executive:</b>							
<b>Report Author (Title):</b>	<b>Stephen Parnell – Assistant Director Improvement &amp; Implementation</b>						

## SITUATION

Transforming services is a key part of the work of all clinical boards and corporate areas. Working together we can provide the services that our patients and communities should come to expect from a modern health service.

The newly formed Improvement and Implementation Team play an important part in the Transformation journey of this health system. The report provides a summary of the following 4 areas of work that the team have been leading on, working towards progressing the transformation agenda across the whole system.

- HealthPathways
- Major Improvement Project - Elective Spinal Pathway
- Visual Management
- Spread & Scale Academy
- 

## BACKGROUND

The Improvement and Implementation Team is a new team made up of the former Continuous Service Improvement Team and the former Programme Management Office. This enthusiastic and energetic team works across the UHB and have a wealth of knowledge about Quality Improvement and Project Management to support the Transformation ambitions of Clinical Boards and the Health System as a whole.

In addition to the four areas detailed below, the team supports the development and implementation of a wide range of projects and change initiatives across the organisation including outpatients, spinal pathways, falls prevention and medicines management.

### HealthPathways

Moving into its eighth month since going live HealthPathways continues to grow in interest and content with over 60 pathways live at the time of writing and 15,000 hits on the site. Phase 2 of the project is now in full swing with the editing team fully trained and working to capacity.

The first Clinical Working Group meeting has taken place with Gynaecology, the approach was well received and will result in the production of at least six pathways being developed with the service. In addition to this, the Working Group provides a platform for development of relationships between primary and secondary care through the shared working and making an important contribution to building relationships as a key part of the programme.

The CAV HealthPathways Team have not only formed strong links with the other 3 HealthPathways



sites in the UK, but also to the other sites and regions in Australia and New Zealand through active participation in the HealthPathways Regional Forum.

The prioritisation exercise to determine of the pathways to be developed between now and July 2020 has now been concluded, with priority areas from primary care, secondary care and strategically important pathways allocated for development. Once agreed, the prioritisation will be communicated across the organisation.

### **Major Improvement Project**

The Improvement and Implementation Team have been commissioned to facilitate a whole of pathway improvement project for elective spinal patients. The scope of this project will follow a patient from initial GP referral to the patients being moved to the recovery area post operation. This project will incorporate the new improvement methodology developed by the Improvement and Implementation Team, Signals from Noise (SfN), by developing a SfN viewer for the spinal pathway and Value Based Healthcare & PROMS.

The project is currently in the 'Assess' phase in which evidential data is being collected, including process observations in clinics and theatres. An 'Assess Report' meeting is to be held, at which all stakeholders within the pathway and other interested parties will be invited to attend. The service project lead, supported by the Improvement and Implementation Team will present the findings and highlight the key issues and opportunities for improvement across the pathway. Finally the 'Assess Report' will highlight areas for improvement which will move the project into the next phase 'Diagnose'

### **Visual Management**

The three main elements of visual management that the team are currently implementing are:

1. Incorporation of Signals from Noise into the improvement methodology, ensuring that SfN viewers are built for each major project, this will give clinicians a view of their part of the system enabling real time decision making. This will also include PROMs measures.
2. Building information rooms/walls for Executive and Clinical Boards, displaying high level KPIs to highlight key business conditions.
3. Displaying key projects in the information rooms/walls to indicate project progress.

Currently the Executive Management Team are designing KPIs around four main themes:

- a. Patient Safety & Quality
- b. Patient Access
- c. Workforce
- d. Financial Stability

It is then planned to roll this out to Clinical Boards and finally Directorates. This integrated system will then allow information to flow upwards and ensure support is directed to relevant areas should it be needed to regain control of wayward measures.

Initially this will be a paper based system, however, it is hoped that this can be electronic in the future.

### **Spread & Scale Academy**

From Monday 30<sup>th</sup> September to Thursday 3<sup>rd</sup> October, Cardiff and Vale UHB, Life Sciences Hub

Wales and the Bevan Commission ran 'The Spread and Scale Academy' with support from the South West Academic Health Science Network (SWAHSN).

Seventeen Teams from across the Health Sector in Wales attended the Academy, an intensive programme of training designed to widen the reach of developed improvement and innovation projects; giving the teams the tools to lead adoption at scale. It was delivered by the Billions Institute, which pioneered the four stage 'Model for Unleashing'.  
The 58 participants, 35 from the UHB, provided extremely positive feedback and have put 90 day plans in place to work towards their 18-36 month aims.

Following discussion and agreement at the Spread & Scale Leadership day a second Spread & Scale Academy is planned for March 2020 with applications opening across Wales in December 2019. See Appendix one for further information.

## ASSESSMENT

Much activity has been undertaken in the four areas where updates were requested. The Improvement and Implementation Team have designed an integrated a process which has incorporated the improvement and project management methodology as part of the Cardiff & Vale Way. The team would like to present this to HSMB at the earliest opportunity and keep HSMB informed of the progress of the spinal pathway project and of the project management system implementation.

## RECOMMENDATION

The Board is asked to:

- Note the progress so far on Transformation
- Request an update on Visual Management at the next meeting

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click [here](#) for more information

Prevention		Long term	✓	Integration	✓	Collaboration	✓	Involvement	
------------	--	-----------	---	-------------	---	---------------	---	-------------	--

**Equality and  
Health Impact  
Assessment  
Completed:**

Not Applicable

# Appendix One

## Spread & Scale Academy Update

Len Richards, CEO Cardiff & Vale UHB



### Introduction

From Monday 30<sup>th</sup> September to Thursday 3<sup>rd</sup> October, Cardiff and Vale UHB, Life Sciences Hub Wales and the Bevan Commission ran 'The Spread and Scale Academy' with support from the South West Academic Health Science Network (SWAHSN).

The Academy was an intensive programme of training designed to widen the reach of developed improvement and innovation projects; giving the teams the tools to lead adoption at scale. It was delivered by the Billions Institute, which pioneered the four stage 'Model for Unleashing'. The model recognises the need to shift mind-sets from a traditional management mind-set of "how can I get all these people to do what I want them to do?" to a better question of "how can I help all these people to do what **they** want to do?" It helps participants more effectively tap into the energy and creativity of hundreds or thousands of other people to get the health outcomes they seek.



The four day Academy was followed by a 'Spread & Scale Leadership Day' for senior leaders across Wales that provided an insight into the Spread & Scale Academy, the Model for Unleashing and the training provided by the Billions Institute. The day included a tailored interactive workshop and feedback from two teams who had taken part in the four day Academy.

**billions**  
institute

### Participants

Following a competitive application process 17 teams comprised of 58 participants were selected to attend the Academy. The participants represented the following organisations:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff Local Authority
- Cardiff & Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hafod
- Hywel Dda University Health Board
- NHS Wales Shared Services
- Public Health Wales
- Swansea Bay University Health Board
- Torbay and South Devon NHS Foundation Trust
- Welsh Ambulance Trust

Each of the teams bought an established improvement or innovation project to the Academy such as ‘improving the hydration of vulnerable patients’ and ‘improving patient access to appointments in primary care using the principles of prudent healthcare’. Through the Academy they each worked through eight learning objectives and left with a 90 day plan to start their spread efforts.

### Learning Objectives

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. Succinctly articulate your personal values and vision for the changes you seek</li> <li>2. Map the components of the system through which you are initiating change</li> <li>3. Choose your leverage points/end game</li> <li>4. Create a compelling 18-36 month aim</li> </ol> | <ol style="list-style-type: none"> <li>5. Choose a suitable “all teach, all learn” structure that unleashes external stakeholders</li> <li>6. Create a liberatory culture that unleashes your team</li> <li>7. Discover antidotes for the ways in which you will unconsciously self-sabotage your effort</li> <li>8. Gain clarity about the ways you can sustainably contribute to planetary transformation at scale</li> </ol> |
|---|---|

### Feedback and Evaluation

A comprehensive evaluation plan is in place that evaluates both the immediate impact of the Academy and also tracks the progress of the teams as they follow their 90 day plans and work towards their 18-36 month aims.

Evaluation during the event showed a significant increase in participants before and after scores when asked;

1. To what extent do you feel able to spread and scale your improvements/innovations?
2. To what extent do you feel you have the knowledge of how to spread and scale?
3. How likely do you think it is that you will be successful in scaling your improvement/innovation?

Feedback from participants was also overwhelmingly positive with quotes such as:



“I used to believe I needed high level authorisation but now realise it can be done from the shop floor”

“A huge mind shift in terms of having a new sense of self belief that large scale change is not just possible but I can be a leader of it.”

“I used to believe that leading large-scale change was impossible with too many factors and forces present to confound me. Now I feel I have the strategies, tricks and resilience to break through and work with teams

across a wider area and watch them take an idea and make it their own”

“I never thought I would come away with such a mind-shift – suddenly my aspirations are so much bigger and my belief that I can do this is so much stronger”

“Was completely caught up in hierarchy system etc. and feeling very stuck. Course has given me clarity and sanity has returned.”

A short video of the Academy can be found at the following link

[https://youtu.be/J3xFvUB\\_GRU](https://youtu.be/J3xFvUB_GRU). Short video soundbites with participants will be available online shortly and a Spread & Scale podcast with the Billions Institute and a number of the teams is being produced by Life Sciences Hub Wales.

### Next Steps

Following discussion and agreement at the Spread & Scale Leadership day a second Spread & Scale Academy is planned for March 2020 with applications opening across Wales in December 2019.

Cardiff and Vale UHB have agreed to allocate an Executive sponsor to each of the teams from the Health Board to provide support, particularly with unblocking barriers. Details of each organisations participants and teams will be sent out to other CEO's so support can be provided where appropriate.

Teams have been asked what further support would be useful and a programme is being developed based on this. This includes future events and access to a monthly coaching call with the Billions Institute faculty.

Discussions are underway with the SWAHSN to develop a UK based fellowship<sup>1</sup> which will mirror the Billions Institute Fellowship Programme in the USA. The fellowship will further develop and support leaders of Spread & Scale, provide UK based cross-regional support for teams to use the Model for Unleashing and support the delivery of future Spread & Scale Academies.

---

<sup>1</sup> Working title only – name to be agreed

<b>Report Title:</b>	Board Assurance Framework (BAF)						
<b>Meeting:</b>	UHB Board				<b>Meeting Date:</b>	28.11.19	
<b>Status:</b>	<b>For Discussion</b>	✓	<b>For Assurance</b>	✓	<b>For Approval</b>	✓	<b>For Information</b>
<b>Lead Executive:</b>	Director of Corporate Governance						
<b>Report Author (Title):</b>	Director of Corporate Governance						

## SITUATION

The Board Assurance Framework (BAF) was first presented to the Board in November 2018 for approval. It highlights the principle risks to the achievement of strategic objectives at Cardiff and Vale University Health Board.

The BAF provides a structure and process that enables the organisation to focus on those risks that might compromise the organisation achieving its most important objectives. It maps out the key controls for managing or mitigating those risks and confirms the assurances on the effectiveness of those controls.

The benefits of a working BAF are:

- A simple and comprehensive method for managing risks to achieve objectives
- It provides evidence to support the Annual Governance Statement
- It helps to simplify Board reporting and prioritisation which allows more effective performance management
- It provides assurances about where risks are being managed effectively and objectives delivered
- It allows the Board to determine where to make efficient use of resources
- It allows the Board to identify priorities and provides confidence that the organisation is able to understand its capacity to deliver.

The BAF is attached at Appendix A.

## REPORT

### BACKGROUND

The BAF has been developed by the Director of Corporate Governance to replace the CRAF which had previously received negative feedback from Wales Audit Office (WAO) regarding its complexity and the regularity in which it was updated and presented to the Board.

### ASSESSMENT

#### BAF

At the Board Meeting in November 2018 the six risks detailed below were agreed as the main risks to the achievement of Cardiff and Vale UHB's Objectives.



At the Board Meeting in March 2019 these risks were confirmed to still be the main risks facing the organisation during 2019/20.

1. Workforce
2. Financial Sustainability
3. Sustainable Primary and Community Care
4. Safety and Regulatory Compliance
5. Sustainable Culture Change
6. Capital Assets (including Estates, IT and Medical Equipment)

The above risks have been reviewed and updated by the Director of Corporate Governance and the Executive Lead for each individual risk.

Changes have been highlighted in red so the Board Members can see what has happened since the BAF was last presented to the Board in September 2019.

### Actions to improve Risk Management

In November 2018 the Director of Corporate Governance identified a number of further key actions which needed to be progressed to ensure that the organisation continued to develop robust risk management arrangements. Progress against these key actions can be seen below:

Action	Update
Report the new BAF process to the Audit Committee so the Committee can provide assurance to the Board	<b>Complete</b> - The new BAF was presented to the Audit Committee at the beginning of December 2018 and has been referenced in the WAO Structured Assessment 18/19.
Continue to develop and then update the BAF with Executive Directors to ensure it remains a dynamic and live document	<b>Complete</b> and continuing
Report individual risks on the BAF to the relevant Committees of the Board to allow the Committees to undertake a more detailed review and then provide assurance to the Board	<b>Complete</b> - This is now happening and Committees of the Board are reviewing risks which are relevant to their Committee to provide further assurance to the Board.
Assess the organisation's 'Risk Appetite'	<b>Complete</b> - A Board development day was held in April to assess the organisation's 'Risk Appetite'. This has now been included within the Risk Management and Board Assurance Framework Strategy presented to Board on 25 <sup>th</sup> July 2019.
Develop Risk Management and Board Assurance Framework Strategy.	<b>Complete</b> – presented to Board on 25 <sup>th</sup> July 2019
Development of Risk Management Procedure	<b>Complete</b> – A new procedure has been developed to support the Strategy approved by the Board on 25 <sup>th</sup> July. <b>Continuing</b> - The new procedure is currently being rolled out to Corporate Directorates and Clinical Boards with small training sessions being run by the Director of Corporate Governance.
Ensure that the work on the Corporate	<b>Continuing</b> - There will be a phased approach to

and Clinical Board Risk Registers is completed within a timely manner and then reported to the Board alongside the Board Assurance Framework	the development of the Corporate Risk Register which will include risks rated 15 and above from Corporate Directorates and Clinical Boards. This phased approach will be supported by a Risk Improvement Programme to ensure the way risk is approached across the UHB is consistent. This plan will be in line with the Risk Management and Board Assurance Framework Strategy presented to Board on 25 <sup>th</sup> July 2019.
First cut of Corporate Risk Register to be presented to the Private Board in November 2019	<b>Complete</b> - Clinical Boards and Corporate Directorates will be written to requesting that they provide their top 3/5 risks to the Director of Corporate Governance using the new template and scoring using the new procedure. The Corporate Risk Register will be reported to the HSMB prior to the Board.
Move to web based risk reporting	Action due by April 2020.

#### **ASSURANCE** is provided by:

- Discussion with Executive Directors on progress being made against the management and mitigation of risks which they lead upon on the BAF.
- Discussion with Executive Directors on the Corporate Risk Register and the work that now needs to take place to make this an effective document.

#### **RECOMMENDATION**

The Board is asked to:

- **APPROVE** the BAF and progress which has been made in relation to the actions, management and mitigation of the key risks to the achievement of objectives.

#### **Shaping our Future Wellbeing Strategic Objectives**

1.Reduce health inequalities	✓	6.Have a planned care system where demand and capacity are in balance	✓
2.Deliver outcomes that matter to people	✓	7.Be a great place to work and learn	✓
3.All take responsibility for improving our health and wellbeing	✓	8.Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4.Offer services that deliver the population health our citizens are entitled to expect	✓	9.Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5.Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✓	10.Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	✓

## Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term	✓	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:		Not Applicable							

Kind and caring  
Caredig a gofalgar

Respectful  
Dangos parch

Trust and integrity  
Ymddiriedaeth ac uniondeb

Personal responsibility  
Cyfrifoldeb personol

## BOARD ASSURANCE FRAMEWORK 2019/20 – November 2019

It is essential that Cardiff and Vale University Health Board is aware of the major risks which could impact upon the delivery of Strategic Objectives as set out in Shaping Our Future Wellbeing.

### Strategic Objectives

1. Reduce health inequalities
2. Deliver outcomes that matter
3. Ensure that all take responsibility for improving our health and wellbeing
4. Offer services that deliver the population health our citizens are entitled to expect
5. Have an unplanned care system that provides the right care, in the right place, first time.
6. Have a planned care system where demand and capacity are in balance
7. Reduce harm, waste and variation sustainably so that we live within the resource available
8. Be a great place to work and learn
9. Work better together with partners to deliver care and support across care sectors, making best use of people and technology
10. Excel at teaching, research, innovation and improvement.

### Principle Risks

Risk	Gross Risk	Net Risk	Target Risk	Context	Executive Lead	Committee
1. Workforce	25	15	10	Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Executive Director of Workforce and OD	Strategy and Delivery Committee
2. Financial Sustainability	25	20	5	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future.	Executive Director of Finance	Finance Committee

3. Sustainable Primary and Community Care	20	15	10	<p>The strategy of “Care closer to home” is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.</p>	Chief Operating Officer	Strategy and Delivery Committee
4. Safety and Regulatory Compliance	16	12	4	<p>Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board.</p> <p>Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.</p>	Executive Nurse Director	Quality, Safety and Experience
5. Sustainable Culture Change	16	8	4	<p>In line with UHB’s Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.</p>	Executive Director of Workforce and OD	Strategy and Delivery Committee
6. Capital Assets (Estates, IT Infrastructure, Medical Devices)	25	20	10	<p>The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.</p>	Executive Director of Strategic Planning, Deputy Chief Executive, Executive Director of Therapies and Health Science	Strategy and Delivery Committee, IG & T Committee, Quality, Safety and Experience Committee

## 1. Workforce

Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff.

<b>Risk</b> <b>Date added:</b> 12.11.2018	There is a risk that the organisation will not be able to recruit and retain a clinical workforce to deliver high quality care for the population of Cardiff and the Vale		
<b>Cause</b>	Increased vacancies in substantive clinical workforce Requirements of the Nurse Staffing Act and BAPM Standards Ageing workforce Insufficient supply of Nurses at UK national level High nurse turnover in Medicine and Surgery Clinical Boards Insufficient supply of Doctors in certain specialties at UK national level (e.g., Adult Psychiatry, Anaesthetics, General Medicine, Histopathology, Neurosurgery) Changes to Junior Doctor Training Rotations (Deanery) Brexit		
<b>Impact</b>	Increase in agency and locum usage Increase in costs of using agency and locum Impact on quality of care provided to the population Rates above Welsh Government Cap (Medical staff) Low Staff moral and sickness Poor attendance at statutory and mandatory Training Potentially inadequate levels of staffing		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	<b>25 (Extreme)</b>
<b>Current Controls</b>	Project 95% Nurse Recruitment and Retention Programme Medical international recruitment strategies (including MTI) Recruitment campaign through social media with strong branding Job of the week Staff engagement with recruitment drive Programme of talent management and succession planning Values based recruitment Medical Training Initiative (MTI) 2 year placement scheme Comprehensive Retention Plan introduced from October 2018 Nurse Adaptation Programme commenced October 2018 Plan in place for recruitment of overseas nurses Social Media Campaign and Open Days		
<b>Current Assurances</b>	Workforce metrics reported to Strategy and Delivery Committee High conversion rates from media campaign and Open Day Highest percentage of students in Wales applied to Cardiff and Vale UHB (23.2%) Nurse monitoring at Nurse Productivity Group (NPG) Medical monitoring at Medical Workforce Advisory Group (MWAG) Trajectory showing next vacancies in nursing Paediatric Surgery now fully established A & E fully established by February 2019 Extra capacity put in place to deal with winter pressure – winter ward Student streamlining produced the biggest intake in Wales due to the way C&V recruit students and engagement. <b>End of year establishment was at 96% with some outliers in Medicine and Surgery CBs</b>		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	<b>15 (Extreme)</b>
<b>Gap in Controls</b>			
<b>Gap in Assurances</b>			

Actions	Lead	By when	Update since 26.09.2019
1. Internal Nurse Transfer Scheme	RW	31/08/2019	This is due to start in September 2019 – <b>scheme has commenced</b>
2. New social media campaign being developed for working on the bank	MD/JB	31/07/2019	Media Campaign due to be launched shortly – <b>action complete</b>
3. Nurse recovery plan for Medicine and Surgery as part of financial recovery plan and business case for international recruitment	SC	30/06/2019	Plan in place with 2 <sup>nd</sup> part of International Nurse Recruitment approved. This will continue until January 2020. Financial Savings still being monitored – <b>action ongoing</b>
4. To consider how resources are used going forward in nursing	SC	31/03/2020	Resources being considered alongside bed occupancy plans – <b>action ongoing</b>
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	<b>10 (High)</b>



## 2. Financial Sustainability

Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent Healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future.

<b>Risk</b> <b>Date added:</b> 20.05.2019	There is a risk that the organisation will not be able to deliver its ambition within the approved plan with Welsh Government		
<b>Cause</b>	Budgets overspent <b>at month 6 by £2.817m plan to breakeven in 2019/20 is in place</b> (two Clinical Boards currently in escalation) Cost Improvement Programme not yet identified in all areas Significant nursing overspend Reduction in income received		
<b>Impact</b>	Unable to deliver approved plan with Welsh Government Reputational Loss		
<b>Impact Score: 5</b>	Likelihood Score: 5	Gross Risk Score:	<b>25 (Extreme)</b>
<b>Current Controls</b>	Full savings programme and financial improvement plan in place Finance Committee meets monthly and formally reports into the Board Performance Meetings held monthly with Clinical Boards Financial performance is a standing agenda item monthly on Management Executives Meeting Standing Financial Instructions in place with clear delegations of authority		
<b>Current Assurances</b>	Performance Meeting outcomes reported monthly to Management Executives Clinical Boards placed in escalation where not meeting budget or agreed financial forecast Finance report presented to every Finance Committee Meeting demonstrating progress and reporting variances		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	<b>20 (Extreme)</b>
<b>Gap in Controls</b>	No gaps currently identified.		
<b>Gap in Assurances</b>	Not all Clinical Boards or Corporate have a CIP in place recurrently		

Actions		Lead	By when	Update since 26.09.2019
1. Clinical Boards in escalation to recover the position and CIP		RC	<del>30/06/2019</del> 31/03/2020	Clinical Boards have produced recovery plans which have been Performance Reviewed and reported to Finance Committee. CB plans continue to be monitored and progressed
2. Investments on hold, pending identification of future savings schemes, to meet corporate affordability gap		RC	<del>30/06/2019</del> 31/03/2020	Action still stands The plans are to remove the year to date deficit and deliver a break even position by year end.
Impact Score: 5	Likelihood Score: 1	Target Risk Score:		<b>5 (moderate)</b>

### 3. Sustainable Primary and Community Care

The strategy of “Care closer to home” is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.

<b>Risk</b> <b>Date added:</b> 12.11.2018	The risk of losing resilience in the existing service and not building the capacity or the capability of service provision in the Primary or Community care setting to provide the necessary preventative and responsive services.		
<b>Cause</b>	Not enough GP capacity to respond to and provide support to complex patients with multiple co-morbidities and typically in the over 75 years age bracket. GP's being drawn into seeing patients that could otherwise be seen by other members of the Multi-disciplinary Team. Co-ordination of Health and Social Care across the communities so that a joined up response is provided and that the patient gets the right care. Poor consistency in referral pathways, and in care in the community leading to significant variation in practice. Practice closures and satellite practice closures reducing access for patients. Lack of development of a multidisciplinary response to Primary Care need. Significant increase in housing provision		
<b>Impact</b>	Long waiting times for patients to access a GP Referrals to hospital because there are no other options Patients turning up in ED because they cannot get the care they need in Primary or Community care. Poor morale of Primary and Community staff leading to poor uptake of innovative solutions Stand offs between Clinical Board and Primary care about what can be safely done in the community Impact reinforces cause by effecting ability to recruit		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	20 (red)
<b>Current Controls</b>	Me, My Home , My Community Signals from Noise to create a joined up system across Primary, Community, Secondary and Social Care. Development of Primary Care Support Team Contractual negotiations allowing GP Practices to close to new patients Care Pathways		
<b>Current Assurances</b>	Improved access and response to GP out of hours service Sustainability and assurance summary developed to RAG rate practices and inform action Three workshops held to develop way forward with engagement of wider GP body in developing future models. Leading to the development of Mental Health and Risk Care Models at scale being implemented.		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	15 (red)
<b>Gap in Controls</b>	Actively scale up multidisciplinary teams to ensure capacity Achieving scale in developing joint Primary/Secondary Care patient pathways Recruitment strategies to sustain and improve GP availability and develop multidisciplinary solutions		

<b>Gap in Assurances</b>		No gaps currently identified.		
Actions		Lead	By when	Update since 26.09.2019
1. Health Pathways – to create a protocol driven of what should and can be done in Primary care/Community care.		SC	31/03/2020	Health pathways launched on 14/02/2019. As at 07/05/2019 32 pathways were live. Pathways will continue to be developed until the end of the financial year <b>60 pathways are now active. Chief Operating Officer has met with partners in New Zealand who are rolling it out.</b>
2. Roll out of Mental Health and MSK MDT's to reduce the primary care burden on GP's		SC	31/01/2019  31/03/2020	Roll out commenced and plan continue to be monitored through GMS Sustainability Implementation Board Continue roll out at scale until the end of the financial year <b>Completion likely to be between last quarter of this financial year and first quarter of next financial year.</b>
3. Roll out digital solutions for smart working		DT	31/03/2020	Platform procured-phased roll out plan to be implemented with completion due by end of the financial year
4. Other digital platforms being considered e.g. Primary Care CAHMS Assessment platform being deployed		SC	31/10/2019	<b>Digital Platform now been agreed for CAHMS</b>
5. Development of recruitment strategies for GP and non GP service solutions		MD	Ongoing	GP Support Unit helps with recruitment and finding GP alternatives action also lined to No 2 above. As an indicator of in hour's resilience GP fill rates for PC out of hour's service have improved leading to a lower escalation status. The focus on a multi-disciplinary solution continues.
6. Develop Health and Social Care Strategies to allow seamless solutions for patients with health and or social needs		SC	Ongoing	<b>These are being developed through the Public Service Board and Transformation work</b>
Impact Score: 5		Likelihood Score: 2		Target Risk Score: <b>10 (high)</b>

#### 4. Safety and Regulatory Compliance

Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board.

Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and feedback. Undertaking a high quality level of investigation to identify the root causes. Implementing solutions to minimise/mitigate the risk of them recurring.

<b>Risk</b> <b>Date added:</b> 12.11.2018	There is a risk that systems of safety and regulatory compliance are potentially not as robust as they could be and this has been demonstrated by the HTA Review, poor decontamination systems and the commissioning of services outside the Health Board which were not of a high quality.		
<b>Cause</b>	Non-compliance with regulatory or statutory requirements Non-compliance with effective decontamination processes to support the delivery of high quality patient care Appointment of contractor without required quality checks being in place to ensure service delivered was of a high standard		
<b>Impact</b>	Harm and distress caused to patients and their families Reputational damage to the Health Board Increase in clinical claims Financial consequences		
<b>Impact Score: 4</b>	Likelihood Score:4	Gross Risk Score:	<b>16 (Extreme)</b>
<b>Current Controls</b>	Human Tissue Act HTA Licencing Standards Statutory Designated Individual in post Clinical Board QSE arrangements; CD&T – regulatory compliance group Quality, Safety and Experience Committee in place supported by robust governance and reporting structure Office of Professional Leadership shares responsibility for Quality Agenda (Medical Director, Executive Nurse Director, Executive Director of Therapies and Health Science) Quality and Safety Team Patient Experience Team Health and Care Standards Decontamination and reusable devices procedure in place Decontamination Group Weekly Executive led concerns/claims and serious incidents meeting Monitoring of ongoing investigations Quality control system that triangulates areas of concern First cut Corporate Risk Register now in place enabling risks in relation to Safety to be identified. Regulatory Tracker in place and reported to each Audit Committee and has received a 'reasonable' assurance rating		
<b>Current Assurances</b>	Annual Report to Quality, Safety and Effectiveness Committee on key quality and safety areas External accreditation processes Monitoring of incident trends, noise in the system or any concerns arising from inspections Heath and Care Standard Self-Assessment undertaken on key areas and reported into the Quality , Safety and Experience Committee Internal Audit reviews on quality and safety HIW Reports		
<b>Impact Score: 4</b>	Likelihood Score:3	Net Risk Score:	<b>12 (High)</b>

Gap in Controls	Lack of central decontamination Unit			
	Lack of robust QSE criteria/monitoring in procurement and commissioning processes			
	Capacity of the Patient Safety and Patient Experience team to enable more proactive approach to quality improvement and data analysis			
	Limited Assurance Internal Audit Report on Legislative/Regulatory Compliance			
	Lack of robust patient identification processes			
Gap in Assurances	Robust ongoing monitoring and assurance reporting on historical areas of concern			
	Internal audit programme needs to be more closely aligned to areas of greatest risk			
Actions		Lead	By when	Update since 26.09.2019
1. Discuss and agree a way forward in relation to central decontamination unit		RW / FJ	<del>30/06/2019</del> 31/12/2019	Investigation of endoscopy decontamination incident will highlight issues which need addressing. A central decontamination unit is likely to be a recommendation from the investigation. <b>The Lead for Decontamination is currently developing a plan which was reported to the Infection, Prevention and Control Committee.</b>
2. Review of procurement and commissioning processes to be undertaken to ensure that robust quality, safety and experience criteria and included		RW/ RC	<del>30/06/2019</del> TBC	Process of investigation been undertaken on ophthalmology insourcing incident – Terms of Reference for investigation include procurement processes in relation to clinical services. <b>The RCA is near completion and the Clinical Expert Reviews are awaited. Timeframe for completion to be confirmed.</b>
3. Review of IRMER breaches to be undertaken to identify trends and themes		RW	<del>31.05.2019</del> 27/08/2019	New action added March 2019 No new IRMER breaches have occurred. IRMER breaches will form part of the Board Development session on Serious Incidents. <b>Action Complete</b>
4. There are currently a number of quality and safety issues/reviews which are requiring focussed attention.		RW/SW	31/12/2019	These will be reported as and when completed through Quality, Safety and Experience Committee
Impact Score: 4	Likelihood Score:1	Target Risk Score:		4 (Moderate)

## 5. Leading Sustainable Culture Change

In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which is building upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.

<b>Risk</b>	There is a risk that the cultural change required will not be implemented in a sustainable way		
<b>Cause</b>	<p>There is a belief within the organisation that the current climate within the organisation is high in bureaucracy and low in trust.</p> <p>Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition.</p> <p>Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB.</p>		
<b>Impact</b>	<p>Staff morale may decrease</p> <p>Increase in absenteeism</p> <p>Difficulty in retaining staff</p> <p>Potential decrease in staff engagement</p> <p>Transformation of services may not happen due to staff reluctance to drive the change through improvement work.</p> <p>Patient experience ultimately affected.</p>		
Impact Score: 4	Likelihood Score: 4	Gross Risk Score:	<b>16 (Extreme)</b>
<b>Current Controls</b>	<p>Values and behaviours Framework in place</p> <p>Task and Finish Group weekly meeting</p> <p>Cardiff and Vale Transformation story and narrative</p> <p>Leadership and Management Development Programme</p> <p>Programme of talent management and succession planning</p> <p>Values based recruitment</p> <p>Staff survey results and actions taken – led by an Executive ( WOD )</p> <p>Patient experience score cards</p> <p>CEO sponsorship for the Values and behaviours (culture) enabler.</p> <p>Executive Director of WOD highly engaged with this enabler</p> <p>Raising concerns relaunched in October 2018</p> <p>Financial resources in place but need to be careful how used</p>		
<b>Current Assurances</b>	<p>Transformation activity reported to monthly to Management Executives, HSMB and Board.</p> <p>Engagement of staff side through the Local partnership Forum (LPF)</p> <p>Matrix of measurement now in place which will be presented in the form of a highlight report</p>		
Impact Score: 4	Likelihood Score: 2	Net Risk Score:	<b>8 (High)</b>
<b>Gap in Controls</b>			
<b>Gap in Assurances</b>			



Actions	Lead	By when	Update since 26.09.2019
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Three Programmes have been developed: (i) Acceler8 (ii) Integr8 (iii) Collabor8 (iv) Oper8 (for Directorate Managers or equivalent)	MD	<del>June 2019</del> 31/10/2019 01/02/2020  October 2019 12 month session	The Integr8 programme was cancelled in October but now happening in January 2020
2. Showcase	MD	<del>31/10/2019</del> 31/03/2020	The venue for the 'showcase' is being identified and the design will commence once this is firmed up. Showcase likely to start March/April 2020
3. Work on triangulating physical, mental and financial wellbeing service being developed	MD	01/01/2020	New action – launching education programme in January 2020
4. Welsh Language Standard being implemented.	MD	From 01/10/2019	New action - Plan in place with Clinical Boards and Executives
5. Work commencing with Cardiff Council to explore 'Project Search' which is for people with learning disabilities. The outcome would be to help ensure a more diverse workforce at Cardiff and Vale UHB	MD	From 01/01/2020	New action
Impact Score: 4	Likelihood Score: 1	Target Risk Score:	4 (Moderate)

## 6. Capital Assets (Estates, IT Infrastructure, Medical Devices)

The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.

<b>Risk</b> <b>Date added:</b> 12.11.2018	The condition and suitability of the estate, IT and Medical Equipment impacts on the delivery of safe, effective and prudent health care.		
<b>Cause</b>	<p>Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B.</p> <p>Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised.</p> <p>Lack of investment in IT also means that opportunities to provide services in new ways are not always possible and core infrastructure upgrading is behind schedule.</p> <p>Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement</p>		
<b>Impact</b>	<p>The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs.</p> <p>Service provision is regularly interrupted by estates issues and failures.</p> <p>Patient safety and experience is sometimes adversely impacted.</p> <p>IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk</p> <p>Medical equipment replaced in a risk priority where possible, insufficient resource for new equipment or timely replacement</p>		
<b>Impact Score: 5</b>	Likelihood Score: 5	Gross Risk Score:	<b>25 (Extreme)</b>
<b>Current Controls</b>	<p>Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating.</p> <p><b>Statutory compliance estates programme in place – including legionella proactive actions , and time safety management actions.</b></p> <p>The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure.</p> <p>IT SOP sets out priorities for next 5 years, to be reviewed in early 2019</p> <p>Medical equipment WAO audit action plan to ensure clinical boards manage medical equipment risks</p> <p>The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP, with regular oversight of the programme of discretionary and major capital programmes.</p> <p>Medical Equipment prioritisation is managed through the Medical Equipment Group</p> <p>Additional discretionary capital £1.7m for IT and £1.6m for equipment which enabled purchasing of equipment urgently needing replacement.</p>		
<b>Current Assurances</b>	The estates and capital team has a number of business cases in development to secure		

the necessary capital to address the major short/medium term service estates issues. Work is starting on the business case to secure funding to enable a UHW replacement to be build.

The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised.

The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks.

Regular reporting on capital programme and risks to Capital Management, Management Executive and Strategy and Delivery Committee

IT risk register regularly updated and shared with NWIS.  
Health Care Standard completed annually

Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group, health care standard completed annually.

Impact Score: 5	Likelihood Score: 4	Net Risk Score:	20 (Extreme)
<b>Gap in Controls</b>	The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the 3 services. In year requirements further impact and require the annual capital programme to be funded by capital to be re-prioritised regularly. Traceability of Medical Equipment		
<b>Gap in Assurances</b>	The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used.  Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year		
<b>Actions</b>	<b>Lead</b>	<b>By when</b>	<b>Update since 26.09.2019</b>
1. Progress implementation on the estates strategic plan	AH	30/11/2019	Forms part of IMTP. Annual report against Estates Plan to be presented to the Board in November 2019
2. Traceability of Medical Equipment sits with Medical Equipment Group	FJ	31/08/2019	Clinical lead working with Welsh Government National Group to get advice on plan to be developed. <b>Action complete</b>
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	10 (high)

**Key:**

<b>1 -3</b>	<b>Low Risk</b>
<b>4-6</b>	<b>Moderate Risk</b>
<b>8-12</b>	<b>High Risk</b>
<b>15 – 25</b>	<b>Extreme Risk</b>

# Vale Locality Mental Health Team 6 month update

Mental Health Clinical Board



# Vale Locality

- ✓ Progress in team
- ✓ Transformation and Innovation Agenda
- ✓ Management Structures
- ✓ Policy and Practice



# Progress update 14 months on



**Review of caseloads- team caseload size reduced from 1400+ to under 850**

**Assessment times down  
4 months to 5 weeks**

**Integration between LA  
and Health still requires  
attention**

**Management models pose  
high levels of complexity**

**Staffing levels improved.  
Consultant post filled for first  
time in 5 years.**

**Piloting Recovery and  
Maintenance Protocol (RAMP)**

**Psychology vacancies  
impact on waiting times**





# Transformation and Innovation

- **Unscheduled care- expertise up front**
- **End of day decision making**
- **Changes to opt in process**
- **Text and information**
- **Dedicated roles and responsibilities**

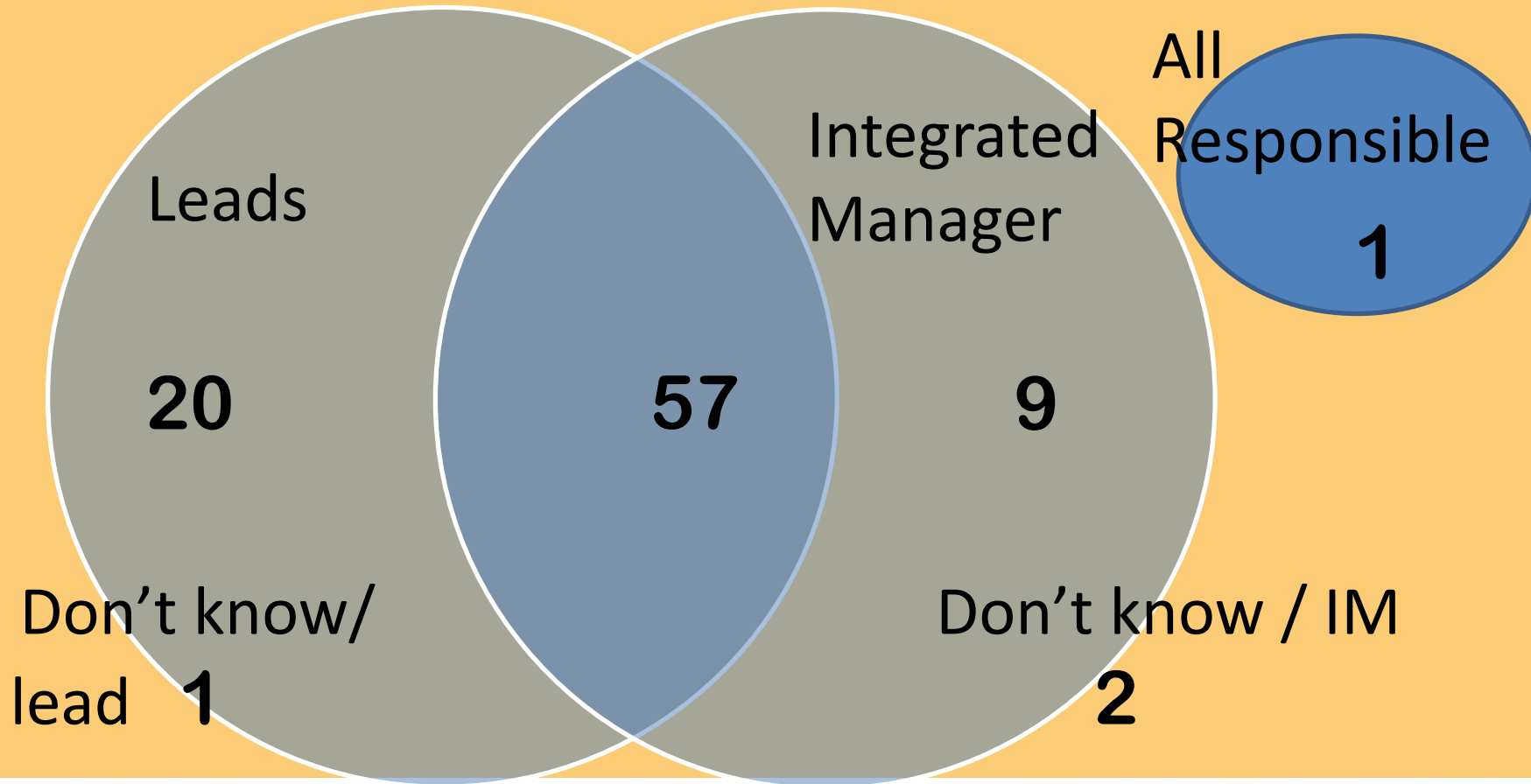




# Management Structures

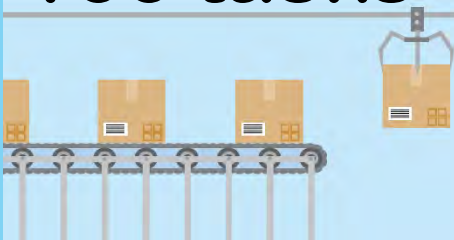


# Overall agreement / disagreement of key team tasks



# Management Structures, work underway

166 tasks



identified

Whole team



approach

Patient at



the centre

Clear  
responsibilities

New



Roles



# Policy Changes

- Wellbeing orientated
- Outcome focused
- Risk sensitive
- Prudent and clinically reasoned
- Overarching



# Q&A





<b>Report Title:</b>	<b>The Nurse Staffing Levels for Adult Acute Medical And Surgical Wards following the Bi-annual Calculation</b>				
<b>Meeting:</b>	<b>Board meeting</b>			<b>Meeting Date:</b>	<b>28/11/2019</b>
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>	<b>For Approval</b>	<b>For Information</b>
<b>Lead Executive:</b>	Executive Nurse Director				
<b>Report Author (Title):</b>	Deputy Executive Nurse Director				

## SITUATION

The Nurse Staffing Levels (Wales) Act 2016 Statutory Guidance requires the designated person to formally present to the Board the nurse staffing requirements for adult in-patient medical and surgical wards. This report provides the Board with a detailed summary of the nurse staffing level for each ward where Section 25B&C applies that has been agreed by the designated person in consultation with the nursing and clinical board team.

## BACKGROUND

The Nurse Staffing Levels (Wales) Act [2016] became law in March 2016. The Act requires health service bodies to make provision for appropriate nurse staffing levels, and ensure that they are providing sufficient nurses to care for patients sensitively. Section 25A of the Act relates to the Health Boards' overarching responsibility which came into effect in April 2017, requiring Health Boards to ensure they had robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their organisations. Section 25B&C identifies wards where there is a duty to calculate nurse staffing levels using a prescribed methodology and maintain nurse staffing levels.

The process of determining the staffing levels across the Health Board is well established. Wards that are included in 25B&C undertake the bi-annual acuity audit and triangulate that information with their professional judgment of the ward, patient population and staff currently in post and a distinct number of patient outcomes that are generally regarded as being nurse sensitive. In addition, the Executive Nurse Director asks all clinical areas outside of 25B&C to undertake a review of their staffing in line with this timetable to ensure compliance with 25A.

## ASSESSMENT

### Evidence of compliance under Section 25A

The Executive Nurse Director has determined that a review of nurse staffing levels across all clinical areas in line with the requirement in 25A will provide assurance that the principles behind the Act are considered. These considerations are informed by professional judgement and national standards where available. In addition, there has been guidance from the Chief Nursing Office / Nurse Director Wales in terms of District Nursing establishments in place for some time and Interim Paediatrics Inpatients Nurse Staffing Principles published in June 2019. This guidance has been considered when determining establishments for these areas and there is an expectation from Welsh Government that the Health Board is working towards full compliance with the principles. Areas to note are:



## Health Board Progress – District Nursing Staffing Principles (Appendix 1)

- Configuration of DN Teams with Clusters/DN /Community nursing voice
  - A significant amount of work continues to be undertaken with internal and external stakeholders to plan and deliver effective District Nursing services in all of the Cardiff and Vale Clusters. The Director of Nursing for PCIC Clinical board has revised all District Nursing teams and renamed and aligned them as close to the cluster footprint as possible.
- Administration support
  - Teams continue to have more than the required 15 hrs of administration support, this role is a well-established in the team and a valued resource in operating safe , effective, efficient services to the local population.
- Plans to increase the number of Deputy Team Leaders with NMC Recordable Qualification
  - Workforce plans are in place for the District Nursing service supporting staff turnover and succession planning, the service is supporting an additional 15 staff to undertake the part time Specialist Practitioner Qualification (SPQ) course and 5 on the full time SPQ course from September 2019. There are 9 staff due to complete the SPQ in 2020. The service has had a number of staff retire over the last 12 months which has impacted on the number of staff in service with an SPQ or equivalent Community Degree.
- Plans re 26.9% Uplift
  - The Health Board, in response to the Nurse Staffing Act and District Nursing principles requirements remain committed to exploring affordable options to support uplift of establishments in line with the requirements. This is included in the IMTP planning process.

## Health Board Progress - Interim Paediatrics Inpatients Nurse Staffing Principles (appendix2)

The Children and Women Clinical Board has undertaken a self - assessment against the principles and responded to Welsh Government accordingly.

- All health boards should have paediatric escalation protocols in place for instances where decreased staffing numbers have been identified
  - The Clinical Board has developed a system where all Ward Sisters meet twice a day with senior staff to discuss staffing across the hospital in order to respond to areas of highest risk.
- 26.9% uplift should be used in calculating the headroom within a roster
  - The clinical wards currently have an uplift of 24% and this will require further investment to achieve 26.9%
- Ward Sisters/Charge Nurses should have access to Senior Professional Support
  - The Clinical Board currently achieves this, being the Childrens Hospital for Wales.

**Changes to note:**

The Clinical Boards and Executive Nurse Director have agreed establishments that they consider will meet all reasonable requirements. However the Board should take note of exceptions:

The Mental Health Clinical Board management team and therefore, the Executive Nurse Director have not been able to sign off all the nursing establishments for these areas as they remain non-compliant with section 25(a) of the Act as the professional and service requirements do not meet the financial envelope (table 1). The Board will recall this being previously reported. In order to manage this risk the Clinical Board reviews staffing levels on a day to day basis by: formal review of rosters every morning; Out-of-hours requests managed by silver manager on call; Shift coordinators move staff around on a daily basis; Use of temporary staffing when required. The Mental Health Clinical Board provided assurances to the Strategy and Delivery Committee in April 2019 that they are looking to address these issues in line with the IMTP processes with support from the wider UHB. This has not been addressed to date.

**Table 1** Wards where establishment has not been signed off in the Mental Health Clinical Board

Hazel	Ash
Elm	Willow
Maple	East 10
Oak	East 12
Beech	East 14
Pine	East 16
East 18	Park Road Houses
Daffodil	Phoenix
Meadow	St Barrucs

A set of draft inpatient Nurse Staffing Principles for mental health inpatients is in development by the All Wales Nurse Staffing Programme. Each Health Board has undertaken an impact assessment against the draft principles which will inform the Health Boards of the implications and resources required to comply with the principles once agreed and implemented. This will be presented in the IMTP.

The UHB is currently looking at the infrastructure to identify how we can move forward with the lead Director for commissioned services to ensure compliance with Section 25(a), in the care we commission both inside and outside of Wales.

### Wards where 25B&C applies

25B&C require Health Boards to calculate the nurses staffing levels using a prescribed method of calculation. Wards included in this section of the Act are currently acute adult medicine and surgery ward. Wards determined to meet this criteria are within four clinical boards (Table2)

**Table 2:** Wards included in Section 25B and 25C by Clinical Board

Medicine	A1, A4, A6S B7, A7, C6, C7S, East 6, East 7, East 4, Gwenwyn, CFU, West 6, West 1, Heulwen winter pressure ward
Specialist	B5, T5, B4H, TCT, C4, B4N, C3, C5, B1
Surgery	B6, Anwen, Duthie, A2, B2, A1 link, CAVOC, A5 Head and Neck, West 4, West 5, A6N, A5 Urology, A3 Link
Children and Women	C1

The recommended establishments for these areas are detailed in Appendix 3

### **Background to actions taken by the Health Board since last report taken to Board (eg where there has been a change to the staffing level and rationale)**

- Medicine Clinical Board has reported the closure of East 2 in University Hospital Llandough (UHL).
- Two wards have been designated as winter pressure areas, these are A4 and Heulwen ward University Hospital of Wales (UHW) respectively 19 and 31 beds. The establishment for these areas are included in the summary of staffing levels (Appendix 3).
- Specialist Clinical Board have reported no changes this iteration.
- Ward B2 has reduced its bed numbers from 38 to 19 with a commensurate reduction in staffing numbers.

### **Evidence of actions taken to maintain staffing levels**

- Clinical Boards continue to monitor the staffing situation daily and ensure that clinical areas manage the risk where there are any staffing deficits, for example by the use of temporary staffing or moving staff from other ward areas.
- In line with decisions made at all Wales level the Health Board is recording the mitigating actions taken in order to maintain the nurse staffing levels in 25B&C ward areas. Ward Sisters/Charge Nurses are asked to highlight the operational steps that have been taken where the nurse staffing levels deviate from the planned roster. This information will be aggregated to make a meaningful report for Boards and Welsh Government in 2022, in line with the reporting outlined in the Act.
- In preparation for an extension of the Act beyond medicine and surgery wards and mindful of the duty set out in 25A the Health Board is also requesting other clinical areas to begin recording this information. This data in addition to the patient outcome information on the number of serious incidents of pressure damage, falls which result in serious harm, the number of medication never events and complaints related to nursing care will enable to Health Board to discharge it's duty to produce a nurse staffing report at the end of the reporting period.

### **RECOMMENDATION**

The Board is asked to:

- **APPROVE** the nursing establishments in compliance with requirements of the Nurse Staffing Levels (Wales) Act [2016]

## Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

## Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term		Integration		Collaboration		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>	<p>Yes / No / Not Applicable</p> <p>If "yes" please provide copy of the assessment. This will be linked to the report when published.</p>								

## Appendix 1

### District Nursing Staffing Principles

Principle 1	Professional nursing judgement should be used in determining district nursing team's establishments
Principle 2	District nursing teams should be structured so they are coterminous with the cluster catchment / footprint. Each district nursing team or unit should have a distinct and identifiable geographical neighbourhood, zone or district within the cluster.
Principle 3	The skill mix within district nurse led teams should be predominantly nurse registrant supported by health care support workers dependent on the patients' care needs.
Principle 4	Each district nursing team or unit should have a clinical lead District Nurse with a NMC recordable qualification (SPQ) or a post registration community nursing degree and leadership training. At least 20% of their time should be spent on case management and at least 20% of their time undertaking supervisory activities, aiming towards a full time supernumerary role as the needs of the team or unit dictate.
Principle 5	There should be at least one deputy team leader District Nurse with a recordable qualification (SPQ) or a post registration community nursing degree and leadership training case manager within each district nursing team.
Principle 6	To promote the continuity of an individual's care and to develop expertise about assets within a community, each district nursing team or unit within a cluster should have a staffing complement of no greater than 15 staff / 12 WTE.
Principle 7	26.9% uplift should be used in calculating the headroom within a team
Principle 8	Each team should have access to at least 15 hours administration support per week.

## Appendix 2

### Interim Principles for Nurse Staffing in Paediatrics

Principle 1	Professional nursing judgement should be used in determining paediatric ward establishments
Principle 2	All health boards should have paediatric escalation protocols in place for instances where decreased staffing numbers have been identified
Principle 3	For inpatient wards the ratio of RNC to patients should not fall below 1:4. This equates to providing an average of 6 Care hours per patient per day
Principle 4	There will be a minimum of 2 RNC rostered at all times, one of whom will have the experience and skills to act as team leader (this should not include the ward sister/charge nurse/manager)
Principle 5	The ward sister/charge nurse/ward manager will be supernumerary
Principle 6	The skill mix for each ward should be a minimum of 70:30
Principle 7	At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS
Principle 8	Ward sisters/charge nurses/managers should have access to Senior Professional Support
Principle 9	26.9% uplift should be used in calculating the headroom within a roster

## Appendix 3

### Summary of Nurse Staffing Levels

<b>Health board/trust:</b>	Cardiff and Vale University Health Board					
<b>Period reviewed:</b>	April 2019 – September 2019					
<b>Number of adult acute medical and surgical inpatient wards where section 25B applies:</b>	<b>Site: UHW</b>				<b>Site: UHL</b>	
	<b>Medical</b>	<b>Surgical</b>	<b>Specialist</b>	<b>Children &amp; Women</b>	<b>Medical</b>	<b>Surgical</b>
	8	9	9	1	7	4

Nurse staffing level per ward where section 25B applies (*)	RN (WTE)	HCSW (WTE)	TOTAL (WTE)
Heulwen Seasonal ward 18 beds	16.48	14.21	30.69
Heulwen South Seasonal ward 13 beds	12.37	11.37	23.74
A4 Seasonal ward	15.21	11.37	26.58
A1	29.70	17.06	47.76
A6S	15.24	11.37	27.61
B7	25.58	17.06	43.64
A7	25.58	19.90	46.48
C6	25.79	20.71	47.50
C7S	13.70	8.52	22.72
East 6	19.89	17.06	37.95
East 7	19.89	17.06	37.95
East 4	19.89	17.06	37.95

Nurse staffing level per ward where section 25B applies (*)	RN (WTE)	HCSW (WTE)	TOTAL (WTE)
C4N	18.5	20.41	38.91
B4N	30.66	19.9	50.56
C3/CCU	34.9	9.54	44.51
C5	31.92	8.53	40.45
B1	29.89	10.56	40.45
B6	27.67	17.06	44.72
C1	22.08	12.64	34.72
Anwen	7.78	4.50	12.30
Duthie			
A2	33.89	15.48	49.37
B2	16.48	8.53	25.01



Gwenwyn	10.51	2.78	14.29
CFU	11.11	2.78	14.89
West 6	19.90	14.21	35.11
West 1	19.90	14.21	35.11
B5	29.89	18.32	48.21
T5	30.7	13.64	44.34
B4H	39.13	15.99	55.12
TCT	20.10	6	26.10
SSSU	29.40	11.73	41.13
SAU	14.70	7.45	22.15

A1link	22.93	8.53	25/02
CAVOC	33.48	14.21	52.69
A5H&N	15.98	8.53	24.51
A5 Urology	15.98	8.53	24.51
West 4	15.21	11.37	26.58
West 5	20.9	9.58	30.47
A6N	19.32	14.21	33.54
A3 Link	20.9	8.53	29.43

<b>Board/Executive level Authorisation</b>	Designated person	Name & signature	Director of Operations	Name & signature	Director of Finance	Name & signature		
--	-------------------	------------------	------------------------	------------------	---------------------	------------------	--	--

<b>Date presented to the Board by designated person</b>	Date, name, title and signature of designated person
---	--

(*) Points to consider: Uplift of 26% has be included applied to RN and HCSW wte, to cover staff absences 1wte ward sisters/charge nurse and managers are supernumerary and has been added
--

REPORT TITLE:	Update on Healthy Travel Charters										
MEETING:	C&V UHB Board Meeting							MEETING DATE:	28 Nov 2019		
STATUS:	For Discussion		For Assurance	X	For Approval		For Information				
LEAD EXECUTIVE:	Executive Director of Public Health										
REPORT AUTHOR (TITLE):	Consultant in Public Health Medicine										
PURPOSE OF REPORT:											

## SITUATION:

Following a paper and presentation to the UHB Board in December 2018 on work to promote sustainable travel and improve air quality in Cardiff, a Cardiff Healthy Travel Charter was signed and launched at Cardiff PSB in April 2019. This includes 14 commitments the Health Board will implement over the next 3 years. A Vale of Glamorgan Charter was launched in October 2019. This paper provides a brief update on the status of the Charters, and work in the UHB to implement the commitments.

## REPORT:

## ASSESSMENT:

Cardiff and Vale UHB signed up to the Cardiff Healthy Travel Charter in April 2019, and the Vale of Glamorgan Charter in October 2019. The partnership agreement to these ambitious commitments and targets is an extremely positive development and demonstrates leadership by the organisations involved on the important overlapping issues of health, social and environmental sustainability.

For the Charters a small cross-partner implementation group has been set up in each area to monitor progress against the commitments, share good practice, and co-ordinate activities such as communications and staff surveys.

The Charters are attached for reference, and include actions to support uptake of public transport, walking and cycling, and switching to low emission vehicles where private cars are unavoidable.

Within the UHB, specific action taken to date to implement the Charter commitments include:

- Extension of hours and increased frequency of UHW Park and ride service from June 2019, associated with an ongoing increase in ridership (funded by Cardiff and Vale Health Charity)
- Introduction of Park and ride service to UHL in July 2019 (funded by Cardiff and Vale Health Charity)
- Introduction of staff shuttle bus between UHW and UHL, to reduce private car use for travel between the sites
- Promotion of Cycle to Work scheme, enabling staff to obtain discounted bicycles
- Successful agreement of staff (corporate) membership of the Nextbike cycle hire scheme, in conjunction with Unison. Roll out of staff membership commenced Nov 2019
- Planned new bike storage shelter for Woodland House
- Regular consistent messaging to staff and public on sustainable transport issues, including using a common communications toolkit established for the Charter
- Senior staff including Executives regularly promoting and modelling walking, cycling and public transport use, e.g. to meetings and through social media channels
- Availability of electric vehicle (EV) charging at Woodland House

A repeat staff travel survey is being carried out over the summer and early autumn across signatory organisations, with results due in late November 2019.

A business Charter has been drafted with colleagues in FOR Cardiff, Cardiff's Business Improvement District, and with leading City Centre firms; and a third sector Charter is being developed in conjunction with C3SC and Glamorgan Voluntary Services. Following an approach from Cardiff University, we are also looking at developing a

Higher and Further Education Charter with these institutions. The Charter work has been recognised as an example of good practice by the Office of the Future Generations Commissioner.

In related developments, a Clean Air Plan has been submitted by Cardiff Council to Welsh Government, to address NO<sub>2</sub> in the City Centre. This is pending final sign off but due to modelled NO<sub>2</sub> levels it is inevitable that in any event there will need to be significant changes to travel in the City centre in place in the next 2 years to address this.

### RECOMMENDATION:

The Board is asked to:

- **NOTE** the recent introduction of a Healthy Travel Charter to the Vale of Glamorgan
- **SUPPORT** current and subsequent initiatives within the UHB to increase rates of sustainable travel by staff and visitors, and reduce pollution from vehicles used for Health Board work, in line with these commitments

### SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click [here](#) for more information

Sustainable development principle: 5 ways of working	Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
--	------------	---	-----------	---	-------------	---	---------------	---	-------------	---

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable									
--	----------------	--	--	--	--	--	--	--	--	--



<b>Report Title:</b>	<b>A Major Trauma Network for South Wales, West Wales and South Powys Programme Business Case</b>					
<b>Meeting:</b>	<b>Board Meeting</b>				<b>Meeting Date:</b>	<b>28/11/19</b>
<b>Status:</b>	<b>For Discussion</b>	<b>X</b>	<b>For Assurance</b>	<b>For Approval</b>	<b>X</b>	<b>For Information</b>
<b>Lead Executive:</b>	<b>Executive Director of Strategic Planning</b>					
<b>Report Author (Title):</b>	<b>As above</b>					

## SITUATION

Following intensive work over the 18 months, led by the NHS Wales Collaborative, a Programme Business Case has been produced which sets out detailed proposals for the establishment of the Major Trauma Network in South Wales, including the Major Trauma Centre at UHW. Boards across South Wales are being asked to support the Programme Business Case.

## BACKGROUND

In March 2018, each of the six health boards in the region formally agreed to recommendations for the development of a Major Trauma Network for South Wales, West Wales and South Powys, in line with the recommendations of an Independent Panel and following a period of formal consultation.

South Wales is the last region in Wales to develop a Major Trauma Network.

## ASSESSMENT

- A significant amount of work has been undertaken by the NHS Collaborative, Health Boards and WHSSC in order to finalise the programme business case. The work on the Major Trauma Centre component of the PBC has been led by our Programme Director and Major Trauma Clinical Lead. The governance and scrutiny process, including external gateway reviews and independent expert advice and scrutiny have informed the PBC's development.
- Within the Health Board, there Major Trauma Programme Board, chaired by the Executive Director of Strategic Planning, has overseen the development of the MTC component of the MTC and Executive Team Reviews have also been undertaken at key points during the development of the PBC.
- The value of investment in major trauma is centred on the benefits from reducing mortality and in reducing the levels of disability in people who have experienced major trauma. Major trauma is one of the major causes of premature death.
- There is international evidence that investment in major trauma is cost effective.
- The report from the Collaborative which accompanies the full programme business case includes the detailed breakdown of the costs by Health Board, and outlines the next steps.
- The Health Board is working at pace to ensure that all the necessary requirements are in place for an April 2020 commencement of the MTC. This includes the recruitment to approximately 200 roles and some capital works, including the replacement of the CT scanner in EU which is beyond its recommended working life and the creation of a Major Trauma Ward.

## RECOMMENDATION

The Board is asked to support the following recommendations:

1. Receive and discuss the Programme Business Case for the network.
2. Note that there has been significant scrutiny of the case, including three formal Gateway Reviews and professional peer review by UK clinical experts.
3. Approve the overall network model described in the case (clinical, operational and governance), including the:
  - a. role of the Operational Delivery Network (ODN)
  - b. role of the health board, as a provider of respective component of service model.
4. Note the importance of the repatriation policy and the importance of the ODN having the authority to implement this, completion of which will form a critical activity in planning network implementation.
5. Note that there will be other business cases over the next two to three years to further develop the major trauma centre and trauma units.
6. Approve the content of the Programme Business Case, subject to confirmation of the NHS resource allocation for 2020/21, the IMTP prioritisation process, and point 7 below.
7. Note that final commissioning decisions on prehospital services, the major trauma centre, relevant specialist services and the ODN, will be taken at meetings of the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC).

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	
------------	---	-----------	---	-------------	--	---------------	---	-------------	--

Equality and  
Health Impact  
Assessment  
Completed:

**Not Applicable** as completed as part of consultation.

Kind and caring  
Caredig a gofalgwr

Respectful  
Dangos parch

Trust and integrity  
Ymddiriedaeth ac uniondeb

Personal responsibility  
Cyfrifoldeb personol



**GIG**  
CYMRU  
**NHS**  
WALES

Cydweithrediad  
Iechyd GIG Cymru  
NHS Wales Health  
Collaborative

# **A Major Trauma Network for South Wales, West Wales and South Powys *Programme Business Case***

**Date:** 18/11/19

**Version:** 1.0 (Final)

## **Purpose:**

In March 2018, each of the six health boards serving the populations of South Wales, West Wales and South Powys formally agreed to recommendations for the development of a Major Trauma Network for the region, in line with the recommendations of an Independent Panel and following a period of formal consultation.

Since that time, a significant programme of work has been undertaken to develop the configuration of the network and the clinical and operational model. This has been enabled and supported through strong and effective clinical leadership and engagement, and taking account of patient experiences.

This work has culminated in the production of a Programme Business Case which describes the totality of the requirements for NHS Wales to establish the South Wales Trauma Network ('the network'), serving the population of South Wales, West Wales and South Powys. The case outlines the requirements for the network to become operational and, also, the trajectory of development over a five-year period.

Boards are asked to:

1. Receive and discuss the Programme Business Case for the network.
2. Note that there has been significant scrutiny of the case, including three formal Gateway Reviews and professional peer review by UK clinical experts.
3. Approve the overall network model described in the case (clinical, operational and governance), including the:
  - a. role of the Operational Delivery Network (ODN)
  - b. role of the health board, as a provider of respective

component of service model.

4. Note the importance of the repatriation policy and the importance of the ODN having the authority to implement this, completion of which will form a critical activity in planning network implementation.
5. Note that there will be other business cases over the next two to three years to further develop the major trauma centre and trauma units.
6. Approve the content of the Programme Business Case, subject to confirmation of the NHS resource allocation for 2020/21, the IMTP prioritisation process, and point 7 below.
7. Note that final commissioning decisions on prehospital services, the major trauma centre, relevant specialist services and the ODN, will be taken at meetings of the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC).



## 1 Introduction

The Programme Business Case (PBC) describes the requirements for NHS Wales to establish the South Wales Trauma Network, serving the population of South Wales, West Wales and South Powys. The PBC outlines the requirements for the network to become operational and, also, the trajectory of development over a five-year period of implementation.

This PBC represents the culmination of significant work to develop the configuration of the network and the clinical and operational model. This has been enabled and supported through strong and effective clinical leadership and engagement, and taking account of patient experiences.

## 2 Background

In March 2018, each of the six health boards in the region formally agreed to recommendations for the development of a Major Trauma Network for South Wales, West Wales and South Powys, in line with the recommendations of an Independent Panel and following a period of formal consultation:

1. A major trauma network for South and West Wales and South Powys with a clinical governance infrastructure should be quickly developed.
2. The adults' and children's major trauma centres should be on the same site.
3. The major trauma centre (MTC) should be at University Hospital of Wales, Cardiff.
4. Morriston Hospital, Swansea, should become a large trauma unit (TU) and should have a lead role for the major trauma network.
5. A clear and realistic timetable for putting the trauma network in place should be set.

Since that time, a significant programme of work has been undertaken, overseen by a Trauma Network Board, which has led to the production of the PBC and initial preparations for implementation of the network.

## 3 Network Structure

The structure of the South Wales Trauma Network will be comprised of the following elements:

- An **Operational Delivery Network (ODN)**, to be hosted by Swansea Bay University Health Board, which will provide the management function for the network. It will be a collaboration between all providers of trauma care services in the region, and its

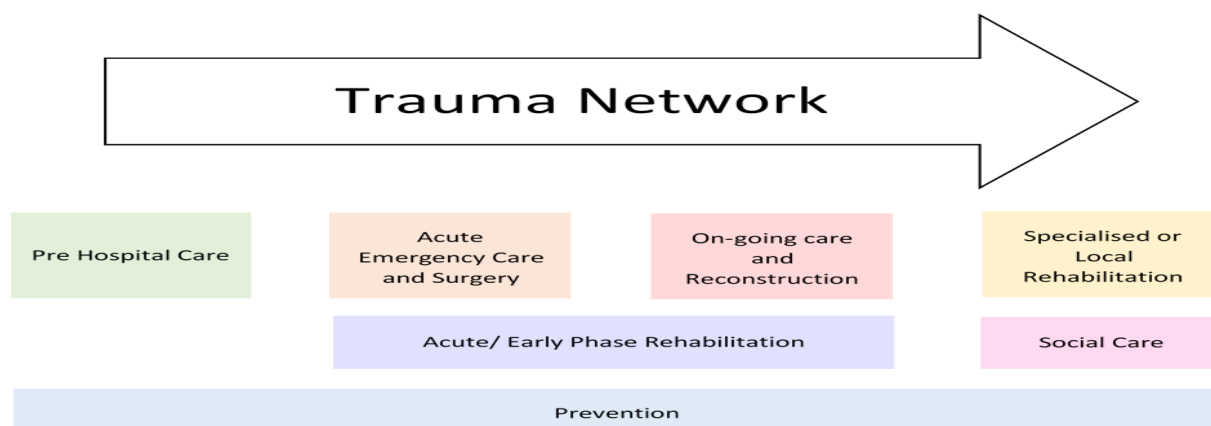
governance arrangements will provide appropriate authority to ensure operational delivery.

- A **pre-hospital triage tool** will ensure major trauma patients are conveyed directly by the Welsh Ambulance Service (WAST) or the Emergency Medical Retrieval and Transfer Service Cymru (EMRTS), or other emergency providers, to the MTC or TUs.
- An **adults' and children's MTC at University Hospital of Wales** (UHW), Cardiff. It will have access to all specialist services relevant to major trauma and take responsibility for the acute care of all major trauma patients in the region via an automatic acceptance policy and manage the transition of patients to rehabilitative care.
- An **adult and paediatric TU, with specialist services, at Morriston Hospital**, Swansea. It will provide specialist support to the MTC and provide specialist surgery for patients who do not have multiple injuries, for burns, plastic, spinal and cardiothoracic surgery.
- **Six adult and paediatric TUs** at the following locations:
  - UHW, Cardiff
  - Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (until the Grange University Hospital is fully operational, planned for April 2021, at which point it will become the single designated TU for Aneurin Bevan University Health Board)
  - Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend
  - Glangwili General Hospital, Carmarthen.

The TUs will provide care for injured patients and have systems in place to rapidly move the most severely injured patients to hospitals that can manage their injuries, in most cases the MTC. They will also receive patients back who require ongoing care in hospital.

- **Rural trauma facilities** at Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest, which will maintain the ability to assess and treat major trauma patients, given their unique geographical locations.
- A **Local Emergency Hospital** at Royal Glamorgan Hospital, Llantrisant. This hospital will not routinely receive acute trauma patients but, should this occur, it will ensure appropriate initial management and transfer to the MTC or nearest TU.

## 4 Clinical and Operational Model



Detailed work has been undertaken to develop the **clinical and operational model** for the network and to estimate changes in **patient flows**. There will be an increase of approximately 300 patients being treated per annum at the University Hospital of Wales due to its planned status as the MTC for the network (full details of estimated changes in patient flow across the network are provided in Chapter 4 of the PBC).

The planning work has led to the adoption of the NHS England quality indicators and service specification. Assessments have been undertaken to review current services against these indicators and the estimated changes in patient flows, which has informed the resource requirements for each component part of the network:

- **Pre-hospital services** (chapter 6) – Five indicators and investment required for new and additional journeys, additional training, establishment of a major trauma desk within the clinical contact centre, and for a transfer and discharge service. These requirements were endorsed by EASC in September 2019.
- **Major Trauma Centre** (chapter 7) – 52 indicators for adult services and 46 for children's services. 38 are currently not met, which form the basis for the required investment, five of which are not essential for 'Day 1' and implementation of which will be phased. Investment is sought for:
  - Emergency Department – quality of immediate response and stabilisation from 24/7 consultant trauma team lead, dedicated nursing and seven day paediatric trauma team lead until 10pm.
  - Theatres – additional theatre availability to improve timeliness of access to theatres.
  - Critical Care – additional capacity for predicted increase in demand.
  - Poly Trauma Unit – dedicated ward for acute admission and early targeted rehabilitation in readiness for discharge to local care.

- Trauma and orthopaedics – additional surgical capacity to meet increased activity flow.
  - Hyper acute rehabilitation service – to provide early rehabilitation plans for trauma patients with intensive rehabilitation needs.
  - Specialist services – new local plastic surgery availability on site to deliver improved outcomes (through collaboration with Swansea Bay University Health Board).
  - MTC directorate – senior leadership to drive improvements in rehabilitation, clinical practice, and audit and outcomes.
- **Trauma Units** (Chapter 8) – 26 indicators, many are already being met or could be met through the provision of network policies and internal re-organisation of resources. The initial focus for additional resources is on key enabling posts to improve clinical governance, data collection and patient flow. Further resources will be required to meet standards in Years 2 and 3. The TU at Morriston Hospital will have a role in providing specialist services support to the network. The PBC includes costs for locating up to four plastic surgeons at the MTC.
  - **Operational Delivery Network** (chapter 5) – investment required to manage the network and coordinate operational delivery.

Essential to the effective operation of the network will be **patient repatriation**, that is arrangements for patients to return to a suitable local hospital as soon as the acute phase of their trauma care is completed. This will enable patients to continue their treatment closer to home, reduce impact on family and carers, and help provide capacity for the MTC to automatically accept new patients. An automatic acceptance policy is proposed for repatriation of major trauma patients from the MTC, but within the context of supporting interventions. The policy is under development, draft principles for which are:

1. Acceptance of the principle that origin health boards are responsible for their patients, irrespective of where they are being treated.
2. Automatic acceptance will be treated in the same way in both directions (i.e. to the MTC and back to the TU).
3. Any delay in repatriation will lead to a delay in automatically accepting new patients to the MTC.
4. Key features of an All Wales Repatriation Policy will be included.
5. The ODN is given operational authority within the escalation procedures for delayed transfers of care.

There will be an opportunity to pilot the policy before the network goes live.

**Rehabilitation services** are vital to the care of patients following major trauma. Major trauma practitioners and rehabilitation coordinators will be

new roles in the health boards and will be vital in ensuring seamless care and key points of contact for patients returning from specialist care to a TU or the community. A consultant in rehabilitation medicine will operate in each health board on a weekly basis, playing a key role in coordinating the team, managing complex patients and facilitating discharge. In Years 2 and 3, and subject to approval of additional business cases, there will be further enhancement of local and community based rehabilitation including core therapy roles as well as some specialist roles, providing both in-reach and out-reach services. For complex patients who return from specialist care (e.g. traumatic brain injury, spinal injuries), a training and education programme for medical and nursing staff will ensure the skill set of the rehabilitation multidisciplinary team at TUs will be identical to the skill set of that based at the MTC.

**Prevention** is an essential component of an inclusive major trauma system and the network will be able to make a significant contribution to injury prevention programmes through data sharing, research and educational initiatives. The ODN will be responsible for ensuring attention to prevention activities and the benefits realisation plan described in the PBC commits the network to the development of an injury prevention strategy, in partnership with Public Health Wales.

## 5 Network Workforce

The PBC identifies significant additional workforce requirements, the majority of which will work within the MTC. This requires collaboration within system-wide arrangements. The network has developed workforce principles to mitigate the risk of destabilising services as a consequence of establishing the MTC. These principles include shared job plans, portfolio roles and rotational posts across the network.

Staff Group	WTE
Medical Staff	43.3
Healthcare Support Workers	37.65
Registered Nurses	85
Allied Health Professionals, Scientists and Technicians etc.	27.5
Administrative and Clerical staff	15
<b>Total</b>	<b>208.45</b>

## 6 Revenue and Capital Costs

The totality of the revenue and capital costs included in the PBC is set out in the tables below. This has been informed by significant scrutiny of the network requirements through the programme arrangements and, also, independently through clinical peer review and Gateway Reviews. Learning lessons from the establishment of major trauma networks in other parts of the UK has been of particular importance. This has informed the scale of the MTC requirements and also the enabling requirements for the pre-

NHS Wales Health Collaborative	South Wales Major Trauma Network Programme Business Case
--------------------------------	---

hospital services, trauma units and the rehabilitation pathway. This will ensure the maximum benefit for the most seriously injured patients, the majority of whom will go to the MTC. There are some elements of the MTC case that are phased and, also, the resource requirements for the TUs reflect a more phased approach.

### Summary of revenue costs

	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
MTC	£922	£10,579	£11,222	£11,222	£11,222
Specialist Services	£150	£910	£910	£910	£910
Trauma Units	£287	£1,278	£1,278	£1,278	£1,278
Operational Delivery Network	£119	£496	£508	£513	£515
Pre-Hospital Care	£58	£1,201	£635	£640	£640
<b>Total</b>	<b>£1,536</b>	<b>£14,465</b>	<b>£14,553</b>	<b>£14,562</b>	<b>£14,564</b>

### Summary of health board and trust funding shares

(Reflects local Trauma Unit / Rehabilitation costs plus share of Major Trauma Centre, Specialist Services and WAST Pre-hospital care)

	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
Aneurin Bevan	£353	£3,549	£3,571	£3,573	£3,574
Cwm Taf Morgannwg	£308	£2,743	£2,758	£2,759	£2,760
Cardiff and Vale	£247	£2,808	£2,826	£2,828	£2,829
Hywel Dda	£262	£2,462	£2,477	£2,479	£2,479
Powys	£27	£225	£226	£226	£226
Swansea Bay	£281	£2,678	£2,695	£2,696	£2,697
WAST (2019/20 funded by WG, Year 1 onwards by health boards)	£58	£0	£0	£0	£0
<b>Total</b>	<b>£1,536</b>	<b>£14,465</b>	<b>£14,553</b>	<b>£14,562</b>	<b>£14,564</b>

## 7 Value, Cost Effectiveness and Benchmark Cost Comparison

The value of investment in major trauma is centred on the benefits from reducing mortality and in reducing the levels of disability in people who have experienced major trauma. Major trauma is one of the major causes of premature death. The NCEPOD report (2007) highlighted that 75 % of major trauma involved young men. Reducing mortality and improving function in this patient group, therefore, has the ability to produce material health gain for any investment. The National Audit Office report (2010) highlighted the potential to reduce mortality by 15 to 40%. This has subsequently been evidenced by the real world experience data from the introduction of the major trauma networks in England, which demonstrated a 19% improvement in case-mix adjusted mortality (Moran 2018).

NHS Wales Health Collaborative	South Wales Major Trauma Network Programme Business Case
--------------------------------	---

There is international evidence that investment in major trauma is cost effective. The NHS Confederation (2010) reported the work of Nicholl (Sheffield University Health Economics) which indicated that, based on a 10% improvement in mortality, a health economy could invest £5m per annum per million population and achieve a quality gain cost effective at within the £20,000 per QALY standard. A comprehensive study from the United States (Mackenzie 2010) compared the outcomes in Level 1 trauma centres with non-trauma centres and quantified the cost effectiveness at \$36,961 per QALY. When adjustments are made to translate into much lower UK health system costs, investment in major trauma compares well against common investment priorities such as hip and knee surgery.

The lack of a comprehensive baseline cost for the MTC makes comparison with other UK benchmarks problematic. However, the incremental unit cost for the MTC across ISS 9 to 15 and >15 (ISS being a score to measure injury severity) has been assessed to start at £15,190 in Year 1 falling to £13,573 by Year 3. The full cost of MTC activity delivered by an NHS England MTC for the North Wales population, based on real world data, has been calculated as £18,650 per case with a range of £23,576 for ISS>15 and £12,083 for ISS 9<15. It is anticipated that, if all baseline costs were included, the full cost of the new MTC would probably exceed the benchmark, but any financial gap will narrow when, as predicted, activity grows and wider system efficiencies from existing TUs begin to be realised.

## **8 Programme Assurance**

Development of the clinical and operational model and the production of the PBC have been coordinated and overseen by the Trauma Network Board, with commissioner scrutiny provided by WHSSC and EASC. There was intensive scrutiny throughout the summer and autumn of 2019, including benchmarking of the MTC financial case against a lead English MTC, Gateway Reviews in July, September and October, and professional peer review by UK clinical experts in August. These have collectively informed the final PBC and the resource requirements to enable the establishment of the South Wales Trauma Network.

## **9 Next steps**

Subject to approval of the content of the PBC and confirmation of funding, the South Wales Trauma Network is planned to go live in spring 2020. Some implementation has already commenced with recruitment to key enabling posts. The Gateway Review undertaken in October 2019 reported growing confidence that a go-live at or around April 2020 would be achievable, with a number of elements of the model being introduced in the first few months after this.

The Trauma Network Programme Board will be refocused on implementation, with a leaner membership once the PBC is approved. There will be some parallel running of the programme team and the new ODN, and full handover to the ODN prior to go-live. Arrangements are planned to hold critical readiness reviews for the MTC and TUs, which will focus on recruitment and, within the MTC, on capital works. Also, the automatic acceptance policy for repatriation will need to be in place. This will inform decisions on the date from which the network will become operational, which will be signed off by WHSSC, as the lead commissioner.

## 10 Recommendations

Boards are asked to:

1. Receive and discuss the Programme Business Case for the network.
2. Note that there has been significant scrutiny of the case, including three formal Gateway Reviews and professional peer review by UK clinical experts.
3. Approve the overall network model described in the case (clinical, operational and governance), including the:
  - a. role of the Operational Delivery Network (ODN)
  - b. role of the health board, as a provider of respective component of service model.
4. Note the importance of the repatriation policy and the importance of the ODN having the authority to implement this, completion of which will form a critical activity in planning network implementation.
5. Note that there will be other business cases over the next two to three years to further develop the major trauma centre and trauma units.
6. Approve the content of the Programme Business Case, subject to confirmation of the NHS resource allocation for 2020/21, the IMTP prioritisation process, and point 7 below.
7. Note that final commissioning decisions on prehospital services, the major trauma centre, relevant specialist services and the ODN, will be taken at meetings of the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC).





GIG  
CYMRU  
NHS  
WALES

Rhwydwaith Thrawma  
De Cymru  
South Wales  
Trauma Network

Serving the population of South  
Wales, West Wales and South  
Powys

Programme Business Case

18 November 2019

For reporting to Health Boards

## Acknowledgements

The authors would like to thank all those who have contributed to the programme over the last five years and to the development of this Programme Business Case.

### Authors

Rosemary Fletcher	Director, NHS Wales Health Collaborative
Dr Dinendra Gill	Clinical Lead, South Wales Trauma Network
Rhys Blake	Head of Planning, NHS Wales Health Collaborative
Jeremy Surcombe	Programme Manager, NHS Wales Health Collaborative
Vickie Harding	Project Support Officer, NHS Wales Health Collaborative

## Contents

<b>1</b>	<b>Executive Summary.....</b>	<b>8</b>
1.1	Introduction.....	8
1.2	Vision .....	8
1.3	Background.....	8
1.4	Strategic Case .....	8
1.5	Case for Change .....	9
1.6	Clinical and Operational Model .....	10
1.7	Operational Delivery Network.....	12
1.8	Pre-hospital Care and Transfers.....	12
1.9	Major Trauma Centre .....	13
1.10	Health Board Configuration.....	14
1.11	Financial Case .....	15
1.12	Economic Case .....	17
1.13	Commercial Case.....	17
1.14	Management Case.....	17
1.15	Summary and Recommendation .....	18
<b>2</b>	<b>Strategic Case.....</b>	<b>20</b>
2.1	Introduction.....	20
2.2	Strategic Context.....	20
2.3	National Drivers for Change .....	21
2.4	Key Interdependent Policies.....	23
2.5	Population and Existing Activity Profiles.....	24
2.6	Overview of the Current Position – The Trauma Pathway .....	26
<b>3</b>	<b>Case for Change .....</b>	<b>33</b>
3.1	Introduction.....	33
3.2	Investment Objectives.....	33
3.4	Health Gain.....	36
3.5	Equity.....	41
3.6	Clinical and Skills Sustainability .....	43
3.7	Value for Money .....	45
3.8	Local Health Board and WAST/EMRTS Specific Benefits .....	47
<b>4</b>	<b>Clinical and Operational Model.....</b>	<b>52</b>
4.1	Introduction.....	52
4.2	Chronology of Developing the Model .....	53

4.3	Initial Service Modelling.....	53
4.4	Non-financial Options Appraisal for MTC Location 2015 .....	58
4.5	Independent Panel Review.....	60
4.6	Public Consultation Process and Recommendations .....	62
4.7	Designation of Trauma Units.....	64
4.8	Predicted Change in Patient Flow .....	66
<b>5</b>	<b>Operational Delivery Network .....</b>	<b>70</b>
5.1	Introduction.....	70
5.2	What is a Trauma Operational Delivery Network (ODN)? .....	70
5.3	Purpose of the Operational Delivery Network .....	70
5.4	Phased Implementation.....	71
5.5	Clinical Informatics Model.....	78
5.6	Training and Education Model.....	81
5.7	Resource Requirements.....	85
5.8	Key Challenges .....	89
5.9	Issues Arising for Resolution.....	89
5.10	Options to the give the ODN Meaningful Operational Authority.....	89
<b>6</b>	<b>Pre-Hospital Care and Transfers .....</b>	<b>91</b>
6.1	Introduction.....	91
6.2	Service Specification and Quality Indicators .....	91
6.3	Welsh Ambulance Service .....	95
6.4	Emergency Medical Retrieval and Transfer Service (EMRTS) .....	103
<b>7</b>	<b>Major Trauma Centre.....</b>	<b>107</b>
7.1	Overview .....	107
7.2	National Major Trauma Quality Indicators .....	107
7.3	Case for Change .....	108
7.4	Workforce Summary.....	109
7.5	Predicted Activity Uplift.....	111
7.6	Workforce Summary.....	116
7.7	Benefits and Risks.....	117
7.8	Planning and Assurance Process.....	117
7.9	Financial Summary .....	118
7.10	The Major Trauma Centre Role within the wider Network and Opportunities for Collaboration .....	119
<b>8</b>	<b>Local Health Board Configuration.....</b>	<b>122</b>
8.1	Introduction.....	122

8.2	Overview of the Model .....	123
8.3	Quality Indicators .....	124
8.4	Additional Service Specification.....	133
8.5	Summary of Quality Indicator Assessment and Information Requests.....	135
8.6	Cardiff and Vale University Health Board .....	136
8.7	Swansea Bay University Health Board.....	137
8.8	Aneurin Bevan University Health Board .....	137
8.9	Hywel Da University Health Board.....	137
8.10	Cwm Taf Morgannwg University Health Board .....	138
8.11	Powys Teaching Health Board .....	138
8.12	Specialist Services Support to the Major Trauma Centre .....	139
<b>9</b>	<b>Financial Case.....</b>	<b>142</b>
9.1	Introduction.....	142
9.2	Context.....	142
9.3	Phasing.....	143
9.4	Revenue Costs.....	144
9.5	Contracting Arrangements.....	149
9.6	Capital Costs .....	149
9.7	Timetable of Future Business Cases.....	150
<b>10</b>	<b>Economic Case .....</b>	<b>152</b>
10.1	Introduction.....	152
10.2	Evidence from Established Trauma Systems.....	152
10.3	Cost Effectiveness .....	153
10.4	Value of the Network .....	154
10.5	Options in Developing the Operational Model.....	155
<b>11</b>	<b>Commercial Case.....</b>	<b>162</b>
11.1	Risk Transfer .....	163
11.2	Procurement strategy.....	163
11.3	IFRIC 12 / FRS5 Accountancy Treatment .....	163
11.4	HM Treasury Guidance. ....	163
<b>12</b>	<b>Management Case .....</b>	<b>164</b>
12.1	Introduction.....	164
12.2	Current Programme Management Arrangements.....	164
12.3	Commissioning Arrangements.....	168
12.4	Implementation and Mobilisation .....	176
12.5	MTC/Health Board TUs/Pre-Hospital Readiness for Go Live.....	182

12.6	Post Go Live: Operations and Governance .....	182
12.7	Business Cases Supporting Implementation and Achievement of Standards.....	191
12.8	Evaluation – Post Implementation.....	191
12.9	Programme Assurance.....	194
12.10	Benefits Realisation Plan.....	199
12.11	Risk Management Plan .....	210
12.12	Communication/Stakeholder Engagement Plan.....	210
12.13	List of Specialist Advisors .....	211
<b>13</b>	<b>Conclusions and Recommendations .....</b>	<b>213</b>

# South Wales Trauma Network

'Serving the Population of South Wales,  
West Wales and South Powys'

## Our mission statement:

'Saving Lives, Improving Outcomes, Making a Difference'

### Pre-hospital care

Treat me quickly and effectively



### Acute emergency care and surgery

Recognise and treat my injuries quickly and effectively



Take me to the right hospital the first time



Explain to my family and me

what is happening at each step

Manage my pain appropriately



### Ongoing care and reconstruction

Give me and my family easy to understand information to make sense of what happened to me, my injuries and make choices about my care  
Provide welfare support and advice to my family

### Rehabilitation and social care

Explain to me how my care is going to change when I leave the Major Trauma Centre

Give me the best possible chance to achieve my full potential after I recover from my injuries



Be honest with me whether I will recover to my full potential



GIG  
CYMRU  
NHS  
WALES

Rhwydwaith Thrawma  
De Cymru  
South Wales  
Trauma Network

# 1 Executive Summary

## 1.1 Introduction

This Programme Business Case (PBC) describes the totality of the requirements for NHS Wales to establish the South Wales Trauma Network ('the network'), serving the population of South Wales, West Wales and South Powys. The PBC outlines the trajectory of the programme over a five year period of phased implementation. It represents the culmination of significant work over seven years.

The trauma network board recommends that health boards, the Welsh Ambulance Service NHS Trust (WAST), commissioners and the Welsh Government approve and support this case, which will lead to improved survival and outcomes for patients.

## 1.2 Vision

The vision for the establishment of the network is to enhance patient outcomes and experience, across the entire patient pathway from the point of wounding to recovery and also including injury prevention. The network will improve patient outcomes by saving lives and preventing avoidable disability, returning patients to their families, work and education. The network will be a partnership between participating organisations, working collaboratively to achieve this common goal and purpose. The aim is to develop an inclusive, collaborative, world leading trauma network, with quality improvement, informed through evidence-based medicine and lessons learnt from others.

## 1.3 Background

The programme was established, following full endorsement by all six health boards in the region, of the following recommendations made by an independent expert panel, following a period public consultation:

- A major trauma network for South Wales, West Wales and South Powys with a clinical governance infrastructure should be quickly developed.
- The adults' and children's Major Trauma Centres (MTC) should be on the same site.
- The MTC should be at University Hospital of Wales (UHW), Cardiff.
- Morriston Hospital, Swansea, should become a large Trauma Unit (TU) and should have a lead role for the major trauma network.
- A clear and realistic timetable for putting the trauma network in place should be set.

The network board was established in May 2018 and significant work has since been undertaken to develop the clinical and operational model, the network structure and to plan for implementation.

## 1.4 Strategic Case

The proposals outlined in this case align with national and international strategic drivers for change, including:

- A Healthier Wales (2018) sets out a long-term vision of a 'whole system approach to health and social care', underpinned by prudent healthcare and value-based healthcare principles.
- NHS Wales service change plans and the National Programme for Unscheduled Care.
- The establishment of trauma networks elsewhere in the British Isles, in response to building evidence of effectiveness:



- NHS England implemented trauma networks between 2010 and 2012 (North Wales has been part of the North West Midlands Network since 2012), based on a number of strategic reports (e.g. NCEPOD, NAO).
- the Scottish Trauma Network was established in 2018, supported by incremental investment from the Scottish Government,
- Both Northern Ireland and Republic of Ireland are making good progress with their respective developments.

Currently, there is no adult and paediatric network serving the population of South Wales, West Wales and South Powys. Evidence from the evaluation of networks in England indicates that the organisation of the trauma pathway through a network approach is associated with significant improvements in both the care process and outcomes of patients after severe injury.

## 1.5 Case for Change

The case for change is compelling, with the prospect of benefits aligned closely with key investment objectives of health gain, equity, clinical and skills sustainability, and value for money, including economic benefits. Thus, a value-based healthcare approach has been applied where appropriate.

### *Health gain – improving patient survival and outcomes*

- Improving survival - NHS England showed an improvement of 19% over five years (1,645 more survivors, which exceeded expected numbers)
- Improving functional outcomes – an Australian study found more patients surviving with less disability burden (increase in disability free years by 28%). Early investments proposed in the rehabilitation model will incur the greatest impact on patient recovery and functional outcome
- Improving timely clinical care and patient experience
- Improving data collection - compliance with Trauma Audit Research Network (TARN) data collection, essential to quality improvement and evaluation
- Enhancing response at major incidents or mass casualty events – lack of a network presents a strategic risk to the region; trauma networks were key in the management of patients following the terrorist attacks in London and Manchester
- Enhancing injury prevention

### *Equity – people of highest health need prioritised*

- Enhancing access to specialist care - the new trauma pathway will lead to an increase in direct and secondary access to specialist treatment and care
- Enhancing patient flow - there will be a requirement for automatic acceptance of patients by the MTC and the timely repatriation of patients for 'care with treatment closer to home'
- Improving system-wide care - learning lessons from England, investment in TUs is required to provide equity of access to improved standards of care
- Increasing equity of care for older people suffering trauma – the region has an ageing population and the group suffering the most major trauma are those aged over 65
- Increasing equity of care for veterans – a veterans trauma network, a collaboration with the MTC, will provide a single point of referral for medical care of veterans with complex physical injuries

### *Clinical skills and sustainability – reducing service and workforce vulnerabilities*

- Enhancing multi-professional training and education – through a network-led programme crossing the entire patient pathway leading to enhanced knowledge and skill base across the network
- Enhancing workforce recruitment and retention – through a network-wide approach to maximise opportunities of joint and rotational posts and to minimise risk to departments and organisations outside the MTC
- Developing new roles and ways of working – through expanded roles for allied health professionals and nurses; and promotion of new areas for training within Wales (e.g. trauma surgery as a specialty)

### *Value for money – demonstrating a cost effective way of generating the anticipated benefits*

- Securing economic benefits – with approximately 14 additional lives saved across the network per year, this is likely to equate to a cost of lives saved of £17m/year. The proposed investment is cost effective and is significantly under the NICE Quality Adjusted Life Year (QALY) threshold for cost effectiveness of £20,000. It is also comparable with NHS England in relation to major trauma and other clinical interventions
- Achieving savings across the system – there will be fewer secondary transfers, less duplication of resources by patients being transferred to definitive care, and a fall in the length of stay in critical care
- Delivering value to other patient groups and networks - development of a new rehabilitation and orthogeriatric model will benefit a wider group of patients (e.g. stroke services and neck of femur fractures)
- Sharing knowledge and learning - including through the approach to and management of clinical and operational governance issues

## **1.6 Clinical and Operational Model**

The scope of the trauma network is to provide seamless care to major trauma patients across all age groups. An inclusive trauma system (ITS) is responsible for all aspects of trauma care across the pathway, from the point of wounding to recovery, and also including injury prevention. It is based on a network structure and features a population-based approach to the assessment of need and the delivery of treatment. It includes a network-wide quality assurance framework covering each stage of care and underpinning providers' clinical governance processes. It also informs commissioning decisions to improve the quality of care.

Detailed work has been undertaken to develop the clinical and operational model for the network. This has led to the adoption of the NHS England quality indicators and service specification, with a phased approach to their introduction, in keeping with English trauma networks. This has included significant scrutiny through professional peer review and a series of Gateways reviews. The most recent Gateway review has provided a delivery confidence assessment of amber green. This indicates that 'successful delivery appears probable. However constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.' The review recognised that two major activities were happening in parallel: the completion and approval process for the PBC and mobilisation for go live. It reported that, since the Assurance of Action Plan review, substantial progress had been made with both the PBC and implementation plans.

The trauma network board has overseen the development of the structure of the South Wales Trauma Network, comprised of the following:

- An Operational Delivery Network (ODN), to be hosted by Swansea Bay University Health Board, which will provide the management function for the network, and coordinate operational delivery
- A pre-hospital triage tool will ensure major trauma patients are conveyed directly by WAST or the Emergency Medical Retrieval and Transfer Service Cymru (EMRTS), or other emergency providers, to the MTC or TUs.
- An adults' and children's MTC at University Hospital of Wales (UHW), Cardiff. The MTC will have access to all specialist services relevant to major trauma. It will take responsibility for the acute care of all major trauma patients in the region via an automatic acceptance policy and manage the transition of patients to rehabilitative care. It will collaborate with and support other hospitals in the network.
- An adult and paediatric TU, with specialist services, at Morriston Hospital, Swansea. It will provide specialist support to the MTC and provide specialist surgery for patients who do not have multiple injuries, for burns, plastic, spinal and cardiothoracic surgery
- Six adult and paediatric TUs at the following locations:
  - UHW, Cardiff
  - Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational, planned for April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Aneurin Bevan University Health Board)
  - Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend.
  - Glangwilli General Hospital, Carmarthen.
- The TUs will provide care for injured patients and have systems in place to rapidly move the most severely injured patients to hospitals that can manage their injuries, in most cases the MTC. They will have a role in receiving patients back who require ongoing care in hospital and will have a suitable 'landing pad' via an automatic acceptance policy
- Rural trauma facilities at Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest. Whilst there are no specific quality indicators for a rural trauma facility, Hywel Dda University Health Board is committed to ensuring these hospitals maintain the ability to assess and treat major trauma patients, given their relatively unique geographical locations
- A Local Emergency Hospital at Royal Glamorgan Hospital, Llantrisant. This hospital will not routinely receive acute trauma patients but, should this occur, it will ensure appropriate initial management and transfer to the MTC or nearest TU

As a consequence of opening the MTC, there will be changes in patient flow which will impact on all providing organisations across the health system. In order to plan for and manage these changes in flow, detailed modelling work has been undertaken to inform this business case and to ensure that the network plans to meet this new configuration.

## 1.7 Operational Delivery Network

The creation of the Operational Delivery Network (ODN), to be hosted by Swansea Bay University Health Board, is central to the development of the network. The ODN involves cross-organisation and multi-professional working through a whole system collaborative approach, ensuring the delivery of safe and effective services across the patient pathway. The role and responsibilities for the ODN are set out on in a service specification and quality indicators. To facilitate a phased implementation, these have been divided into 'essential', 'desirable' and 'aspirational'. It is essential that the ODN is established in advance of the network 'going live' in order to:

- Implement the clinical and operational framework and structure across the trauma pathway and work with all participating organisations to ensure a state of readiness for delivery of the network within agreed timelines
- Test clinical and non-clinical policies
- Ensure baseline TARN data collection is optimised
- Quality assure key components of the training and education programme
- Establish clinical informatics structures to allow appropriate data collection
- Oversee stakeholder communication and engagement

Key challenges for the network are anticipated as being maintenance of optimal patient flow between the MTC and the TUs and the inability to hold partner organisations to account. It will be essential that the ODN is provided with meaningful authority and this is provided through the design of the network governance structure, outlined in the management case.

## 1.8 Pre-hospital Care and Transfers

The Welsh Ambulance Service (WAST) is a critical enabler in the success of the South Wales Trauma Network. For the vast majority of patients who suffer major trauma, their first contact with NHS Wales will be with the ambulance service when they receive initial care at scene. The service will also play a critical role in taking patients either home following care in the secondary care setting or onwards for their specialist rehabilitation.

There are five quality indicators for pre-hospital care. Presently one is met, two are partially met and two are not met. All of these quality indicators will be met on Day 1. WAST has identified the following requirements to support the establishment of the network:

- Appropriate funding for the new and additional journeys its crews will be making
- Additional training for its staff
- The need for a major trauma desk within the Clinical Contact Centre, Cwmbran
- Resources to support a transfer and discharge service

For completeness and information, the case sets out the requirements for 24/7 availability of EMRTS in South Wales, aligned with the timeline for the network becoming operational. This development has been subject to a separate approval process and recruitment to posts has commenced.

## 1.9 Major Trauma Centre

The establishment of the MTC is pivotal to the development of the trauma network. The case for change identifies areas where investment will be required in order to deliver timely and improved quality of care. The investment required aligns to meeting national adult and children's MTC quality indicators and service specification and a predicted activity uplift of approximately 290 additional patients in year 1. Learning lessons from NHS England, the proposal requires some considerable frontloading, in order to demonstrate maximal benefit.

An analysis has been undertaken reviewing current Cardiff and Vale UHB services against the agreed national quality indicators for MTCs. There are 52 adult indicators and 46 children's indicators in total, with 20 key indicators not currently being met which form the basis of the required investment. The new investment will provide:

- Emergency Department – quality of immediate response and stabilisation from 24/7 consultant trauma team lead; dedicated nursing and seven day paediatric trauma team lead until 10pm.
- Theatres – additional theatre availability to improve timeliness of access to theatres.
- Critical Care – additional capacity to enable the predicted increase in demand.
- Poly Trauma Unit – dedicated ward for acute admission and early targeted rehabilitation in readiness for discharge to local care.
- Trauma & orthopaedics – additional surgical capacity to deliver increased activity flow.
- Hyper acute rehabilitation service – to provide early rehabilitation plans for trauma patients with intensive rehabilitation needs.
- Specialist services – new local plastics surgery availability on site to deliver improved outcomes particularly for debridement surgery and via joint operating. (Through collaboration with SBUHB).
- MTC directorate – senior leadership to drive improvements in rehabilitation, clinical practice and audit & outcomes via the Trauma Audit Research Network (TARN).

Furthermore, the existing arrangements and capacity for specialist rehabilitation at Rookwood Hospital and Neath Port Talbot Hospital will be maintained.

The MTC's role and responsibilities in relation to support and collaboration within the wider network are outlined below and will considerable value to the investment made by all health boards:

- **Clinical Advice & Leadership** - providing clinical advice to other providers within the network, including in pre-hospital stage and whilst patients are awaiting transfer to the MTC for definitive treatment or following acute care when the patient is discharged to on-going specialised or local rehabilitation services.
- **Training, Audit & Quality Improvement** – being actively engaged and contributing to the network, particularly in operational requirements, training, governance and audit, as part of an effective trauma Quality Improvement programme.
- **Rotational Posts & Joint Appointments** - ensuring the development of the MTC does not destabilise other health boards' services; aligned with the principles of workforce recruitment into the MTC.

- **Audit and Quality Improvement** - additional TARN coordinator roles will support the timely and quality entry of a large percentage of network data into the National Audit. This will be key for developing an audit programme for the MTC, in collaboration with the network.
- **Rehabilitation** - providing early/hyper acute rehabilitation as well as a managed transition to rehabilitation and the community. Key roles within this case such as the rehabilitation consultant, consultant AHP, lead therapist and nurse, and psychologists will integrate into the network to support wider programmes of quality improvement, training and education.
- **Collaboration with other Specialist Services** - there are a number of interdependent services and specialties required to work in partnership to deliver seamless and high quality care. In particular, services for major trauma patients with orthoplastic requirements will need close working between C&VUHB and SBUHB to ensure care delivered is to an excellent standard regardless of where the patient is treated.

## 1.10 Health Board Configuration

The structure of the trauma network will include TUs, LEHs and rural trauma facilities, as defined in section 1.6 above.

All TUs are already managing moderate and major trauma patients. In the trauma network, TUs will continue to provide initial assessment, imaging and treatment of trauma patients. They will also enhance existing systems to rapidly move the most severely injured to specialist centres that can manage injuries. In doing so, TUs will develop an effective quality improvement programme. By Day 1, all TUs will have undertaken the requisite level of medical and nursing training and education and embedded network policies within their systems. Organisational governance structures will have been established.

Major trauma practitioners and rehabilitation coordinators will be new roles in the health boards and will be vital in ensuring seamless care of major trauma patients and key points of contact for patients returning from specialist care to the TU or community. A consultant in rehabilitation medicine will operate in each health board on a weekly basis, playing a key role in coordinating the team, managing complex patients and facilitating discharge. Compared to NHS England, the network board have made a commitment to early enablers to improve the rehabilitation pathway, in keeping with the importance of improving functional outcome.

In years two and three, there will be further enhancement of local and community based rehabilitation including core therapy roles as well as some specialist roles (e.g. neuropsychology), providing both in-reach and outreach services.

For complex patients who return from specialist care (e.g. traumatic brain injury, spinal injuries), the network will develop a training and education programme for medical and nursing staff caring for these patients. Thus, the skill set of the rehabilitation multidisciplinary team based at the TU will be identical to the skill set of that based at the MTC.

There are 26 quality indicators for TUs; many are already being met or could be met through the provision of network policies and internal re-organisation of resources. Where additional resources are required, these will be introduced using a phased approach with the initial focus on key enabling posts to improve clinical governance, data collection and patient flow.

Within the network structure, there are two rural trauma facilities in West Wales which will need to maintain the ability to assess and manage major trauma patients. These facilities will be supported by:

- Trauma desk and network pre-hospital triage tool to guide decision-making
- Confirmation of 24/7 EMRTS availability, providing pre-hospital critical care and hyper-acute transfers
- Remote telemedicine to guide management of trauma teams in rural trauma facilities ahead of arrival of EMRTS
- An operational policy between the TU and rural trauma facilities, forming part of the network operational policy

The trauma unit at Morriston Hospital will also have a role in providing specialist services support to the network (e.g. orthoplastics, spinal surgery, level 1 rehabilitation). In addition the trauma unit in ABUHB provide a spinal service for some trauma patients.

## 1.11 Financial Case

The totality of the revenue and capital costs is set out below. The case for the MTC is front-loaded having learnt lessons from the implementation of networks in the rest of UK, which has reinforced the need to achieve quality indicators and service standards at an early stage. This will ensure the maximum benefit for the most seriously injured patients, the majority of whom will go to the MTC. However, there are some elements of the MTC case that are phased. The resource requirements for the TUs reflect a much more phased approach and subsequent business cases may be required (where appropriate) to meet service specification and quality indicators that cannot be met on Day 1.

### Summary of Revenue Costs

	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
MTC Costs	£922	£10,579	£11,222	£11,222	£11,222
Specialist Services Costs	£150	£910	£910	£910	£910
Trauma Unit costs	£287	£1,278	£1,278	£1,278	£1,278
Operational Delivery Network Costs	£119	£496	£508	£513	£515
Pre-Hospital Care	£58	£1,201	£635	£640	£640
<b>Total</b>	<b>£1,536</b>	<b>£14,465</b>	<b>£14,553</b>	<b>£14,562</b>	<b>£14,564</b>

The costs have been derived through an iterative process of reviewing the gap between commissioning expectations and provider costs.



The summary revenue contribution for each health board is outlined below:

<b>Summary of funding of Trauma Network by Health Board</b>					
<b>Reflects local Trauma Unit / Rehabilitation costs plus share of Major Trauma Centre, Specialist Services and WAST Pre-hospital care</b>					
	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
Aneurin Bevan	£353	£3,549	£3,571	£3,573	£3,574
Cwm Taf Morgannwg	£308	£2,743	£2,758	£2,759	£2,760
Cardiff and Vale	£247	£2,808	£2,826	£2,828	£2,829
Hywel Dda	£262	£2,462	£2,477	£2,479	£2,479
Powys	£27	£225	£226	£226	£226
Swansea Bay	£281	£2,678	£2,695	£2,696	£2,697
WAST (2019/20 funded by Welsh Government, year 1 onwards by Health Boards)	£58	£0	£0	£0	£0
<b>Total NHS System Revenue</b>	<b>£1,536</b>	<b>£14,465</b>	<b>£14,553</b>	<b>£14,562</b>	<b>£14,564</b>

There are several factors which will impact on revenue costs and apportionment, including:

- Monitoring changes in RTA income during 2020/21 by health board
- Assessing the impact of the planned earlier repatriation of patients from the MTC to TU 'landing pads'
- Assessing and managing slippage
- Testing the assumption that capital charges will be funded by Welsh Government
- Further review of staffing plans for the MTC
- Monitoring operational efficiencies.

Capital costs will be met through the Welsh Government strategic capital route. Estate development and equipment has been identified by both Cardiff and Vale UHB and Hywel Dda UHB:

<b>Programme Capital Requirements</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
MTC Cardiff & Vale (MTC Construction and Equipment)	£5,426				
Hywel Dda Trauma Unit (West Wales General)			£1,252		
<b>Capital Total</b>	<b>£5,426</b>	<b>£0</b>	<b>£1,252</b>	<b>£0</b>	<b>£0</b>

Future revenue and capital business cases will be prepared by the relevant organisations and a timetable is provided in chapter 9.

## 1.12 Economic Case

There is consistent national and international evidence indicating that the establishment of trauma networks is cost effective.

Within a mature trauma system, investment in the MTC in itself is cost-effective, with evidence of a five to 15 fold return on investment for each patient successfully returned to work. In terms of cost per life year saved, regionalised MTC care costs are cost-effective when compared with the provision of other medical interventions. A recent study from NHS England indicated that English trauma network have been cost effective, given that they are significantly under the NICE QALY threshold for cost effectiveness of £20,000. Based on the expected number of 'candidate' major trauma patients (2,112) across the entire South Wales Trauma Network, the investment is significantly below the NICE QALY threshold of £20,000 (£6,896 per additional QALY gained), comparable with the 2013 study from NHS England on cost effectiveness of trauma networks and with other interventions (e.g. hip and knee replacements).

In addition, approximately an extra 14 lives will be saved per year based on experience of enhanced survival in NHS England. For the given investment, this would equate to a cost of lives saved of approximately £17m per year. Thus, the service would pay for itself in terms of economic benefit.

Linked to cost effectiveness, value will come from realising benefits as outlined in a comprehensive benefits realisation plan. Whilst it is imperative that the network focuses on the key investment objectives of improving survival and functional outcomes, one of the areas that will be measured are the wider system benefits.

## 1.13 Commercial Case

The commercial case outlines the proposed procurement and capital requirements in respect of the preferred way forward. It should be noted that responsibility for the production, delivery and management of capital cases identified as part of this PBC will sit with the providing organisation but will need to be supported by the ODN and wider network.

## 1.14 Management Case

The management case sets out the actions required to ensure the successful delivery of the trauma network against the agreed investment objectives and timeline. To achieve this, it sets out the programme management arrangements and implementation plan. It gives details of the commissioning arrangements and considers how these will affect the organisational and clinical governance arrangements once the network is operational.

Since approval of the recommendations of the independent panel review by health boards in 2018, the programme and the development of this case has been overseen by the trauma network board, which is accountable to WHSSC Joint Committee.

The scope of the commissioning framework is summarised as;

- The ODN will oversee the delivery of trauma services to the population of South Wales, West Wales and South Powys.

- The ODN, Major Trauma Centre at University Hospital Wales and orthoplastic services at Morriston Hospital will be commissioned by WHSSC.
- The Emergency Ambulance Services Committee will commission WAST and the EMRTS.
- Health boards will be responsible for local commissioning.
- Existing trauma commissioning arrangements for Betsi Cadwaladr UHB will be retained.

As the network moves from its planning phase to implementation and operational delivery, hosting of the network will shift from the NHS Wales Health Collaborative to Swansea Bay UHB. A robust and methodological programme arrangement will continue to be applied, but the roles and representation across the programme will be amended as the focus moves from planning for implementation to mobilisation.

The operational governance structure will ensure clear lines of accountability and responsibility across the pathway in order to achieve the best possible outcomes and experience for patients. This will align with the network's mission statement of 'saving lives, improving outcomes, making a difference.'

Evaluation is an essential requirement and the ODN management team will manage the process in partnership with the lead commissioner (WHSSC) and will include participation in national peer review.

## 1.15 Summary and Recommendation

The network board has overseen the development of the structure of the network, comprised of the following elements:

- An Operational Delivery Network (ODN) hosted by Swansea Bay University Health Board
- Pre-hospital developments including WAST and 24/7 EMRTS
- An adult's and children's MTC at UHW, Cardiff
- An adult and paediatric TU with specialist services at Morriston Hospital, Swansea
- Six adult and paediatric TUs at the following locations:
  - UHW, Cardiff
  - Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Aneurin Bevan University Health Board)
  - Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend
  - Glangwilli General Hospital, Carmarthen
- Rural trauma facilities at Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest
- A Local Emergency Hospital at Royal Glamorgan Hospital, Llantrisant

The network board has also developed a phased clinical and operational model, based on the NHS England quality indicators and service specification for major trauma services. All providers and relevant commissioning bodies have agreed this model and requisite resource requirements, following several tiers of internal and external reviews.

The case describes the delivery of absolute requirements for Day 1, but also the schedule of business cases that will follow as part of the phased introduction of the network. In doing so, the case also sets out a timeline for implementation of the network (and composite parts) on 1<sup>st</sup> April 2020, with the ODN management team being put into place in January 2020. Whilst this presents an ambitious timeline, the programme is committed to achieving this.

In order to manage implementation, the case describes a revised implementation structure, commissioning and organisational governance arrangements and workforce principles to maximise positive benefits of recruitment for the wider healthcare system. Finally, a focus is placed on giving the ODN operational authority, particularly in relation to the repatriation of patients from the MTC and maintaining patient flow across the network.

The network board recommends that health boards, commissioners and Welsh Government approve and endorse this Programme Business Case, the agreed structure and the requisite phased resource requirements for the establishment of the South Wales Trauma Network, serving the population of South Wales, West Wales and South Powys, so that it can proceed with implementation.

The programme team would like to thank all contributors for their time and advice in developing this complex and challenging Programme Business Case.

## **2 Strategic Case**

### **2.1 Introduction**

The purpose of this section is to explain how the scope of the proposed programme and investment aligns with national drivers, interdependent policies and the strategic vision for Wales. It also sets out how the programme supports and complements the existing business strategies of NHS Wales, local health boards (health boards), Welsh Ambulance Service NHS Trust (WAST), the Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru, Welsh Government and NHS Wales as a whole. In doing so, it sets out the case for change, in terms of the existing and future operational needs of these organisations, pertaining to major trauma care.

In particular, this section of the Programme Business Case (PBC) demonstrates the strong links between policies, strategies and the drivers of joint working and how these can be used to deliver better trauma services, more efficiently for the people of South Wales, West Wales and South Powys.

The programme is also committed to delivering value for our patients, to provide the best patient outcomes through optimally directing our resources.

### **2.2 Strategic Context**

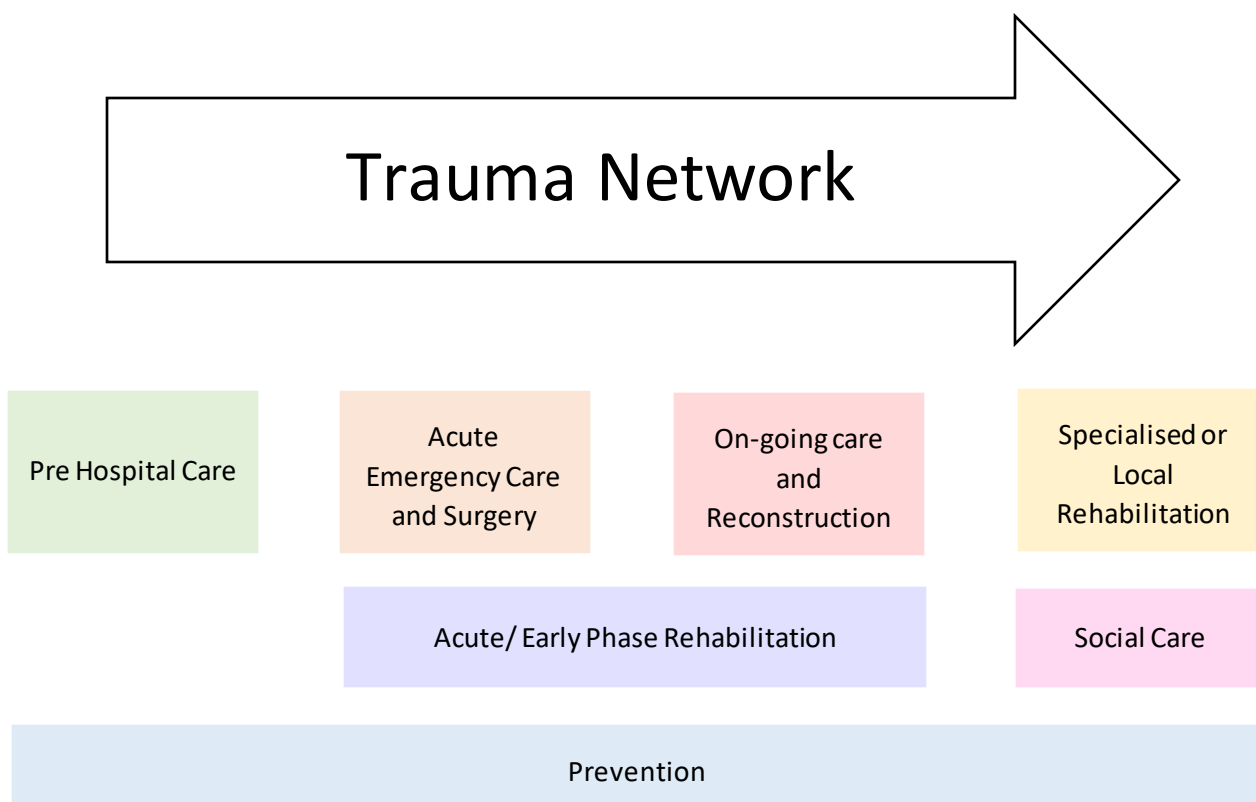
This section outlines the strategic context for the proposed change as follows:

- National drivers for change
- Key interdependent policies
- The local context – population and existing activity profiles
- An overview of the baseline position with respect to the trauma pathway

The vision for the establishment of a trauma network for the population of South Wales, West Wales and South Powys is to enhance patient outcomes and experience, across the entire patient pathway from the point of wounding to recovery and includes injury prevention. The network represents a partnership between participating organisations, each responsible for working collaboratively to achieve this common goal and purpose. The trauma network will improve patient outcomes by saving life and preventing avoidable disability, returning patients to their families, work and education.

A trauma network consists of a Major Trauma Centre (MTC), with a number of Trauma Units (TUs) and Local Emergency Hospitals (LEHs), and rehabilitation services. The trauma network ensures rapid transfer of patients who are most severely injured from the scene of an incident or other hospitals to the MTC, in order to benefit from timely and efficient specialist care. Care continues closer to home or in the community once specialist care is completed. Care closer to home is generally facilitated through rehabilitation. Indeed, the key to keeping the trauma pathway open is for specialist and local rehabilitation to be optimally organised and resourced, linking into continuing healthcare packages for patients who need them. Benefit for patients is realised across the network, not just in the MTC.

The trauma pathway consists of a number of component parts in the patient's journey, with the relationship between, and integrity of, component parts being critical to the successful delivery of the network. Each part has equal merit. This is summarised in the diagram overleaf.



## 2.3 National Drivers for Change

This section sets out the links between the proposed investment and key national drivers for change.

### 2.3.1 A Healthier Wales

*A Healthier Wales* (2018) sets out a long-term vision of a “whole system approach to health and social care”. Underpinning this is the ‘quadruple aim’ of improving population health and wellbeing; better quality and more accessible health and social care service; higher value health and social care and a motivated and sustainable health and social care workforce. Thus, both Prudent Healthcare and Value-Based Healthcare principles underpin the plan. The development of the trauma network sits firmly within this strategic space, as it will deliver care in the right way and at the right time:

- A whole system approach with seamless coordination between health and social care – as reflected in the above trauma pathway
- An equitable system, which achieves the best health outcomes for all – equity of access to specialist care is an important investment objective for the trauma network
- Delivery of services as close to home as possible – this aligns with the requirements for a congruent health and social care model, so that once specialist care is complete, rehabilitation can be delivered within the community setting as soon as possible
- Using technology to support high quality, sustainable services – this is explored further in Chapter 5 on improving data collection on outcomes and experience

### 2.3.2 Strategic Drivers

The development of the trauma network aligns itself with a number of other strategic drivers specific to Wales:

- **NHS Wales Service Change Plans** – NHS Wales is undergoing a series of changes focusing on the reshaping of acute clinical services, with a view to changing the delivery of some services. This includes centralisation of specialist care (e.g. for patients who sustain cardiac arrests and regain a pulse), with the rationale of delivering improved clinical outcomes and ensure services remain sustainable in the face of challenges in the medical workforce. Each health

board will have its own clinical priorities. Specific examples include Hywel Dda University Health Board plans for Transforming Clinical Services and the development of The Grange University Hospital for specialist and clinical critical care services in Aneurin Bevan University Health Board (ABUHB).

- **National Programme for Unscheduled Care** – The aim of this programme is to redesign unscheduled care processes across the total patient journey and to alleviate pressure within the system including the National Collaborative Commissioning Unit's current programme of work in these areas (e.g. the Emergency Department Quality and Delivery Framework).

### 2.3.3 Trauma Specific National Drivers

There are a number of trauma specific national drivers relevant to the development of the trauma network, which will increasingly have an impact on the delivery of health services across Wales. The points below summarise these drivers:

- **National Reports** – the National Audit Office (2010) report on major trauma care in England and the *National Confidential Enquiry into Patient Outcome and Death* (2007) were key reports highlighting deficiencies in trauma care in the UK and resultant negative impact on survival and outcomes for patients suffering major trauma. These reports identified that services achieve better care and outcomes when formal trauma networks are in place.
- **Trauma Networks in the UK and Ireland** – based on the above, NHS England established regional trauma networks. In 2010, London introduced its pan-regional major trauma system, consisting of four trauma networks, each with an MTC. Following this, regional trauma networks were established in the rest of England, now consisting of 11 adult MTCs, 5 children's MTCs and 11 combined adult and children's MTCs. Delivery of these networks occurred simultaneously in April 2012 and have taken five years to develop and mature. In 2018, the Scottish Trauma Network was established, with four regional trauma networks and MTCs in Aberdeen and Dundee, as part of a phased five-year development. The Scottish Government is making an incremental new investment of £27 million per year into major trauma services. Furthermore, both Northern Ireland and the Republic of Ireland are making good progress with their respective developments.
- **Trauma Network in North Wales** – since 2012, North Wales has formed part of the North West Midlands and North Wales Trauma Network, with patients from TUs in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital going to the MTC at Royal Stoke University Hospital.
- **Service Specification and Clinical Standards** – a hallmark report, NHS Clinical Advisory Groups (CAG) Report (2010) *Regional Networks for Major Trauma*, underpinned the development of the above networks, which provides detailed recommendations for the delivery of trauma services across the patient pathway. This report formed the basis of the NHS England service specification and quality standards. The North Wales service already aligns with the position set out in this report. Furthermore, there are number of evidence-based clinical guidelines that support the service specification (e.g. National Institute of Clinical Excellence *Trauma Guidelines* – 2018, British Society of Rehabilitation Medicine *Core Standards for Specialist Trauma Rehabilitation* – 2014).

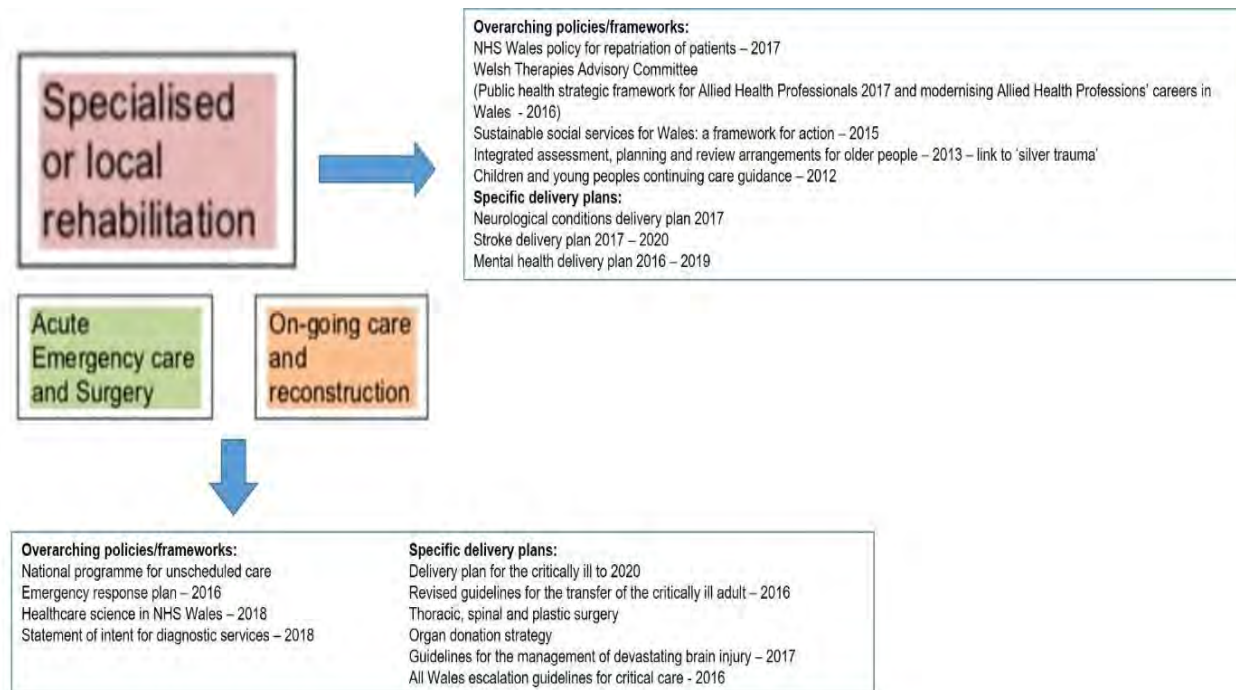
In March 2018, based on the above and the work undertaken since 2012 to develop a trauma network (see subsequent chapters for details), all six health boards covered by the proposed trauma network fully endorsed the recommendations of an independent expert panel review, which indicated that:

- A major trauma network for South and West Wales and South Powys with a clinical governance infrastructure should be quickly developed
- The adults and children's MTCs should be on the same site

- The MTC should be at University Hospital of Wales, Cardiff
- Morriston Hospital should become a large TU and should have a lead role for the major trauma network
- A clear and realistic timetable for putting the trauma network in place should be set

## 2.4 Key Interdependent Policies

There are a number of clinical and non-clinical policies developed and endorsed by Welsh Government that align with the development of the trauma network as shown below:



### 2.4.1 Critical Care

The Welsh Government *Critical Care Task and Finish Group Report*, published in July 2019, set out a national directed programme, which looks strategically at the issues and challenges for critical care services across Wales. The approach builds on the work already being taken forward with the implementation of the delivery plan for the critically ill. The report is honest about the challenges facing critical care, and provides a strategic view on the steps necessary to ensure services for people who are critically ill are fit for the future.

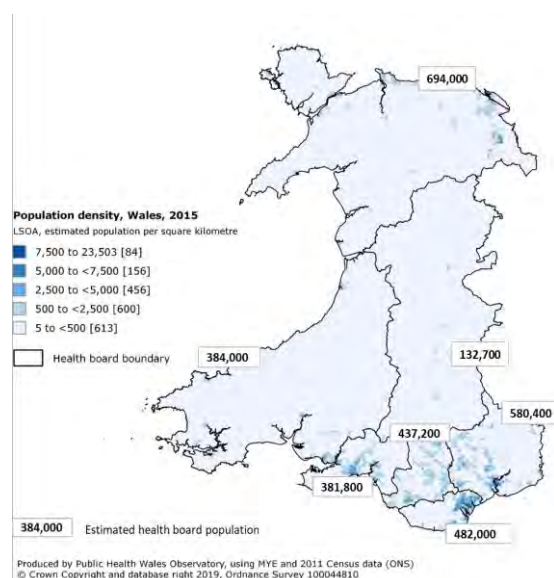
The report makes a number of recommendations that will benefit the establishment of the trauma network. These include the establishment of a non-emergency transfer service for critically ill adults, the development of a long-term ventilation unit, some additional critical care capacity within regional services as well as supporting the development of local services such as post-anaesthetic care units (PACU) and critical care outreach. This work will not replace the need for investment in critical care services, which are necessary for major trauma patients within the MTC.



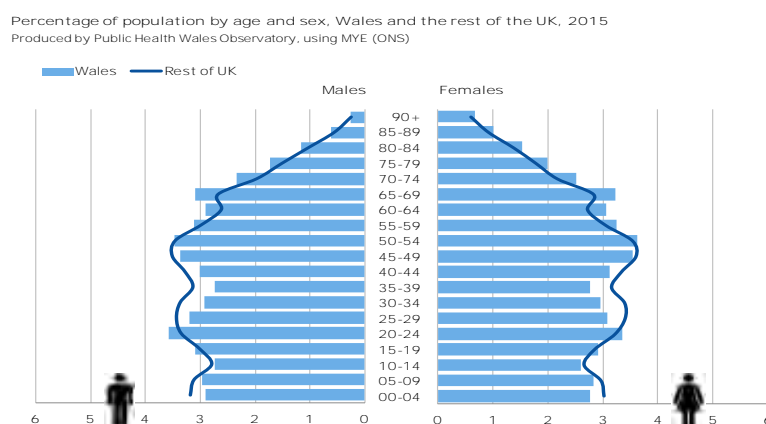
## 2.5 Population and Existing Activity Profiles

### 2.5.1 Population Profile

In 2015, the total population of Wales was approximately three million people, excluding transient populations. The population of South Wales, West Wales and South Powys was 2.4 million people. The map below shows population density and breakdown per health board (Note a boundary change took effect from April 2019):



The above graphic illustrates that the population of South Wales is concentrated in the densely populated urban areas of Cardiff, Newport and Swansea, with a spread across more sparsely populated rural areas. It is likely that major trauma would follow this distribution, being concentrated in more urban areas of higher population density.



The above figure demonstrates that Wales has a similar population structure to the rest of the UK, but with slightly more older people and fewer younger working age adults aged 25-50 years. Furthermore, the age structure of the population varies across South and West Wales, with Pembrokeshire, Monmouthshire and Swansea (in that order) demonstrating a higher proportion of older people compared to Cardiff. Moreover, in the last 10 years, the population of Wales has become older with a 54% increase predicted in the over 65s by 2036. This provides evidence for considering the design of the trauma network, taking into account the changing population.

Paediatric major trauma is most common in children under the age of one year, with this peak in incidence often being accounted for by non-accidental injury. Across all paediatric age groups, road

traffic collisions are the commonest mechanism of injury and head injuries are the predominant injury type. Severely injured children present mostly in daytime hours with a peak in the evenings and at weekends. Paediatric major trauma after midnight is rare. It should be recognised that a significant number of children with major trauma arrive at emergency departments by car and therefore may continue to attend their nearest hospital.

## 2.5.2 Existing Activity Profiles

Fewer than 0.1% (1/1000) patients who arrive at an emergency department will have major trauma. Based on the population of South Wales, West Wales and South Powys this equates to approximately 2,400 cases per year. In 2016, approximately 750,000 people attended an emergency department and the Welsh Ambulance Service attends approximately 800 emergency calls across Wales per day. Thus, major trauma represents a small proportion of the unscheduled care workload.

Furthermore, the incidence of paediatric major trauma is even lower. However, the face of major trauma is changing. Whilst the overall incidence of major trauma has not increased in the UK, the incidence of major trauma in older people greatly exceeds earlier predictions in NHS England. Rather than being something that afflicts young men, the majority suffering major trauma are now older than 65 years of age. This is likely to hold true for Wales, given the population profile described above.

The table below illustrates the expected number of cases per year modelled on the Trauma Audit Research Network (TARN) data reported for 2016-2017, using hospitals with good TARN data collection. The data is broken down according to Injury Severity Score (ISS) – see glossary of terms:

Site	Moderate Trauma ISS 9-15	Major Trauma ISS>15	'Candidate' Major Trauma Total
Morriston Hospital	227	147	374
Princess of Wales Hospital	91	59	150
Aneurin Bevan UHB	255	166	421
University Hospital Wales	181	335	516
Prince Charles Hospital	97	63	160
Royal Glamorgan Hospital	84	55	139
Bronglais General Hospital	41	27	68
Glangwili General Hospital	111	72	183
Withybush General Hospital	65	42	107
<b>Total</b>	<b>1,146</b>	<b>966</b>	<b>2,112</b>

Finally, a TARN report for the region from 2017-2018, demonstrated that falls from greater than two metres were the commonest mechanism of injury (56%), followed by road traffic collisions, falls from

less than two metres and penetrating trauma (e.g. shootings and stabbings). Falls from less than two metres demonstrate no seasonal variation whilst the peak time for road traffic collisions/falls from height appears to be between 3pm-6pm, with the lowest period of activity between 12am-6am.

## **2.6 Overview of the Current Position – The Trauma Pathway**

Currently there is no adult and paediatric trauma network serving the population of South Wales, West Wales and South Powys. Whilst there are examples of good clinical and operational governance within participating organisations, there is no oversight of strategic planning, operational delivery, local advice, maintaining quality and standards of care and partnership development. NHS organisations in South Wales, West Wales and South Powys have undertaken the following to assess the value gap and level of confidence in the existing trauma pathway.

### **2.6.2 Pre-hospital Care and Secondary Transfers**

#### **Welsh Ambulance Service NHS Trust (WAST)**

The main provider of pre-hospital care and secondary transfers for major trauma patients is WAST, which is commissioned by the Emergency Ambulance Services Committee (EASC). However WAST is supported by a number of organisations including the Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru, healthboards, the Critical Care Network, paediatric retrieval services and third sector organisations.

As part of WAST's quality strategy (2016-2019) there have been a number of advances with respect to trauma management, including improvements in guidelines, equipment, and administration of Tranexamic acid. In 2015, WAST introduced a new clinical response model to identify those patients who require an immediate life-saving response, to receive the highest priority response in the fastest time possible, which was evaluated as part of the Amber Review in 2018.

Presently, a number of patients are taken by WAST directly to specialist units. This includes patients suffering from an ST elevation myocardial infarction (heart attack) and cerebrovascular accident (stroke). However, in the absence of pre-hospital enhanced care, ambulance crews take many patients suffering major trauma to the nearest emergency department (ED), rather than directly to specialist definitive care. Whilst a pre-alert process exists for informing EDs about critically injured patients, this is not consistently undertaken and delivered across the regions. There is also variation in the handover of these patients on arrival at the ED.

#### **Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru**

In April 2015, EMRTS went live from its South and Mid Wales bases. EMRTS represents a collaboration between NHS Wales and the Wales Air Ambulance Charity Trust (WAACT). The service is hosted by Swansea Bay University Health Board and commissioned by the Emergency Ambulance Services Committee (EASC). It is a consultant led, consultant delivered, road and air based service providing the following:

- Pre-hospital critical care for all age groups (advanced airway management and anaesthesia, surgical interventions and advanced haemorrhage control including blood products).
- Time critical adult and paediatric inter-hospital transfers.
- Coordination of above and provision of advice to WAST through a National Air Support Desk staffed by an EMRTS Critical Care Practitioner (CCP) and allocator, with remote support by a 'Top Cover' consultant.

The above has allowed enhanced decision-making for major trauma patients to bypass their local hospital and be taken directly to specialist centres at University Hospital of Wales, Cardiff and Morriston Hospital, Swansea. The service has robust operational and clinical governance in place and

a number of best practice Standard Operating Procedures related to major trauma. Major trauma represents approximately half of the service's workload.

In 2017, the service expanded to include North Wales. In addition, the WAACT provided a charity funded service from Cardiff Heliport for Paediatric/Neonatal retrieval teams and long distance repatriations.

The EMRTS is currently only a 12 hour service (8am-8pm). Outside of these hours, voluntary organisations (including BASICS schemes in South and Mid Wales) provide a doctor at the scene on an ad hoc basis to provide a variable level of care for major trauma patients outside standard ambulance service practice.

The service is undergoing a phased temporal and geographical expansion as part of the ongoing programme of service development. The first phase of this expansion will be the introduction of a South Wales overnight service with effect from April 2020. (See chapter 6)

### **Third Sector and Commercial Organisations**

For the provision of extrication and initial management of trauma patients in austere environments, there are six Mountain Rescue services and several Royal National Lifeboat Institute Coastguard services. In addition WAST provides a tier of volunteer Community First Responder, who will frequently be first on scene at an incident.

Since 2015, Bristow has run commercial helicopter operations from Caernarfon airport and RAF St Athan in Cardiff, providing Search and Rescue services. The service is principally for rescue and recovery, but will frequently take patients to nearest accessible Emergency Department. Requests from health boards for support with transfers, regardless of urgency, are not guaranteed to be undertaken and are chargeable. In recent years, the service has developed a close working relationship with WAST and EMRTS.

### **Adult and Paediatric Critical Care Transfers**

In the absence of the EMRTS, health boards are required to undertake adult critical care transfers for patients that require definitive care in specialist centres, using WAST to access an ambulance. These transfers are overseen by the Wales Critical Care and Trauma Network (principally it is a trauma network due to the already-established Trauma service for North Wales), who provide oversight of clinical and operational governance. Health boards also perform time-critical paediatric transfers in the absence of the EMRTS. In addition, the Wales and West Acute Transport for Children Service (WATCH), based in Bristol undertake paediatric critical care transfers that do not require immediate onward transfer.

## **2.6.3 Acute Emergency Care and Surgery**

### **Overview of Provision**

There are six health boards covering the region of South Wales, West Wales and South Powys. Across the region, 10 emergency departments currently receive major trauma patients. Variation exists in the seniority of trauma team leaders and the threshold for activation of trauma teams. The composition of trauma teams also differs, but all hospitals have access to anaesthetists, intensive care physicians, general surgeons and trauma and orthopaedic surgeons. The rapid availability of blood products is achieved through activation of hospital massive transfusion protocols. There is also access to CT scanning, emergency theatres and intensive care, but variable access to MRI scanning.

Historically, University Hospital of Wales (UHW) and Morriston Hospital have been the main centres for receiving major trauma patients in the regions.

### **University Hospital of Wales (UHW), Cardiff**

UHW (Cardiff and Vale University Health Board – C&VUHB) has established a major trauma directorate, which since 2016 has been overseeing the development of a cohesive plan for a high quality trauma

service for patients. Activities have included establishing major trauma service models, clinical governance, training, patient experience, pathways and protocols. So far, this has been overseen by a clinical lead and deputy lead, trauma manager and two major trauma practitioners.

Patients arrive by road or by air (at a co-located 24 hour lit helipad) and receive treatment in the emergency unit. The unit has the following features: a seven bedded resuscitation room including a dedicated paediatric bay equipped with advanced airway equipment; ultrasound; rapid blood transfusers; and a co-located CT scanner allowing selected patients to be transferred direct to the scanner by the EMRTS. There is a tier of consultants in emergency medicine and paediatric emergency medicine, supported by a multidisciplinary team.

Radiology is supported by 24-hour access to interventional radiology following the centralisation of vascular surgery in South East Wales and 24 hour access to MRI scanning. UHW also has two 24 hour emergency theatres and a trauma and orthopaedic theatre. Several surgeons currently have a specific interest in trauma surgery.

In addition to the services outlined above, UHW provides the following specialties pertaining to emergency trauma surgery:

- Neurosciences – 10 neurosurgeons provide the single adult and paediatric neurosurgery unit for the region, including two neurosurgical theatres.
- Cardiothoracic surgery – the service is delivered by five cardiac and three thoracic surgeons. The service includes repair of blunt and penetrating injuries, aortic injuries (including endovascular repair) and rib fixations. There are three dedicated cardiothoracic theatres.
- Welsh Centre for Spinal Trauma and Surgery – provided by seven spinal surgeons with access to emergency and trauma and orthopaedic theatres.
- Vascular/endovascular Surgery.
- Oral and maxillofacial surgery, urology, ENT surgery and obstetrics.

In addition to the above the trauma and orthopaedic unit provides specialist care for patients with pelvic and acetabular trauma and complex extremity trauma. However, there is no dedicated plastic surgery service.

UHW is host to the Noah's Ark Children's Hospital for Wales, which includes a paediatric intensive care unit, neonatal intensive care unit, general paediatric medicine, specialist paediatric medicine, paediatric surgery, paediatric trauma and orthopaedics, children's theatres and children's x-ray department.

### **Morriston Hospital, Swansea**

Morriston Hospital (Swansea Bay University Health Board - SBUHB) has an emergency department with a five-bedded resuscitation room, with patients arriving by road and by air at a 24 hour lit helipad. In addition to the services outlined above, Morriston Hospital provides the following specialties pertaining to trauma surgery:

- Welsh Centre for Burns and Plastic Surgery – the centre provides tertiary care for plastic surgery for South Wales, West Wales and South Powys. Adult burns care is provided for both South Wales and South West England. The service consists of dedicated burns and plastics theatres and an intensive care unit, led by specialist multidisciplinary teams. This forms part of the regional Burns Network for adults, with transfer of paediatric major burns to the Bristol Children's Hospitals.
- Cardiothoracic surgery – five cardiac surgeons and two thoracic surgeons. Following a recent independent review of thoracic surgery in 2017 and a public consultation process, Health Boards have recommended a single thoracic centre at Morriston Hospital.

- Trauma and orthopaedics – one consultant with an interest in orthoplastic surgery, pelvic surgery, complex extremity surgery and rib fixations.
- Spinal surgery – three spinal surgeons provides urgent but not emergency spinal surgery for trauma.
- Oral and maxillofacial surgery, urology and ENT surgery.

#### **All Other Health Boards**

The following hospitals currently provide acute emergency and predominantly non-specialised surgery for major trauma patients:

- Aneurin Bevan University Health Board (ABUHB) – The Royal Gwent Hospital, Newport (with some urgent pelvic and spinal surgery) and Nevill Hall Hospital, Abergavenny. This is pending the opening of The Grange University Hospital in Cwmbran (Spring 2021) which will result in a single acute hospital site within the health board.
- Cwm Taf Morgannwg University Health Board (CTMUHB) – Prince Charles Hospital, Merthyr Tydfil, Princess of Wales Hospital, Bridgend (following Health Board boundary changes in April 2019) and Royal Glamorgan Hospital, Llantrisant.
- Hywel Dda University Health Board (HDUHB) – Glangwili General Hospital, Carmarthen, Withybush General Hospital, Haverfordwest and Bronglais General Hospital, Aberystwyth.

Of note, Powys Teaching Health Board (PTHB) does not have an acute hospital. In the absence of the EMRTS, WAST conveys major trauma patients in South Powys to Bronglais General Hospital, Prince Charles Hospital, Nevill Hall Hospital and Hereford County Hospital (which is a TU).

All health boards include a number of minor injury units to which major trauma patients may infrequently self-present, but are rapidly transferred to the one of the above hospitals.

All health boards have the ability to transfer radiology images using the PACS (Picture Archiving and Communications Systems).

#### **Major Incidents**

WAST is a 'Category 1 responder' under the auspices of the Civil Contingencies Act 2004, with responsibilities at a major incident or mass casualty event for co-ordinating health resources, casualty triage, treatment, and casualty removal from scene. Augmenting this responsibility is a tiered response from the EMRTS and hospital based MERIT teams. All health boards have emergency planners and hospital major incident plans in place. Strategically, there is a national framework in place for mass casualty events including capacity planning in the event of a major incident.

### **2.6.4 On-going Care and Reconstruction**

#### **Intensive Care Medicine**

All of the hospitals proposed for MTC, TU or LEH status have intensive care units providing Level 2 (high dependency) and Level 3 (intensive care) ongoing care for major trauma patients.

UHW has a 33-bedded adult intensive care unit supporting a number of regional trauma tertiary services including neurocritical care, spinal injuries, oral and maxillofacial surgery, vascular, and thoracic Surgery. It has the presence of consultants delivering a 24 hour resident service. It has recurrent funding to staff 28 Level 3 beds. In addition, UHW has a dedicated cardiac intensive care unit and paediatric intensive care unit.

Morrison Hospital has a 22-bedded adult intensive care unit, a cardiac intensive care unit and an adult burns intensive care unit.

## **Surgery and Ward Care**

Presently, UHW provides regional neurosciences services including an 18 bedded high care ward with a further 35 general neurosurgical beds. Facilities also exist for the management of craniofacial trauma spinal trauma and hand surgery.

In the present system, patients who require definitive surgery for orthoplastic trauma are transferred to Morriston Hospital, which has facilities for managing complex orthoplastic surgery, peripheral nerve injuries, and hand injuries. Specialist burns management is also provided.

None of the receiving health boards has dedicated trauma services that directly admit major trauma patients. Currently, patients are admitted under the speciality that covers the predominant injury or the one requiring operative intervention. Whilst all health boards have orthogeriatric input into the care of patients with neck of femur fractures, there is variable input into the care of older major trauma patients.

### **Repatriation ('Care Closer to Home')**

An NHS Wales policy, endorsed by all health boards, outlines the process for repatriating individual patients for 'care closer to home' once specialist care is complete. This consists of an operational process, escalation procedures and the requirements to complete a repatriation database including delayed transfer of care.

WAST undertakes transfers of patients from specialist care to their local hospital including use of the Non-Emergency Patient Transfer Service (NEPTS).

## **2.6.5 Rehabilitation**

The Welsh Health Specialist Services Committee (WHSSC) commissions adult and paediatric rehabilitation for spinal injury, brain injury and paediatric rehabilitation and health boards provide services for older people and for musculoskeletal rehabilitation. WHSSC commissioned services provide equitable access across the geographical region covered by the planned trauma network. The services provided by the health boards are varied and there is no current agreed service model.

WHSSC commissions 26 spinal injury beds and 22 acquired brain injury beds based at Rookwood Hospital in Cardiff. Both teams provide a weekly in-reach service to review acute referrals and provide advice to the University Hospital of Wales. Both teams review approximately three times the number of individuals than they admit to their beds. There is provision at Llandough Hospital for managing individuals with spinal injury requiring ventilation, but this is not a formally commissioned service.

There are 12 acquired brain injury beds at Neath Port Talbot hospital. These beds would be defined as a Level 1 unit by the English definition of rehabilitation services: serving a population of over a million people and led by a consultant in rehabilitation medicine. There are no English definition Level 2 units commissioned by WHSSC or the health boards. Community services are patchy, with no agreed model and centre on brain injury provision. The region currently has consultants in adult rehabilitation medicine, supported by neurology consultants and a senior speciality doctor. There is one rehabilitation medicine trainee in Wales based at Rookwood Hospital, rotational neurology trainees and three junior posts at Rookwood Hospital.

There are community neurological rehabilitation teams in all of the health boards but there are no common referral criteria or service models. There is a community brain injury service in C&VUHB, CTUHB and SBUHB, but again with different service models and referral criteria.

The paediatric rehabilitation commissioned at the Children's Hospital for Wales provides inpatient rehabilitation. This Phase 1 provision has avoided the need for external specialist placements (e.g. Tadworth) but the resources do not allow formal outreach services provision to the other health boards. There is no Certificate of Completion of Training (CCT) in paediatric rehabilitation and a paediatric neurologist with an interest in this area leads the team.

With respect to psychology and neuropsychology for adult and paediatric patients that experience major trauma, there is a variable and complex provision across the region, which is complex. In C&VUHB, patients with spinal injuries have access to inpatient psychological support at Rookwood Hospital or during their care in Intensive Care, but not on the spinal ward or in the community. This also applies to patients who go to SBUHB, there is a community traumatic brain injury service with a one whole time equivalent (WTE) clinical psychologist and the same in HDUHB. There are no acute or in-reach neuropsychological assessments or treatment in the health board.

A number of third sector organisations work alongside the healthcare sector (e.g. Headway).

### **Trauma Prevention Programmes**

In Wales, prevention programmes are led through Public Health Wales. In 2011, a report by Public Health Wales was published on the burden of injury in Wales and outlined a series of recommendations. The main interventions that have occurred are in relation to preventing falls in older patients.

## **2.6.6 Clinical and Operational Governance**

### **Training and Education**

There have been a number of improvements in the awareness of trauma management by WAST, predominantly through local educational initiatives and EMRTS engagement events. In relation to acute emergency care, each health board has developed its own approach to trauma training. In 2012, Morriston Hospital established the Trauma Resuscitation Education and Training Sessions (TREATS) for a multidisciplinary audience. TREATS has now been adopted by Hywel Dda University Health Board. UHW runs an equivalent course (titled the Cardiff Trauma Course). A number of locally run courses exist for trauma team leader training and emergency trauma anaesthesia. In addition to this, all health boards are providers for and/or have access to the Advanced Trauma Life Support Course (ATLS), Advanced Paediatric Trauma Life Support (APLS) or the European Paediatric Life Support Course (EPALS). There are no providers of the European Trauma Course (ETC) in the region. Some senior nurses across the network have attended the Trauma Nursing Core Course (TNCC). In addition, there is senior nursing representation on the National Major Trauma Nurses Group, which informs standards and competencies for nurses across trauma networks. Finally, training in Damage Control Surgery is outsourced to the Definitive Surgical Trauma Skills (DSTS) Course.

In 2018, Health Education and Improvement Wales (HEIW) was established as a new special health authority in Wales, bringing together the Wales Deanery, NHS Wales' Workforce Education and Development Services (WEDS) and the Wales Centre for Pharmacy Professional Education (WCPPE). There is a material link with supporting the development of trauma training and education across the network.

### **Trauma Audit and Research Network (TARN) and Research**

TARN is the national clinical audit for traumatic injury across England, Wales, Ireland and a number of hospitals across Europe. It holds the second largest global trauma registry and has become a key national provider for the delivery of evidence of quality of trauma care for both clinical and commissioning purposes, providing and supporting the functionality for hospitals to collect individual patient data. TARN delivers information in the form of national clinical reports and dashboards to support hospitals in their governance of trauma care. Its data has been the driver for commissioning of trauma services in England and is hosted by Manchester University.

Five health boards across the region contribute to TARN, but case ascertainment and accreditation within health boards varies considerably. One health board contributes to TARN Patient Reported Outcome Measures (PROMS) and Patient Related Experience Measures (PREMS). Two health boards have dedicated TARN coordinators (hosted by clinical audit departments) to identify cases and submit



entries to TARN. All participating health boards have non-dedicated support for data collection (e.g. clinicians).

There are a number of opportunities for research in the area of trauma management across the region and examples from both UHW and Morriston Hospital (incl. the Welsh Centre for Emergency Medicine Research). Furthermore, Swansea University has a long history of supporting trauma research at an international level through the Secure Anonymised Information Linkage (SAIL) database.

### **Clinical Informatics**

Currently, clinical informatics support for the various stages of the patient pathway is provided by health board informatics departments, WAST and the NHS Wales Informatics Service (NWIS). Whilst much progress has been made at a national level to create a single integrated patient record accessible through the Welsh Clinical Portal (WCP), there exists a number of opportunities to further enhance the linkage and transfer of information between care providers. WAST and EMRTS maintain pre-hospital records, and these are available in both paper and electronic form. Health boards maintain a combination of paper based and electronic records. Local informatics departments support the work of those who collect TARN data locally by producing reports of potential major trauma patients facilitating access to results of investigations and tracking of patient notes. The current process is labour intensive, but could be improved through the linkage and improved use of routinely collected data.

WAST and the EMRTS already work together to improve the data quality feeding of national audits (e.g. National Cardiac Arrest Registry), and are both working to improve accessibility to patient data to improve healthcare delivery across the range of patients seen (e.g. ongoing national WCP trials). As already mentioned, one health board already collects PROMS for TARN, in addition to existing PROMS data collection by EMRTS as part of its ongoing service evaluation.

A number of systems currently support patients who suffer from major trauma at various stages in their patient journey. These include: MIS C3 Ambulance control system; WAST Anoto e-Pen system; EMRTS Clinical database; Emergency department systems; Welsh Care Records Service (WCRS); Welsh Clinical Portal (WCP) Welsh Patient Referral Service (WPRS); Welsh Results Reports Service (WRRS); Welsh Patient Administration System (WPAS); Welsh GP Record; and TARN data collection system.

## 3 Case for Change

### 3.1 Introduction

This chapter sets out a comprehensive case for establishing a trauma network for the population of South Wales, West Wales and South Powys. It should be recognised that major trauma patients are already being managed across our healthcare system including in specialist centres; therefore, the development of a trauma network represents a significant service change, but not a new service development. Thus, the programme has been developed based on strengthening existing clinical services through re-organisation, introducing new pathways and enhancing clinical and operational governance. Furthermore, requirements for additional resources have been considered within the context of enhancing existing service specifications to meet national standards for major trauma.

Building on the current position described in chapter two, details are provided on the difficulties and service gaps associated with existing organisations against the trauma pathway, compared to what is occurring in regions with established trauma networks.

Furthermore, key benefits are identified using an evidence-based approach and lessons learnt from both national and international experience. An emphasis is placed on the added value of developing a trauma network to wider NHS clinical services. In doing so, this chapter makes a strong case for benefits being realised, against the key investment objectives outlined below, to ensure NHS Wales leads the way in the provision of excellent trauma care through establishing the network.

Finally, this chapter describes the value to individual organisations and how the network development aligns with their strategic plans.

### 3.2 Investment Objectives

The overarching investment objective of a trauma network for the population of South Wales, West Wales and South Powys can be summarised by the network's mission statement:

**'Saving Lives, Improving Outcomes, Making a Difference'**

Furthermore, key investment objectives defined by Welsh Government are referenced throughout this business case with added value that could be delivered. These include:

- **Health gain:** improving patient experience and outcomes.
- **Equity:** where people of highest health needs are targeted first.
- **Clinical and skills sustainability:** reducing service and workforce vulnerabilities and demonstrating solutions that are flexible and robust to a range of future scenarios.
- **Value for money:** demonstrating the least costly way of generating the anticipated benefits.
- **Affordability:** given the revenue assumptions, there should be an explicit reference to reducing revenue costs. This will be discussed in section chapter 10 – the economic case.

During the development of the programme, the network board recognised the importance of all of the above investment objectives, however, health gain for the population was deemed most important and aligns with the mission statement of the network.

A fundamental rationale is to improve patient outcomes through organising services into a trauma network and enhancing services through a phased investment and working towards meeting national standards. The table below summarises these benefits against key investment objectives which are expanded on in this chapter, chapter 12 and evidenced by a recent literature review focused on the value of major trauma networks (see Appendix 1):

Investment objective	Benefits
<b>Health gain</b>	Improving survival Improving functional outcomes Improving timely clinical care and patient experience Improving data collection Enhancing response at major incidents or mass casualty events Enhancing injury prevention
<b>Equity</b>	Enhancing access to specialist care Enhancing patient flow System wide improvements in care Equity of care for trauma in older people Veterans trauma network
<b>Clinical and skills sustainability</b>	Enhancing multiprofessional training and education Enhancing recruitment and retention of workforce Developing of new roles and ways of working
<b>Value for money</b>	Economic benefits Savings across the system Value to other patient groups and networks

### 3.3 Summary of Service Opportunities

Following on from the key investment objectives, the intention of the programme is to establish a model of care, using a phased approach, aligned with quality indicators and service specification. These are summarised below and developed further in chapters five - eight:

- There is an opportunity for new investment in major trauma services in South Wales, West Wales and South Powys to clearly improve the outcomes in major trauma.
- In doing so, there is an opportunity to develop an adult and paediatric trauma network covering the region of South Wales, West Wales and South Powys.
- There will be a designated adult and/or paediatric MTC to serve the region of South Wales, West Wales and South Powys.
- There is an opportunity to implement and develop designated regional TUs to serve the region of South Wales, West Wales and South Powys.
- Consistent clinical standards and specifications will be put into place for the management of seriously injured patients across the region. Furthermore, there will be a network management structure overseeing how care is being coordinated or provided.

- WAST will be able to develop and utilise a pre-hospital trauma triage tool to identify patients requiring specialist centres. The opportunity to develop a trauma desk facility will enable coordination and remote clinical incident support.
- The EMRTS will become a 24 hour service in April 2020 as part of its phased development. There will be dedicated access to pre-hospital critical care or transfer capability for major trauma patients.
- There will be a single point of access and an automatic acceptance policy into specialist centres in the region. Referrals have previously been often made to multiple teams in the receiving centres for those patients requiring hyper-acute transfers. The development of the network will directly avoid delays in access to treatment.
- Pathways for patients requiring urgent transfer for injuries that require operative intervention in specialist centres will be developed.
- The network will ensure there is an end to variation in seniority of trauma team leaders and the composition of hospital trauma teams across the region, responsible for reception and resuscitation.
- Specialist centres will be able to guarantee the presence of a consultant trauma team leader 24 hour a day. Furthermore, there can be consistency in initial and ongoing clinical assessment and treatment, imaging and documentation. In particular, systems can be established to recognise and manage trauma in older people.
- There is an opportunity to eliminate the variation in the anaesthetic and surgical approach to managing trauma patients with significant haemorrhage.
- There is an opportunity for specialist centres to have major trauma service or ward under which patients are admitted and managed. This will be addressed with the network approach to major trauma. Currently, patients are often admitted under several specialties.
- There is an opportunity to improve access to hyper-acute rehabilitation and develop an early rehabilitation plan for trauma patients.
- Patients will have better and more rapid access to specialist neuro and spinal rehabilitation than they currently do. There will be automatic repatriation of trauma patients from specialist centres to their local hospital or coordination across health boards.
- Hospital and community rehabilitation services will be configured to support recovery, rehabilitation and re-enablement of trauma patients.
- There is the opportunity to develop consistent and robust clinical and operational governance processes (including training and education) in place and improve sharing of learning from clinical issues is variable.
- There will be full participation from the health boards in TARN. TARN data entry relies on retrospective review of case notes following clinical coding which has and investment in this function will provide alleviation of stretched clinical audit staff.
- There will be 'live' identification of patients at all points of the pathway. Data can then be routinely shared between health boards even when the patient crosses these multiple boundaries
- There will be a more uniform approach to incident reporting systems and an opportunity to remedy the issue of data being manually shared when an incident crosses over multiple organisations.

- There will be development of a mechanism to conduct multi-disciplinary trauma quality improvement in either the specialist centres or other hospitals and a regional quality improvement structure to address issue that cross between providers.
- There will be development of a mechanism to ensure that innovation in trauma care is fostered in the region and to ensure that innovations adopted by one provider is compatible with systems of care in other providers who may treat the same patient.

## 3.4 Health Gain

### 3.4.1 Improving Survival

The following case illustrates the current situation in South Wales, West Wales and South Powys (no patient identifiable information to maintain confidentiality):

A young male was assaulted late at night in a rural part of Wales. He sustained a significant head injury and was unconscious at the scene. A paramedic ambulance was deployed and the patient was taken to the local acute hospital. On arrival in the emergency department, his windpipe was obstructed and his oxygen levels were very low. A junior emergency department doctor and anaesthetist managed him and after some delay, the patient was transferred to the CT scanner.

A CT scan demonstrated an extensive bleed with pressure on the brain and a significant chest injury. After delays in a referral being accepted, the hospital transfer team transferred the patient to the nearest neurosurgical facility eight hours after the injury. Unfortunately, he deteriorated *en route* and, despite emergency neurosurgery, had a poor outcome.

There is a significant body of evidence that demonstrates that patients who suffer major trauma and are treated within a trauma network generally have better outcomes and a greater chance of survival. Evidence shows that severely injured patients are 15%-20% more likely to survive their injuries if they are admitted to an MTC (Celso *et al*, 2006). MTCs have 24 hour access to consultant trauma team leaders, available on arrival of the patient in the emergency department with rapid coordination of initial assessment, resuscitation and imaging. All key surgical specialties are available, performing multidisciplinary management of patients and provision is made for these patients to receive early operative management and ongoing surgery. Patients are also cared for under the umbrella of the major trauma service, with multidisciplinary input. It is difficult to isolate which part of the MTC system contributes most to improvements in survival.

Improvements in survival have been substantiated by a large national longitudinal study of 110,863 patients using the TARN dataset, which demonstrated that in the first five years after the launch of the English trauma networks, there has been a significant (19%) improvement in survival for patients alive on arrival at hospital, with 1,656 more survivors than would be expected based on historical performance (Moran *et al*, 2018). This is ahead of the target of 450-600 additional survivors that NHS England predicted. Scaling these results to the relevant population, an estimated 70 additional trauma patients over five years would survive in South Wales, West Wales and South Powys if the trauma network were implemented.

This benefit was conferred across trauma networks and not just in the MTCs, as a significant proportion of major trauma patients continue to be appropriately managed locally. Furthermore, the trend towards improving survival is consistent with international studies (e.g. McDermott *et al*, 2007 and Gabbe *et al*, 2011).

Locally, the picture has been similar for North Wales with patients being treated at the MTC in Royal Stoke University Hospital; approximately 900 patients were transferred to the MTC since 2013, with 18 more survivors from major trauma than expected.

Therefore, evidence indicates that patients in South Wales, West Wales and South Powys are set to benefit from improvements in survival from major trauma through the establishment of a network. It can be concluded that more patients are currently dying compared to other regions in the UK that have trauma networks in place, including North Wales.

As illustrated in the one-year evaluation of the EMRTS (2016), there is an intrinsic relationship between pre-hospital critical care and acute hospital care in improving health gain for trauma patients, strengthened further in the presence of a trauma network. The EMRTS has made significant progress in demonstrating the benefit of early critical care interventions at the scene of the incident, transfer of more trauma patients to definitive specialist care and setting patients on the correct trajectory (e.g. taking patients direct to CT imaging at UHW). Furthermore, international evidence indicates improvements in survival of major trauma patients taken to MTCs by physician-led Helicopter Emergency Medical Services compared to paramedic-led transfer (Engel *et al*, 2010). However, the full benefit of the EMRTS will only be realised within the context of an integrated trauma system.

### 3.4.2 Improving Functional Outcomes

The following cases illustrate the current situation in South Wales, West Wales and South Powys (no patient identifiable information to maintain confidentiality):

A young boy was a pedestrian in a road traffic collision and sustained a severe traumatic brain injury. He had a protracted stay in hospital, followed by specialist neuro-rehabilitation. His mother described his acute care and specialist rehabilitation as excellent, but on discharge home there was a lack of appropriate discharge planning and awareness of her son's acquired brain injury. There was a lack of consideration given to adaptations at home, integration back into education and long-term rehabilitation. Furthermore, there was a lack of support for the mother as his main carer.

Whilst the boy's mother managed to cope due to good family support, she fears others may not cope if placed in a similar situation.

A 20 year old female had a fall from a significant height and sustained a severe traumatic brain injury and multiple fractures. She was admitted for emergency neurosurgery and spent several weeks in the specialist centre before being discharged. She was promised ongoing rehabilitation but nothing materialised. The patient was left with no hearing in the left ear, left sided weakness and severe hip pain. It took 26 calls over 6 weeks to arrange follow-up for these problems. The patient felt that she had been forgotten about once she left the specialist centre and believes that this had an impact on her ability to return to work sooner and on her psychological wellbeing.

Functional outcomes define results of patient care focused on physical ability. The two main ways to determine a patient's physical ability is either to ask about abilities (Patient Related Outcome Measures - PROMS) or to observe physical ability (Performance Measures). A good functional outcome is often best defined by a level of physical ability that matters to the patient. For example, TARN PROMS measures change in ability to work and other activities six months after injury, reporting extreme problems and a visual analogue score on how they rate their health at six months. Currently, only one hospital contributes to TARN PROMS, making it challenging to objectively understand the current levels of functional outcome and the impact any interventions might have.

As illustrated by the above patient stories, rehabilitation is key to improving functional outcome. The British Society of Rehabilitation Medicine (2013) defines rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological

function, participation in society and quality of living. This has to be inclusive of hyper-acute, specialist, TU and community based rehabilitation of trauma patients.

Since 2010-12, there have been significant advances in acute care of trauma patients in NHS England. Despite the NHS Clinical Advisory Groups (CAG) Report (2010) clearly indicating the importance of the rehabilitation pathway, there was a lack of new investment in rehabilitation in NHS England and this is one of the main lessons that has been learnt through the establishment of regional trauma networks. To date, no national functional outcome data have been published, which is likely to reflect the significant variation in rehabilitation capability across the English networks. Consequently, in 2014, the British Society of Rehabilitation Medicine published core standards for trauma rehabilitation, indicating a substantial body of trial-based evidence to support the effectiveness of trauma rehabilitation, in particular for patients with traumatic brain injuries. These guidelines form the basis for the development of clinical and operational service modelling for all trauma networks.

In contrast, a site visit to Scotland in October 2018, revealed that the Scottish Trauma Network has identified trauma rehabilitation as a key enabler for improving functional outcome and patient flow. Their mission statement is 'saving lives, bringing life back.' In doing so, the network will be providing resources for an additional 30 rehabilitation allied healthcare professionals (AHPs) and 17.6 trauma coordinators between 2018-2022. NHS Scotland are learning the lessons from NHS England in focusing on improving rehabilitation capacity from the outset.

Internationally, there is a body of evidence demonstrating improvements in functional outcome in trauma systems that have incorporated rehabilitation across the pathway from the outset. Gabbe *et al* (2012) reported that following the formation of the Victorian State Trauma Service in Australia, risk-adjusted functional outcomes improved significantly. That is, not only were more patients surviving, they were doing so with less disability. Furthermore, a 10-year study from this trauma system demonstrated that years of life lost decreased by 43% and lost disability-adjusted life years fell overall by 28% over the period. This indicates that enhanced survival associated with trauma networks does not necessarily result in an overall increase in non-fatal injury burden (Gabbe *et al*, 2015). A systematic review of multidisciplinary rehabilitation in major trauma patients revealed the importance of early recognition and initiation of rehabilitation in this group, which was associated with improved functional outcomes (Khan *et al*, 2012).

Furthermore, service providers for rehabilitation echoed the views of patients with respect to current trauma rehabilitation in South Wales, West Wales and South Powys at a rehabilitation workshop in December 2018. Providers raised concerns about the lack of rehabilitation services within health boards, especially for rural areas. There was a recognition that health boards are not sufficiently resourced or experienced to accept complex trauma patients back from specialist centres. Providers felt that they currently lacked the expertise in managing these patients and in meeting their rehabilitation requirements. This is compounded by the inability to access outreach rehabilitation support from the specialist centres. Finally, providers indicated that 'without investment in the back door there was not value in investing in the front door.' They saw the benefit of improvements in rehabilitation as not only giving patients the best possible experience and chance of a good functional recovery, but as a vehicle for improving patient flow across the system.

### 3.4.3 Improving Timely Clinical Care and Patient Experience

The following case illustrates the current situation in South Wales, West Wales and South Powys (no patient identifiable information to maintain confidentiality):

A 72 year old male presented overnight to an emergency department having fallen down three to four steps at home. He was seen by a junior doctor several hours later and received an x-ray of his neck, chest and pelvis. The next morning, he was seen by a consultant, who organised CT scans, which demonstrated multiple injuries. With some difficulty, the patient was admitted under the trauma and orthopaedic team. Over the course of next few weeks, the patient moved wards at least four times, developed delirium secondary to a urine infection and was eventually placed in a residential home. There was no multidisciplinary review of the case. Furthermore, the health board did not contribute to TARN, making it challenging to understand the extent of the problem.

The above case illustrates a common problem with trauma care in South Wales, West Wales and South Powys. In the presence of a trauma network, the patient may still not have been taken direct to the MTC, but would have received a pre-alert to the local TU and been received by the hospital trauma team. There would have been early recognition of significant injuries with whole body CT on arrival and a detailed secondary survey undertaken for detection of smaller injuries. The initial review would include an assessment of cognition and frailty. Clear network operational procedure would have guided the admitting speciality. Early orthogeriatric review and referral to a care-of-the-elderly physician may have reduced the number of moves to different wards, whilst improving patient recovery. Furthermore, in the event of an adverse event, this case would be subject to TU multidisciplinary case review and escalated to the network clinical governance structure, to ensure lessons learnt were shared transparently and widely.

From patient experience and rehabilitation workshops, one of the key reasons given for a poor experience by trauma patients and their families or carers was the lack of good quality communication and coordination across the pathway. All patients interviewed cited this issue as important to them. Patients talked about delays in treatment and how these were not adequately explained to them. Information was not shared in simple language that could be easily understood. There was a lack of consistent information conveyed between healthcare providers (particularly between specialist centres and local hospitals and community healthcare). Variation in clinical informatics systems has been given as a reason for this. Furthermore, the expectations of patients and their families or carers were not well managed, with a lack of support provided by specialist centres once patients were discharged. Finally, practical support for families and carers was often overlooked (e.g. accommodation for those travelling some distance, signposting financial/legal advice and welfare services). Monitoring of patient experiences is limited with only one health board contributing to TARN PREMS. Thus, the workshops have provided a useful insight into current issues to ensure patient experience is considered in the design of the network.

### 3.4.4 Improving Data Collection

There are significant improvements in health gain that can be achieved by improving data collection. It is recognised that there is a lack of consistent TARN data collection across the region, despite contribution to TARN being a mandatory audit for health boards in the annual national clinical audit and outcome review annual plan as illustrated by the TARN network report, 2018 overleaf.



## Case Ascertainment & Accreditation

If case ascertainment is low then the analysis in the rest of the report may not be reflective of true practice.

Trust / Hospital	01 April 2017 to 31 March 2018				01 April 2016 to 31 March 2017			
	N	E	C (%)	A (%)	N	E	C (%)	A (%)
<b>ABM University Health Board</b>	<b>600</b>	<b>663 - 787</b>	<b>76.2 - 90.5</b>	<b>95.6</b>	<b>643</b>	<b>663 - 787</b>	<b>81.7 - 97</b>	<b>95.2</b>
Morriston Hospital	595	474 - 559	100+	96	594	474 - 559	100+	95.2
Princess of Wales Hospital	5	189 - 228	2.2 - 2.6	89	49	189 - 228	21.5 - 25.9	95.9
<b>Aneurin Bevan Local Health Board</b>					<b>1</b>	<b>530 - 634</b>	<b>0.2 - 0.2</b>	<b>54.8</b>
<b>Cardiff and Vale University Health Board</b>	<b>627</b>	<b>709 - 843</b>	<b>74.4 - 88.4</b>	<b>95.7</b>	<b>687</b>	<b>709 - 843</b>	<b>81.5 - 96.9</b>	<b>94.9</b>
University Hospital Llandough	12	51 - 68	17.6 - 23.5	95	23	51 - 68	33.8 - 45.1	92.6
University Hospital of Wales	615	658 - 775	79.4 - 93.5	96	664	658 - 775	85.7 - 100+	95.0
<b>Cwm Taf Health Board</b>	<b>373</b>	<b>373 - 452</b>	<b>82.5 - 100+</b>	<b>85.5</b>	<b>444</b>	<b>373 - 452</b>	<b>98.2 - 100+</b>	<b>87.0</b>
Prince Charles Hospital	156	200 - 242	64.5 - 78	72	254	200 - 242	100+	81.5
Royal Glamorgan Hospital	217	173 - 210	100+	95	190	173 - 210	90.5 - 100+	94.3
<b>Hywel Dda Health Board</b>	<b>186</b>	<b>444 - 546</b>	<b>34.1 - 41.9</b>	<b>95.8</b>	<b>195</b>	<b>444 - 546</b>	<b>35.7 - 43.9</b>	<b>91.0</b>
Bronglais General Hospital	149	82 - 105	100+	98	144	82 - 105	100+	97.9
Glangwili General Hospital	8	230 - 277	2.9 - 3.5	78	50	230 - 277	18.1 - 21.7	71.2
Withybush General Hospital	29	132 - 164	17.7 - 22	89	1	132 - 164	0.6 - 0.8	85.7

**N** The number of approved submissions for the period

**E** The expected number of submissions for the period (from HES / HIPE / PEDW)

**C** The case ascertainment % for the period

**A** The accreditation % for the period

This indicates that case ascertainment (i.e. completion of the dataset) was 54.8-65.7% (average 60%). This is below the target of 80%, making subsequent data analysis difficult to interpret. Nonetheless, data accreditation (i.e. quality of entry) at 93.5% was acceptable, but still below the target of 95%. In England, most networks now have case ascertainment and data accreditation exceeding the target threshold, owing to the deployment of TARN coordinators across the network and enhanced 'live' case identification, which South Wales, West Wales and South Powys currently lacks. Furthermore, the total number of cases submitted to TARN increased from 23,211 in 2011/12 to 44,059 in 2016/17.

The absence of TARN data available to health boards has resulted in a number of problems. Firstly, it has led to an inability to objectively determine the current level of clinical care and gaps. Secondly, it has affected both the deliverability and impact of any quality improvement interventions. Thirdly, it has made it difficult to identify outlier cases for further evaluation and longitudinal review. Fourthly, as a network has not yet been established, TARN does not produce dashboards for each hospital to provide comparison with English hospitals or North Wales. Finally, it has made predicting future changes in patient flow particularly challenging.

It is recognised that the network will need to have informatics systems established to ensure both TARN data and data that fall outside the remit of TARN is collected and available for quality improvement, commissioning and research, which will allow the development of an effective data-driven system to improve patient outcomes.

A work programme will be established to implement a central trauma-specific electronic patient administration system. The system will aim to identify patients at the earliest opportunity, ideally pre-hospital, or in the emergency department, and start to track the patient's journey through the pathway. It will integrate with local and national systems in use across NHS Wales (including the Value Based Healthcare Programme and National Data Resource Plans) providing the relevant near real-time information to all involved in the management of the pathway. This includes clinicians, managers, clinical audit, and administrative staff. It will also link with systems used to communicate with patients to facilitate TARN PROMS/ PREMS. A cohort of the patients who are TARN eligible will then be fed into the TARN database. This approach will allow Wales to hold its own trauma registry for operational management, with potential for service evaluation, additional audits and research. With a scope wider than the TARN criteria, it will provide unique opportunities to improve service delivery and facilitate injury prevention activities. The system will also support clinical governance processes through tracking of case reviews.

### **3.4.5 Enhanced Response at Major Incidents or Mass Casualty Events**

The Health Prepared Wales conference in 2017 demonstrated the benefit of having trauma networks during the recent terror attacks in London and Manchester, where patients were effectively managed across several MTCs and TUs. System knowledge and coordination allowed pre-hospital teams to appropriately triage patients and subsequently minimise the number of patients needing transfer later to MTCs. For the London terror attacks, the London Trauma System effectively turned a mass casualty event into several smaller incidents that fell well within the capacity and capability of the receiving hospitals.

Whilst there have been significant improvements due to the creation of a national framework for mass casualty events including capacity planning, there is scope to go further. The establishment and integration of a regional trauma network into the national framework will be a key enabler for the successful management of a major incident or mass casualty event. South Wales and, in particular, Cardiff host many large, high-profile sport and music events every year. The region remains a potential target for terrorist activity now and in the future. The lack of a trauma network presents a significant strategic risk to the region and its population. Furthermore, there is currently a lack of alignment with England, leading to an inability for NHS Wales to provide an effective mutual aid response to NHS England as part of the national response to a major incident.

### **3.4.6 Enhancing Injury Prevention**

In Wales, most injury prevention strategies are coordinated through Public Health Wales. Road traffic collision prevention is coordinated by multiple agencies including local authorities and the police service. In the future, the trauma network could make a significant contribution to injury prevention programmes through data sharing, research and educational initiatives (e.g. motorcycle safety, wearing cycle helmets). Opportunities also exist to access funding to prevent serious knife and gun crime. Furthermore there is a material link between the establishment of the trauma network and the national falls prevention programme being undertaken by Public Health Wales.

## **3.5 Equity**

The benefits that the trauma network can deliver in improving equity can be explored through a number of lenses.

### **3.5.1 Enhanced Access to Specialist Care**

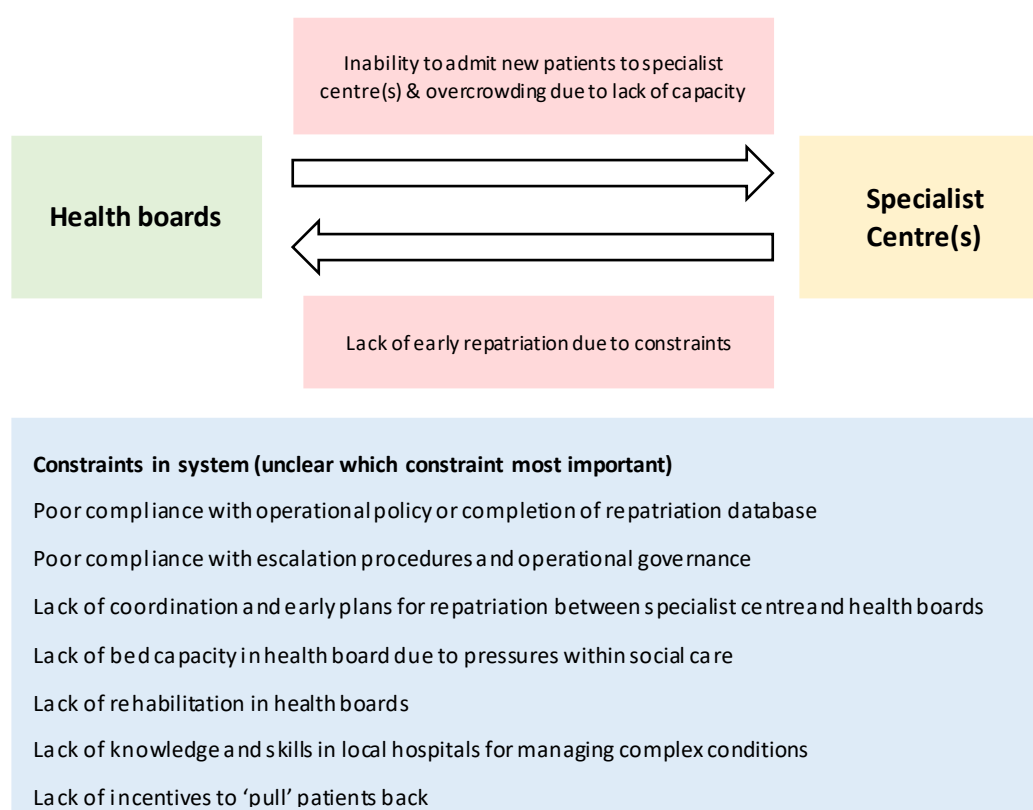
Equity of access to specialist trauma care remains an issue for patients who are injured outside the normal catchment area of specialist centres and, in particular, for rural areas (e.g. in Mid and West Wales). The presence of the EMRTS since 2015 has helped improve equity and timeliness of access to definitive specialist trauma care. The one year evaluation demonstrated 58% of patients being transferred directly to specialist care. EMRTS is currently only a daytime service but plans have been agreed to expand to 24/7 from the South Wales base from April 2020. Overnight and when the service is busy, major trauma patients continue to be taken to their local hospital. This is compounded by a lack of a pre-hospital triage tool and WAST trauma desk facility to coordinate the transfer of patients to specialist centres. Sinclair *et al* (2018), who introduced a clinician-staffed trauma desk as part of the Scottish Trauma Network, have highlighted the benefit of this approach. They demonstrated a significant increase in the sensitivity for identifying major trauma from 11.3% to 25.9%.

In the absence of a regional MTC and the lack of an automatic acceptance policy to support both direct admissions and secondary transfers, a significant proportion of trauma patients who could benefit from specialist care currently do not. This is illustrated by the fact that the assumed current position for moderate and major trauma going direct or being transferred to UHW is low and pre-dates 2011 from NHS England (see Appendix 2).

Evidence from NHS England (see Appendix 2) indicates an increase in the proportion of moderate and major trauma cases taken direct to the MTCs from 2011 to 2013, after which a steady state was reached. For major trauma, there was a decrease in transfers from TUs to MTCs, owing to enhanced pre-hospital triage. Overall, this resulted in a significant increase in the proportion of patients having an MTC as an initial (53% to 72%) or final (73% to 82%) care destination. Thus, in the presence of a trauma network, more trauma patients from South Wales, West Wales and South Powys are set to benefit from specialist care, reducing inequity of access. Currently, geographical inequity exists across Wales, with trauma patients in North Wales benefitting from accessing MTC care at the Royal United Hospital, Stoke.

### 3.5.2 Enhanced Patient Flow

To reduce inequity, a number of requirements are important in the design of the network. Firstly, 24 hour availability of the EMRTS, with pre-hospital triage and a remote facility to support decision-making by paramedics. Secondly, the MTC will need to maintain an automatic acceptance policy, but this will be determined by the ability of the MTC to maintain sufficient capacity and this depends upon the timely repatriation of patients for 'care with treatment closer to home.' Currently, there are significant delays in the transfer of care for patients who have completed specialist care, where ongoing care could be managed locally whilst waiting for discharge home or specialist rehabilitation. Data on the magnitude of the problem is sparse, as the NHS Wales Repatriation database is frequently not completed; however, local data indicates a 6-8 week delay in the transfer of patients with head and spinal injuries from UHW to health boards. As part of the network development, a patient flow workshop was undertaken in February 2019 to explore the reasons for delays. This is summarised in the process map illustrated below:



Constraints included a lack of an automatic repatriation policy and coordination, a lack of local rehabilitation services for trauma patients and an inability to manage complex patients (e.g. tracheostomy care, bowel and bladder care, behavioural disorders). System wide issues were also

raised including a lack of bed capacity due to poor access to packages of social care and pressures on unscheduled care. Finally, the current fragmented commissioning of services pertaining to major trauma was considered to be a key problem. These issues are not isolated to NHS Wales. In NHS England, some regional trauma networks have developed escalation procedures for patients in MTCs to be transferred back to their local Emergency Department; however, this forced measure has rarely been enacted.

### **3.5.3 System-Wide Improvements in Care**

Leading on from the above, a key lesson from the English trauma networks relates to a lack of new investment in TUs compared to MTCs. Given that, in 2017, 61% of moderate trauma and 36% of major trauma remained in English TUs, this lack of investment was an oversight. To address this, NHS England are in the process of developing a best-practice tariff for TUs, similar to that developed for MTCs. For patients who remain in TUs and LEHs in South Wales, West Wales and South Powys, there should be equity of access to improved standards of care and this will require some additional investment. Without this additional investment in TUs, LEHs and community-based rehabilitation, all patients who are treated in the region are set to be disadvantaged in achieving the best functional outcomes possible. Furthermore, patient flow will not be maintained without getting the 'landing pad' (see section 8.4.2) at the TUs optimised for patients discharged from the MTC. This will have a direct impact on the ability of the MTC to accept new patients from across the network.

### **3.5.4 Equity of Care for Trauma in Older People**

Equity must also be considered in the context of the patient's age, given population profiles (chapter 2). A further lesson learnt from the establishment of English trauma networks, was a lack of planning in relation to the 'changing face of trauma' (Kehoe *et al*, 2015). In 2017, TARN produced a report based on data from England and Wales, indicating that the majority of major trauma occurs in patients older than 65 years. The commonest cause of death was traumatic brain injury and falls from standing height were the commonest mechanism of injury. Existing pre-hospital tools were not good at identifying older major trauma patients. Consequently, there was a lack of activation of hospital trauma teams and seniority of initial assessment. There was a higher mortality in this group. Nonetheless, those that did survive major trauma did not have a higher incidence of disability compared to younger people. Thus, it is imperative that network design takes into consideration the specific requirements of older patients to ensure equity for this population group.

### **3.5.5 Veterans Trauma Network**

Finally, the establishment of the trauma network lends itself to supporting the Veterans Trauma Network (VTN). The VTN exists to ensure that the needs of veterans with complex physical injuries are met. It is specifically focused on those who sustained complex physical injuries because of military service. The VTN has been successfully established in NHS England, based upon a collaboration with the MTCs. It provides a single point of referral for all stakeholders who are concerned about the medical care of a veteran with complex physical injuries, including patients, clinicians (from both physical and mental health services in primary or secondary care) and third sector agencies. Equity of access to ongoing surgical care and rehabilitation for those injured through military conflict would be an important benefit.

## **3.6 Clinical and Skills Sustainability**

### **3.6.1 Enhanced Multi-Professional Training and Education**

Presently, there is no regionally agreed training and education programme. Existing arrangements for the delivery of training and education pertaining to trauma can be divided into nationally/internationally recognised resuscitation courses or locally developed solutions. Resuscitation courses are expensive and thus often only accessible to doctors. Currency is often

challenging, with one 'candidate' TU reporting that only half of its Emergency Medicine consultants were current. Whilst locally developed solutions are cost effective and accessible to a wider audience, they vary in content, quality assurance and delivery. Discussion with trainees indicates variations in practice between hospitals, leading to inconsistencies in key educational messages and consequently patient care. To date, there has been no formal evaluation of these latter courses. Furthermore, all trauma courses focus on pre-hospital care and initial emergency care of trauma patients. There is less emphasis on the rest of the trauma pathway including surgical skills, critical care, ongoing care (especially for local hospitals receiving patients back from specialist care) and rehabilitation. The establishment of a trauma network also enhances training in the psychological aspects of physical trauma including supporting victims, their families and providers.

In England, each regional trauma network has taken a different approach to training and education, but there has been no determination of which strategy is most effective. Several programmes have aligned with national nursing competencies as defined by the National Major Trauma Nursing Group, to give nurses career progression opportunities. Furthermore, Scotland are in the early stages of developing a network wide training and education programme, but with no answer on the best approach.

There is an exciting opportunity to develop a network wide educational programme using a combination of established courses and those developed through the network. The programme will need to be multi-professional, aligned with national competencies and bridge the entire patient pathway. There is an opportunity work in collaboration with Health Education and Improvement Wales as a new, innovative health authority, in order to ensure that the programme is firmly linked with the network governance structure and is subject to formal evaluation. This will lead to an enhanced knowledge and skill base across the network.

Finally, learning from a site visit to the Scottish Trauma Network, the establishment of an annual event, bringing together healthcare professionals from across the network was seen as a key step in sharing best practice, stakeholder engagement and driving interest in the development. Currently there are no conferences specific to major trauma held in Wales, but as the network develops there is an opportunity to explore this further as part of its establishment.

### **3.6.2 Enhance Recruitment and Retention of Workforce**

Currently health boards across South Wales, West Wales and South Powys struggle to recruit to key disciplines pertaining to major trauma such as Emergency Medicine, Intensive Care Medicine, Rehabilitation Medicine and surgical specialties. For many senior trainees interested in major trauma, the absence of a trauma network clearly factors in their decision-making and choice of consultant posts. Whilst there is a paucity of evidence to quantify the impact of a trauma network on recruitment, it is likely that its development will positively contribute to both recruitment and retention of medical personnel. It is likely that the MTC will benefit most from this; the challenge will be to ensure this applies across the network, to include TUs and LEHs. This could be overcome by ensuring that all new posts in the MTC are made as joint appointments with other health boards, where appropriate, ensuring a network approach to the workforce strategy. This will also help mitigate against depletion of workforce from health boards outside the MTC.

Appropriate resourcing of the entire network will be required to prevent the development of an MTC focused approach, as was demonstrated in England. Improved consistency of clinical governance and standards across the network will benefit trainees who rotate across the health boards. The enhancement of recruitment and retention can also be extended to include allied health care professionals (e.g. nurses, paramedics, theatre staff, therapists), reinforced by the development of new roles working across the network including major trauma practitioners and rehabilitation coordinators.

The establishment of the EMRTS, which placed clinical and skills sustainability as an important investment objective, demonstrated enhanced recruitment and retention. Since its establishment, the service has recruited four consultants in Emergency Medicine to Wales and contributed to enhanced retention. This is a trend that is likely to be mirrored in-hospital once the trauma network is established, through the creation of attractive and varied job plans.

### **3.6.3 Development of New Roles and Ways of Working**

The establishment of the network presents an opportunity for the development of new roles and ways of working. There will be an opportunity for allied health care professionals to engage in new roles included in an extended scope of practice (incl. tertiary assessments, frailty/cognitive assessments) traditionally undertaken by the medical profession. For therapists there is an opportunity to expand their remit of practice to include a broader range of presentations. Nursing staff in health boards are likely to benefit from training offered by rehabilitation specialists in line with developing the right conditions for patients returning for 'care with treatment closer to home.' This includes tracheostomy care, bowel and bladder care and behavioural management.

The development of the network as a platform for training and education will promote new areas of training, previously not considered in Wales. For example, the adoption of the curriculum for training in trauma surgery, fellowships in trauma surgery and the creation of trauma surgery as a speciality in Wales.

## **3.7 Value for Money**

### **3.7.1 Economic Benefits**

With enhanced investment across the trauma pathway (including rehabilitation), there is evidence of improvements in functional outcome and, therefore, reducing ongoing healthcare requirements and improving ability to return to work. Gabbe *et al* (2015) demonstrated that after 10 years of introducing the Victorian State Trauma Service, there was a cost saving per case of \$633,446 in 2010-2011, compared with 2001-2002, owing to increased disability free years.

Taylor *et al* (2012) demonstrated that Helicopter Emergency Medical Services working within the context of a mature trauma system resulted in a reduction in hospital mortality leading to a cost per life saved of \$1,566,379, \$533,781 and \$519,787 in all patients, patients with serious injury and patients with traumatic brain injury respectively. The cost savings are not just related to additional patients who survive, but to all patients who survive. With improvements in rehabilitation, enhancements in functional recovery will be seen across a wide group of patients.

Furthermore, there are a number of studies demonstrating cost effectiveness of rehabilitation interventions. Wood *et al* (1999) demonstrated an estimated lifetime saving in the cost of care of over £1 million per patient receiving neuro-rehabilitation with good functional outcome. The same trend has been demonstrated in other studies related to the provision of neurorehabilitation.

With 14 additional lives saved across the network per year, this is likely to equate to a cost of life saved of approximately £17 million, with the economic benefits from improving functional outcomes to be quantified as part of the benefits realisation plan.

Furthermore, national and international trauma networks have demonstrated costs effectiveness in terms of Quality Adjusted Life Years (QALYs). This is explored further in the economic case.

### **3.7.2 Savings across the System**

There are savings across the system through the introduction of the network. Firstly, five years' experience from England indicates that through the introduction of enhanced pre-hospital triage and enhanced pre-hospital care the proportion of moderate and major trauma transferred directly to

MTCs has increased. Thus, overtime the number of acute secondary transfers has fallen, by taking the 'right patient to the right place in the right time.' The effects on hospital personnel required to undertake these transfers should not be underestimated, particularly out of hours. Furthermore, there is an impact on WAST due to increased secondary transfers. Thus, there is a direct cost-saving to hospitals and WAST in not having to undertake these transfers but these benefits will take time to be realised.

It is possible that this benefit will be largely due to pre-hospital enhanced care and decision-making provided by the EMRTS and support provided to WAST by a trauma desk facility. However, by delivering patients direct to definitive care, there will be less duplication of trauma team activation, assessment and investigations (including imaging and pathology). Furthermore, patients are likely to require fewer operations if managed with definitive surgical care from the outset. For example, a local study demonstrated that 80% of patients requiring operative intervention for open fractures required two procedures or fewer in the first 12 months after injury if managed by specialists compared to 28% in whom surgery was less well coordinated.

Whilst there are likely to be more emergency department attendances, increased operative requirements and requirements for critical care/ward-based care at the MTC (Yip *et al*, 2016), by contrast TUs and LEHs will see and admit less moderate and major trauma. Although major trauma represents a small proportion of overall unscheduled care workload, patients are often complex with a median length of stay in hospital of nine days. Thus, centralisation of trauma care is likely to allow TUs and LEHs to focus more on routine unscheduled care and create space for elective operative workload to support referral-to-treatment times.

Savings can also be demonstrated through collaboratively commissioning patient pathways, with new approaches leading to maximum utilisation of allocated resources and effective monitoring.

Finally, whilst there was no significant reduction in the length of stay of trauma patients since the introduction of the English trauma network, the median length of stay for critical care fell from 4 to 3 days (Moran *et al*, 2018).

### **3.7.3 Value to other Patient Groups and Networks**

The development of an appropriate rehabilitation model across the network with additional resourcing is likely to benefit a wider group of patients with non-traumatic problems, as the knowledge and skill base of allied healthcare professionals will extend beyond trauma. This includes strokes and complex neurological problems. Enhancement of orthogeriatric trauma will lead to improvements in the care of patients with fractured neck of femurs, an area where there is a variability of input from orthogeriatricians across health boards.

Once the network is established for South Wales, West Wales and South Powys, developing a national position will bring benefits to North Wales. Initially, the availability of national trauma desk will allow enhanced support and coordination of trauma cases directed to the TUs or MTC in Stoke-on-Trent. Later, there will be enhancement of clinical and operational governance, and the opportunity to support the development of a trauma rehabilitation model, with learning from the experiences in South Wales.

If successful, there will be significant learning from the operational capability of the network for other networks (e.g. the approach taken to clinical governance and repatriation for patients for 'care with treatment closer to home'). Whilst patient groups will be different, the system challenges will be the same. Thus, there will be an opportunity to learn from new and innovative practice. This benefit also extends to how we commission clinical services and specialist clinical services in the future, through commissioning differently.

## 3.8 Local Health Board and WAST/EMRTS Specific Benefits

In this section, organisational specific benefits are described, with an emphasis on how additional resources may provide wider benefits and align with the organisations strategic plans.

### 3.8.1 Cardiff and Vale University Health Board (C&VUHB)

The mission for the health board is 'Caring for People, Keeping People Well.' The vision is 'a person's chance of leading a healthy life is the same wherever they live and whoever they are.' These statements align with the aims for the trauma network.

The development of an adult and paediatric MTC at UHW presents an exciting time for C&VUHB. There are clear links between the establishment of the MTC and C&VUHB Strategic Goals in its 'Shaping our Future Wellbeing Strategy 2015-2025.' The Strategy sets out objectives that link directly with the delivery of a MTC:

- Reduce health inequalities
- Have an emergency care system that provides the right care, in the right place, first time.
- Be a great place to work and learn.
- Work better together with partners to deliver care and support across care sectors, making best use of our people and technology.
- Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives.

The establishment of the MTC will address a number of service gaps specific to UHW that need to be addressed which will be explored further in Chapter 7:

- There is currently no MTC for adult or paediatric patients in the South Wales, West Wales and South Powys region.
- There is no single point of access into C&VUHB as a specialist centre for major trauma cases. There is limited repatriation or transfer of patients to their local hospital following specialist treatment.
- Consultant led trauma team leaders are not 24/7 in the Emergency Unit.
- There is limited capacity for treating the current number of seriously injured patients who are brought to C&VUHB. This is evident in areas such as the Emergency Unit and theatres.
- There is no dedicated ward or area where multiply injured patients are managed and cared for as a cohort.
- There is a lack of consistent coordinated care and clear communication with seriously injured patients and their families/carers.
- There is no multidisciplinary approach to governance, quality improvement, research and audit at present.
- Seriously injured patients are not currently provided with any rehabilitation plan/prescription.
- The critical care unit at UHW is recognised as being under strain.

In addition to those benefits detailed in this chapter, the expected quality benefits for attending the MTC are set out below:

- Patients will receive a service that delivers the highest possible care for patients 24 hours a day, seven days a week.



- Reduction in preventable deaths, in particular enhancing the rate of unexpected survivors.
- Improved functional outcome, from early rehabilitation interventions.
- Improved patient and carer experience through increased coordination of care and communication around expected pathway and ongoing care plan.

### **3.8.2 Swansea Bay University Health Board (SBUHB)**

SBUHB recognises the pivotal role it plays in the delivery of major trauma services to patients and their families in South West Wales, as well as providing wider-scale specialist services in relation to burns and plastics. The establishment of the trauma network lends an opportunity for the community to see the same improvement in standards of care for trauma patients as delivered elsewhere in the UK and globally. To achieve the national quality indicators for major trauma requires an increase in staff and service capacity to deliver an effective pathway from before the 'front door', through to the patient returning for rehabilitation and back into the community. Through a multi-disciplinary approach, embracing clinicians, therapists and managers, SBUHB has benchmarked against best practice to identify where the investment will add most value.

Admittedly, there are constraints on space at Morriston Hospital, which will be addressed through opportunities for collaboration with HDUHB via the ARCH programme, optimising the use of existing workforce and infrastructure assets across South West Wales and addressing potential areas for improvement in patient pathways and shared learning. Swansea Bay has acknowledged the need to redistribute some of the work currently undertaken at Morriston Hospital, which will require investment, over and above that linked to the delivery of the network. For example, when neurosurgery moved from Swansea to Cardiff, the remaining spinal services at Morriston Hospital were funded on an elective basis and so additional resources will be needed to deliver this service to support the emergency aspects of the network. With the implementation of the network and subsequent capacity constraints at Cardiff, there may be a further impact on patient pathways relating to urgent, not emergency, spinal surgery. Investment in spinal services will support delivery of care for some spinal trauma patients as well as an opportunity to improve the management of non-traumatic conditions such as cauda equina syndrome and malignant spinal cord compression.

The focus on the importance of creating the 'landing pad' at Morriston Hospital (to enable early repatriation from the MTC to a more local treatment and care facility) has identified extra capacity within the inpatient setting, with a concomitant uplift in the number of therapy and nursing staff. The coordination of care for major trauma patients – ensuring seamless transition from acute care into recovery and rehabilitation – is seen as key to the efficient delivery of the network, given the range of services that will require synchronisation to deliver best outcomes. Isolated open lower limb fractures and transfers of patients needing orthoplastics intervention, will require wider trauma coordinator input than the average TU. The network will need to ensure that there is a robust plastics surgery presence on both the Morriston Hospital and UHW sites to deliver a proactive surgical service. Thus, there is an opportunity to build a foundation for better collaboration between the two sites, which is part of a wider strategy on tertiary service partnerships. The network will provide the best opportunity to deliver gold standard care to improve survival and outcomes for major trauma patients and fits with the longer-term vision for Morrison Hospital being the site to support this goal.

### **3.8.3 Aneurin Bevan University Health Board (ABUHB)**

ABUHB welcomes the development of a unified Trauma network across South Wales, West Wales and South Powys that will ensure that patients receive prompt specialist trauma care when needed.

When the trauma network is established, it is less likely that patients will require a secondary ambulance transfer to a specialist centre and the resources previously devoted to managing these patients within the health board will be able to be directed towards other ABUHB patients. When significantly injured patients do present to emergency departments in ABUHB, there will be a simple and clear pathway to facilitate transfer to the MTC.

The health board currently accepts major trauma patients into its two emergency departments at The Royal Gwent Hospital and Nevill Hall Hospital sites, from where patients often require a secondary ambulance transfer to UHW in order to receive specialist treatment not available at ABUHB. These transfers lead to delays in patients receiving definitive care and depletion of resources at the referring hospitals as well as reducing WAST resources available for the local community.

The health board actively engaged in the consultation process in relation to major trauma and more latterly, the TU designation process outlined in chapter four.

The expected benefits of the major trauma network for the ABUHB population, the health boards and partner services are as outlined in the benefits outlined in this chapter.

#### **3.8.4 Cwm Taf Morgannwg University Health Board (CTMUHB)**

CTMUHB sets patients and the delivery of quality services at the heart of everything that they do. The health board is focused on exploring opportunities to further develop their population healthcare system into one that is more preventative and person-centric. The proposals developed by the health board are to take forward the implementation of its TUs as part of the network, within the context of the health board's Integrated Medium Term Plan (IMTP) to ensure that:

- There is provision of high quality care as locally as possible where it is safe and sustainable.
- Services provided are accessible and sustainable into the future.
- Service delivery will be innovative, reflect the principles of prudent healthcare and promote better value for users.
- District general hospitals will work together.
- Emergency services will be provided across district general hospitals with a focus on early comprehensive assessment driving care in the right setting.
- There is development of local and regional hospital service planning and delivery where appropriate.
- The health board continues to improve scheduled and unscheduled patient care, patient flow and urgent care processes.

The main benefits of enhancement of rehabilitation services will add considerable value and will have a positive impact on wider health care delivery within the health board, in particular as part of the ongoing redesign of trauma and orthopaedic services. Provision of care of the elderly and orthogeriatric physicians will add value to both major trauma patients as well as those with fractured neck of femurs. Finally, improvements in TARN data collection leading to better opportunities for quality improvement.

#### **3.8.5 Hywel Dda University Health Board (HDUHB)**

HDUHB faces a significant challenge in delivering equitable health care to a geographically spread population with large remote and rural catchment areas. Key to improving timely access and equity for people living further away from the MTC are:

- Provision of a 24/7 EMRTS response.
- Provision of a triage trauma tool.
- High quality advice for paramedics and hospital clinicians through the trauma desk.
- Streamlined early acceptance for transfer to specialist care.

Maintaining clinical governance standards across a large geographical area is also challenging. Co-ordination, information gathering and sharing is key. Although there is an exemplar in Bronglais Hospital, Aberystwyth, TARN completeness is generally poor, with heavy reliance on clinician time to enter data. The appointment of TARN coordinators and major trauma practitioners will be vital to improving information to allow proper understanding of performance and identify areas for improvement. Additionally, the provision of training and value for money via a network-training programme will improve the ability to keep distributed workforce skilled.

There is a significant gap in rehabilitation provision for patients. Regular local access to a rehabilitation consultant, the development of inpatient rehabilitation beds, the presence of a rehabilitation co-ordinator and some skilled assistant practitioner resource will enable quality local teams, such as the established community neuro-rehabilitation team, to work more effectively and in a more co-ordinated way both in hospital and the community. There will also be potential benefits for complex rehabilitation needs beyond trauma. In line with the health boards strategy of increasing care closer to home where possible, the addition of a rehabilitation coordinator role will improve the ability to deliver quality community based care and greater access to specialist rehabilitation clinics within the health board. Previously, patients may have had to travel out of area.

### **3.8.6 Powys Teaching Health Board (PTHB)**

The reality of rurality within Powys generates considerable challenges for managing trauma (and indeed just about any other hospital-based care pathway) in that, with no secondary care facility in Powys, all hospital admissions occur out of county. This generates issues that impact in many areas: equity, effectiveness, convenience, accessibility and continuity for both patients and their family and wider support networks. The drive to develop a trauma network for South Wales, West Wales and South Powys is a very welcome development for the people of South and Mid Powys and will address some of the issues, although time and distance from the TUs will remain an enduring issue in terms of equity and outcome.

It is acknowledged that Powys' principle contribution to maintaining patient flows through the network pathways will be by providing rehabilitation services. Expansion of the therapy service will also allow Powys the opportunity to develop new services that will help to deliver against the broader agenda of the Healthier Wales strategy by providing more complex services closer to home.

### **3.8.7 Welsh Ambulance Service NHS Trust (WAST)**

WAST is a critical enabler in the success of the trauma network for South Wales, West Wales and South Powys. For the vast majority of patients who suffer major trauma their first contact with NHS Wales will be with the ambulance service as care is initially provided to them at scene and then during their journey to either a MTC or TU.

The service will also play a critical role either in taking these same patients home or for local or specialist rehabilitation.

The role that the ambulance service is being asked to play within the new network aligns seamlessly with the organisation's recently agreed long-term strategy for ambulance services in Wales - Delivering Excellence. A strategy, which articulates a desire by 2030 to:

- Ensure quality is at the heart of everything we do.
- Providing the right care, in the right place wherever and whenever it is needed.
- Enable our people to be the best they can be.

WAST's and EASC's 2019/20 IMTPs both articulate a commitment to develop an all Wales transfer and discharge service. Such a service, which will not only be critical to the success of the network but will also help support improvements in wider system flow in time. It will also act indirectly as a 'spring board' to the wider strategic development so that it can, in time, support the transfer and discharge needs of other strategic service changes, most notably the opening of the new Grange University Hospital in ABUHB, which will flow circa twelve months after the trauma network becomes operational.

### **3.8.8 EMRTS**

As a national service, EMRTS already has experience of working within the North West Midlands and North Wales Trauma Network. Therefore, the service has a familiarity with the operational and clinical governance arrangements provided by a trauma network and its role as a provider within that structure. The service has seen the value of these both in terms of receiving feedback on all major trauma patients taken to the MTC in Stoke and participation in network clinical activities.

The development of the trauma network in South Wales, West Wales and South Powys is seen as a key driver for the expansion of EMRTS to provide a 24/7 response. The expansion of the service will benefit wide groups of patients with both critical illness and injury, and will support health boards make decisions about reconfiguration of their acute services.

The establishment of the network will also bring maximal benefit from the interventions undertaken and triage decisions made by the service, as other components of the trauma pathway will start to align. Ultimately, this will allow EMRTS to realise many of the benefits outlined during its inception, particularly improvements in functional outcome, which will come from optimisation of the entire pathway and not just pre-hospital elements.

## 4 Clinical and Operational Model

### 4.1 Introduction

This chapter sets out the detailed work undertaken to develop the clinical and operational model for the trauma network for South Wales, West Wales and South Powys over the last seven years. It describes the historical context, with the establishment of the major trauma project and clinical reference groups, leading to a non-financial options appraisal for the location of the MTC, an independent panel review and the subsequent public consultation on the decision to establish a trauma network and the chosen site for the MTC. Subsequently, a description is provided of the designation process for TUs and LEHs. This section also presents a summary of the work undertaken to understand the predicted change in activity across the region.

A summary is also provided of recent peer reviews of business case submissions by all providers, in order to deliver the robust clinical and operational model presented here.

Subsequent chapters summarise baseline assessments for the MTC, TUs and pre-hospital providers against the agreed quality indicators and service specification including where these are already being met, could be met through internal re-organisation, or where additional resources will be required. This section also provides details of the phasing of the quality indicators and service specification over a five-year period in developing the clinical and operational model. The approach is aligned with recommendation derived following clinical peer review.

Finally, based on the above and on the predicted change in activity, additional resource requirements are quantified and justified in line with the phased introduction of the model for the following:

- Operational Delivery Network - ODN (including clinical informatics as well as training and education requirements) – Chapter 5.
- Pre-hospital provider (WAST and EMRTS) - for EMRTS this is provided for reference only, as resourcing for EMRTS expansion has been subject to a prior separate business case process – Chapter 6.
- Adult and paediatric MTC – Chapter 7.
- Morriston hospital – TU with specialist services – Chapter 8.
- Health boards (including TUs and LEHs) – Chapter 8.

The provision of rehabilitation and repatriation for ‘care with treatment closer to home’ will be incorporated into the above where appropriate. The results will inform the schedules presented in the financial case (Chapter 9) and make the case for the establishment of a trauma network for South Wales, West Wales and South Powys, with the benefits that this will bring as described in Chapters 3 & 12.

## 4.2 Chronology of Developing the Model

The following table outlines the stages of developing the clinical and operational model for the trauma network. Subsequent sections describe each of these stages in more depth.

Date	Key Decision Milestones
October 2012	Workshop held to discuss development of trauma network
May 2015	Service model agreed by Major Trauma Project Group & Clinical Reference Group
June 2015	Options appraisal for MTC location (UHW and Morriston Hospital taken forward)
March 2017	Recommendations from independent panel review published on MTC location
November 2017 – February 2018	Full public consultation on recommendation of independent panel review
March 2018	Recommendations of independent panel review endorsed by all six health board chief executives
November 2018	Designation of TUs endorsed by health board chief executives
September 2019	Designation of TU in HDUHB

## 4.3 Initial Service Modelling

### 4.3.1 Defining Quality Indicators and Service Specification

In 2012, the South Wales Programme (SWP) was established to develop clinically safe and sustainable service models in consultant-led maternity and neonatal care, in-patient children's services and emergency medicine for the population of South Wales and South Powys. The SWP covered Cardiff and Vale University Health Board, the former Abertawe Bro Morgannwg University Health Board, the former Cwm Taf University Health Board, ABUHB and PTHB. The programme did not specifically consider major trauma but as part of the work reviewing emergency medicine services, clinicians identified the need to develop a trauma network as a priority, following the establishment of the English trauma networks between 2010-12.

Following the conclusion of the SWP, NHS Wales Chief Executive Officers (CEs) asked the South Wales Health Collaborative (superseded by the NHS Wales Health Collaborative) to develop a service model for the trauma network. A project board was established, supported by a clinical reference group (CRG). Both groups comprised representatives from each of the health boards in the region, WAST, EMRTS and WHSSC. The scope was widened to include Hywel Dda University Health Board, which had not been involved previously in the SWP.

In England, quality indicators and a service specification were developed from the national service specification for major trauma (NHS England D15/S/a 2013) and the NHS clinical advisory group report

of major trauma workforce (CFWI, March 2011). These support the NHS England quality surveillance programme for major trauma services, enabling quality improvements, both in terms of clinical and patient outcomes. The indicators cover adult and paediatric major trauma services across the whole trauma pathway from point of wounding to recovery. They include sections for the Operational Delivery Network (ODN), pre-hospital care via ambulance services, adult and paediatric MTCs and TUs. There are no quality indicators or service specification for LEHs. The quality indicators are provided in Appendix 3. Presently the English clinical reference group oversees the review and development of the quality indicators with a cohort of national experts led by Professor Chris Moran (national director, major trauma, NHS England).

The CRG decided that the development of the service model would align with the quality indicators for NHS England for the following reasons:

- Quality indicators and service specification led to the effective establishment and delivery of major trauma services in England.
- Subsequently, these formed the basis of the national evidence-based clinical guidelines for major trauma (e.g. National Institute of Clinical Excellence *Trauma Guidelines* – 2018, British Society of Rehabilitation Medicine *Core Standards for Specialist Trauma Rehabilitation* – 2014).
- North Wales had already adopted these quality indicators and service specification as part of the North Wales and North West Midlands Trauma Network. Establishing a different set of standards would create inequity with North Wales.
- Data from TARN was being used to support the review of the quality indicators and health boards already had a mandate to contribute to TARN, thus allowing comparison with other networks. Establishing a different set of standards would necessitate creating a separate audit process and registry.
- Allow participation in the English peer review process.

The major trauma project board endorsed this decision in 2015 and the standards formed part of the supporting documentation for the consultation in 2017/18. In March 2019, CEs via WHSSC Joint Committee re-confirmed their support for adopting the NHS England quality indicators and service specification, but indicated their preference for a phased approach to their introduction, in keeping with the English Trauma Networks. It was noted that the development of the trauma network based on these quality indicators would not affect existing arrangements in place in North Wales.

#### **4.3.2 Purpose of the Service Model**

In considering the development of the service model, a number of principles were defined by the CRG to underpin subsequent processes, which align with the key investment objectives for establishing the network. These principles are outlined as follows:

To improve quality and safety of care for patients (health gain) by:

- Providing a comprehensive system of specialist care for people who have suffered serious injury (major trauma) through the delivery of a trauma network for all age groups.
- Improving the functionality, health and psychological well-being in those patients who survive their traumatic injuries, increasing their quality of life.
- Ensuring that services meet agreed national clinical and workforce standards.
- Always meeting fundamental standards of care.

- Valuing patient experience as much as clinical effectiveness.
- Ensuring responsibility for each patient's care is clear and communicated.
- Providing effective and timely access to care, including appointments, tests, treatments and moves out of hospital.
- Ensuring robust arrangements for transferring care are in place ('care with treatment closer to home').
- Tailoring services to meet the needs of individual patients, including vulnerable patients and older people.
- Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment.
- Ensuring the quality of the system is monitored and subject to a process of continuous quality improvement.
- Reducing avoidable deaths in the population of patients who would previously have died of their injuries.

To improve access for patients (equity) by:

- Delivering a system based on a pathway of care from the pre-hospital phase through acute care, ongoing care and rehabilitation and a return to socio-economic functioning.
- Ensuring effective triage and assessment of emergencies to enable conveyance by the most appropriate means to the most appropriate destination according to agreed criteria.
- Improving information and support to patients and families to encourage them to be active participants in their care.

To improve the sustainability of services to patients (clinical and skills sustainability) by:

- Providing robust staffing arrangements that comply with employment legislation (e.g. working time directive) and meet the requirements for clinical training and supervision where appropriate.
- Developing clinical roles to provide future workforce flexibility, enhancing recruitment and retention.
- Ensuring the population has access to major trauma services within a reasonable timeframe.
- Planning capacity to meet demand and providing appropriate resources across the network.
- Ensuring the network is kept under continuous review and responds to changes in relevant strategies, standards and policies.

The above principles have been taken forward in the planning phases of trauma network.

#### **4.3.2 Outline of Scope and Structure of the Trauma Network**

The scope of the trauma network is to provide seamless care to major trauma patients, characterised by an Injury Severity Score (ISS >15) and most patients with moderately severe trauma (ISS >8), from the point of injury to recovery. This includes all age groups.

An inclusive trauma system (ITS) is responsible for all aspects of trauma care across the pathway, from the point of wounding to recovery, and injury prevention. Each ITS comprises one or more trauma network and features a population-based approach to assessment of need and treatment, a role for every hospital and provider of care and provision of rapid transfer to the MTC. It includes a quality



assurance structure that penetrates across the region at each stage of care, underpinning providers' clinical governance processes and identifying inadequate performance in order to support its correction. It also informs commissioning about quality of care being delivered.

A trauma network is the name given to the collaboration between all providers commissioned to deliver trauma care services in a geographical area. The trauma network for South Wales, West Wales and South Powys will have the following structure:

- **Pre-hospital providers** – pre-hospital triage tool to convey patients directly to the MTC or TUs. These include WAST, EMRTS, Search and Rescue Services and voluntary agencies.
- **MTC** – a multispecialty hospital, on a single site, optimised for the provision of trauma care for all types of injuries through the provision of consultant level care. It will have access to all major trauma specialist services relevant to major trauma. It will provide a managed transition to rehabilitation and the community. It will take responsibility for the care of all patients with major trauma in the region covered by the network via an automatic acceptance policy. In addition to an active, effective quality improvement programme, it will collaborate and support other hospitals in the network. The adult and paediatric MTC for the region will be at UHW.
- **TUs** – there will be a number of TUs in the trauma network that provide care for injured patients and will be optimised for definitive care of injured patients. They will provide a managed transition to rehabilitation and the community. They will run an active, effective quality improvement programme. In addition, they will have systems in place to rapidly move the most severely injured patients to hospitals that can manage their injuries, in most cases, the MTC. TUs will have a role for receiving patients back who require ongoing care in hospital and have a suitable 'landing pad' via an automatic repatriation policy. See chapter 8 for TU designation.
- **TU with specialist services** – in addition to the above specification for TUs, Morriston Hospital will provide specialist services support to the MTC and provide specialist surgery for patients who do not have multiple injuries, given the presence of burns, plastic, spinal and cardiothoracic surgery.
- **LEHs** – these will be hospitals within the network, which do not routinely receive acute trauma patients, however, they must have processes in place to ensure that should this occur, there is appropriate initial management and transfer to the MTC or nearest TU. See chapter 8 for operational model for Hywel Dda University Health Board.
- **Rehabilitation** – hyper-acute rehabilitation will be initiated early at the MTC with local rehabilitation occurring in hospitals (TUs/LEHs) and the community within each health board. Specialist rehabilitation will continue to be managed at Rookwood Hospital, Cardiff and Neath Port Talbot Hospital.

Overseeing the above will be an Operational Delivery Network (ODN), hosted by SBUHB, which will comprise the management function of the network, in order to undertake strategic planning, operational delivery, tactical and local advice to commissioners, improve quality and standards of care and partnership development.

### 4.3.3 Summary of Service Model

The major trauma project board approved the work of the CRG in May 2015. Details of this are provided in Appendix 4. Pathways for care were derived from the Regional Networks for Major Trauma, NHS Clinical Advisory Groups (CAG) Report (2010), which formed the basis of the development of quality indicators and service specification in NHS England. The pathways included

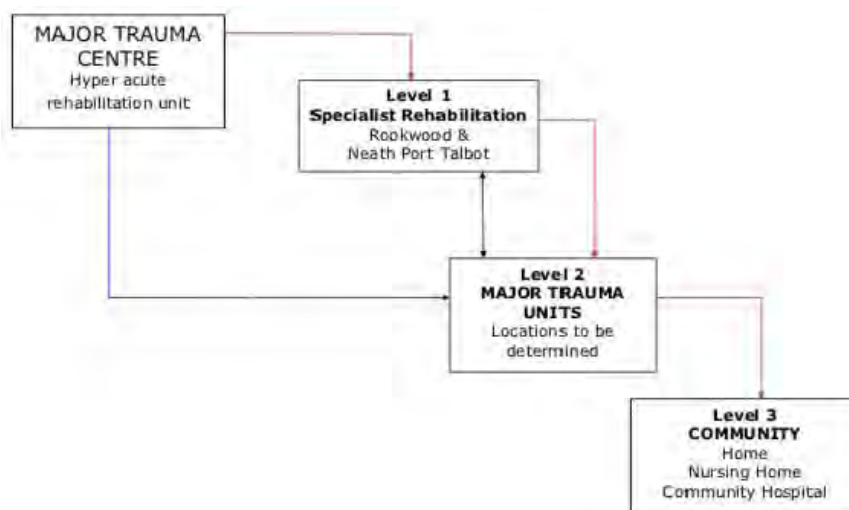
quality indicators and service specification for pre-hospital care, referral and the MTC (i.e. emergency care and surgery, diagnostics and radiology, ongoing care and reconstruction). It also included early and hyper-acute rehabilitation, specialised and local rehabilitation, network delivery, discharge planning and continuing care. In addition, there were sections on patient transfer, communication, audit, data management, governance and quality improvement.

The work undertaken by the CRG was refreshed in October 2018, when baseline assessments for all participating organisations were undertaken against the NHS England quality indicators and service specification. A detailed map of the service model is provided in Appendix 4. Thus, the service model developed by the CRG has been referenced here in order to note the historical context and as a demonstration of the breadth of work that has been undertaken incrementally since 2015.

#### 4.3.4 Summary of Rehabilitation Service Model

The CRG was also tasked to develop the rehabilitation model. Throughout the work to develop the model, clinicians consistently highlighted rehabilitation as a key part of the patient pathway commencing at admission, continuing through the inpatient phase to discharge from the MTC or TU out into the community. It is believed that this is a true enabler to achieving the best outcomes for the patient and improving patient flow across the system. Details of this are provided in Appendix 5. The aim of the rehabilitation model is to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable trauma rehabilitation services at all points along their care pathway, in line with best practice. Paediatric rehabilitation is discussed within the context of the final operational model, as this did not form part of the historical work undertaken.

The structure of the rehabilitation model is based on the British Society of Rehabilitation Medicine Core Standards for Specialist Trauma Rehabilitation – 2014 and is illustrated below:



##### Hyper Acute Rehabilitation

Rehabilitation will start as soon as is appropriate after admission, ideally in the critical care setting and in line with NICE guideline CG83: rehabilitation after critical illness in adults (2014). The hyper-acute service will enable early rehabilitation input to patients who have intensive rehabilitation needs. Patients with poly-trauma, head injuries, spinal injuries or multiple fractures will be co-located within a designated ward/unit area within the MTC site allowing enhanced co-ordination from the multi-disciplinary team involved in their care.

### **Level 1 – Specialist Rehabilitation**

A small number of very complex trauma patients will require the skills and facilities of a Level 1 specialist rehabilitation facility. These patients will typically present with complex disabilities and a range of medical, physical, sensory, cognitive and behavioural problems. The patients will require input from a wide range of rehabilitation disciplines, including trained nurses, physiotherapy, occupational therapy, dietetics, speech and language therapists, psychology and artificial limb and appliance services (ALAS).

Specialist rehabilitation input will be initiated early during the patient's journey. This may commence when the patient is in ITU and will continue beyond this phase of treatment. Rehabilitation input will commence with the initiation of a rehabilitation plan within 72 hours, which will define the rehabilitation needs of patients and identify how these needs will be addressed. A rehabilitation consultant, through a specialist rehabilitation plan, will provide access to specialist rehabilitation.

When the patient is ready to move from a hyper acute rehabilitation facility, they may be transferred to a Level 1 facility according to their needs. In some cases, patients will be transferred to their nearest TU or back into the community whilst waiting for specialist rehabilitation, thus maintaining patient flow across the system.

### **Level 2 – Acute Ongoing Rehabilitation in TUs**

For the majority of patients whose needs will be less complex and at a lower level, acute and ongoing rehabilitation will be provided in a TU near their area of residence. They may be directly admitted to the TU or as a 'landing pad' via the MTC. The patients will require input from a wide range of rehabilitation disciplines, including trained nurses, physiotherapy, occupational therapy, dietetics, psychology and ALAS. Rehabilitation input will commence with the initiation of a rehabilitation plan within 72 hours and will be overseen by a consultant in rehabilitation medicine, helping to manage risk and expedite discharge. The TU rehabilitation team will have the capacity and skill set to advise the community teams and local rehabilitation hospitals and provide outreach to local hospitals or units for patients with ongoing rehabilitation needs.

### **Level 3 – Ongoing Rehabilitation in the Community**

As patients improve and no longer require care within an acute setting, they will be transferred into a community setting to continue their rehabilitation. The local model of care, which will be different across the network area depending on rural or urban localities, will contain vocational/social participation and third sector support as necessary. Many patients will return home from the MTC and have community based rehabilitation needs. A consultant in rehabilitation medicine will maintain an overview and patients will be reviewed and managed within the community. There will be links with GPs, the wider primary care team and third sector organisations. Specialist community teams such as those working in acquired brain injury and spinal injury will support primary care teams with a seamless approach between community and specialised care.

TU rehabilitation coordinators will have important role in ensuring patients returning to the community have appropriate involvement in planning in their care journey, including the interface with social care.

## **4.4 Non-financial Options Appraisal for MTC Location 2015**

In June 2015, a workshop led by clinicians considered the options available to support the development of a trauma network for South Wales, West Wales and South Powys and specifically the

location of the MTC. A detailed report of the work is provided in Appendix 6. The workshop comprised representatives from health boards throughout the region, WAST and EMRTS. Patient representatives were invited through the third sector support groups and the community health councils (CHC) in an observer capacity. The workshop incorporated a non-financial option appraisal process and concentrated on the clinical benefits of the different options. In doing so, delegates were asked to consider the infrastructure requirements for the number of MTCs in a sustainable system and siting of major trauma services, based on the clinical service model and proposed activity developed by the CRG. Furthermore, consideration was given to co-located and interdependent services required at the MTC and scoring of each option against a series of benefits criteria.

A 'long list' of options was considered as illustrated below:

Investment objective	Description
<b>Option 1 – Do nothing</b>	This option described the current situation and clinical pathway delivery and was used as the baseline comparator. Currently there is no trauma network serving South Wales, West Wales and South Powys and no hospitals have been designated MTC or TU.
<b>Option 2 – Single site, UHW</b>	This option proposed the development of a single-site MTC at the UHW, Cardiff. This would mean the designation of UHW as the MTC serving South Wales, West Wales and South Powys with other consultant-led emergency departments acting as TUs within the trauma network structure, some providing specialist services.
<b>Option 3 - Single site, Morriston Hospital</b>	This option proposed the development of a single-site MTC at the Morriston Hospital, Swansea. This would have meant the designation of Morriston Hospital as the MTC serving South Wales, West Wales and South Powys with other consultant-led emergency departments acting as TUs within the trauma network structure, some providing specialist services.
<b>Option 4 – Dual site</b>	This option proposed the development of an MTC delivered across two sites: UHW and Morriston Hospital. This would have meant that the full requirements for a MTC would not be provided on each site. One of these sites would be the designated lead for the trauma network. Some specialist services would need to be provided from Morriston to UHW (e.g. burns and plastics) and from UHW to Morriston (e.g. neurosurgery) through emergency outreach clinical teams. The remaining consultant-led emergency departments would act as TUs within the trauma network structure.
<b>Option 5 – Outsourced service (no MTC in South Wales)</b>	This option proposed that a MTC was not established within South Wales but that this service would be commissioned from a provider partner outside Wales. This would have meant the designation of a MTC in England serving South Wales, West Wales and South Powys with the consultant-led emergency departments in South and West Wales acting as TUs within the trauma network structure, some of which may provide specialist services.

The following benefit criteria were used to score each option at the workshop. These criteria were aligned with those used for other national programmes and were given a weighting, agreed by the CRG and project board:

- **Quality and safety** – 35%
- **Equity** – 10%
- **Strategic fit** – 10%
- **Sustainability/future proof** – 25%
- **Access** – 15%

Details of the methodology and outcomes are provided in Appendix 7, which included sensitivity analysis of the outcomes.

The outcome of the analysis was that the option to do nothing and continue with the South Wales area remaining as the only region not being supported by a trauma network was quickly eliminated. It was also agreed that to support a population of approximately 2.4 million the network would need to be supported by a MTC located within the region. This was in keeping with similar sized populations being supported by networks in England. Thus, the outsourcing option was ruled out.

The potential for a dual site solution was seriously considered but subsequently eliminated because the critical mass for sustainability could not be delivered through such an arrangement and experience of some English trauma networks, which had operated a dual site solution and encountered significant operational problems.

UHW and Morriston Hospital were the only two hospitals in the region identified as having the potential to meet the necessary quality indicators and service specification for a MTC. This was due to the specialist nature of the trauma service itself and the need for co-location with other specialist services.

Thus, the preferred option from the non-financial options appraisal was to develop a trauma network for South Wales, West Wales and South Powys that contained a number of TUs supported by a single site MTC.

These options were taken forward through an independent panel review and public consultation.

Following the options appraisal, an Equality Impact Assessment was completed to support engagement with key stakeholders.

## 4.5 Independent Panel Review

Building on the work of the project board and the outcome of the clinical workshop, the NHS Wales Health Collaborative Executive Group (chief executives) agreed with the recommendation to establish a trauma network with the MTC located in either UHW or Morriston Hospital.

To facilitate the decision on the preferred location of the site for the major trauma centre, NHS Wales CE's meeting as the Collaborative Executive Group proceeded to recommend that an independent, expert clinical panel be commissioned to review the available evidence and provide advice. The proposed process for the independent panel was endorsed through individual public board meetings. CHC chief officers were also briefed as part of this process.

Professor Chris Moran chaired the independent panel, with support from a group of eight experts selected to be part of the panel based on their national and international reputations as experts in trauma care and the development of trauma systems.

The panel was provided with all the relevant information required to enable them to consider the position for the region. This included a high-level financial appraisal of the indicative capital and revenue requirements for either option and WAST resources (see Appendix 8). This appraisal did not include an assessment of capital and revenue requirements for TUs or the ODN. Furthermore, isochrone maps were developed indicating the proportion of the population within 60 minutes of the MTC for both UHW and Morriston Hospital (see Appendices 9 & 10). Clear terms of reference were provided to inform the assessment.

In February 2017, a session was convened with the panel where representatives from across the region and other key stakeholders were invited to attend. This included: clinical representatives from all participating health boards; Public Health Wales; Welsh Government; CHCs; EMRTS; WAST; WHSSC and EASC. Colleagues from UHW and Morriston Hospital gave presentations.

When considering the location of any new service, the Independent Panel determined that there were three main factors that need to be taken into consideration:

- **Clinical interdependencies (services that must be located together)** - the independent panel advised that one of the most important factors in the effective management of major trauma is the immediate availability of key specialist services. Most of those specialist services were already provided in both UHW and Morriston Hospital. However, specialist neurosurgery was only provided in UHW and burns and plastics services only in Morriston Hospital. Given that approximately 60% of major trauma cases require support for head injuries, the panel advised that same-site provision of specialist neurosurgical services (adult and paediatric) should be a key requirement for the location of the MTC. The panel also recognised the importance of the burns and plastics service as part of the trauma network and identified that whilst co-location was not a critical factor, it was imperative that the burns and plastics centre worked very closely with the MTC to make sure patients receive the care they need.
- **Critical mass** – it was recognised that neurosurgery and burns and plastics services were so specialist they could only be provided from one hospital site for the population of South Wales, West Wales and South Powys. The same held true for the establishment of a single MTC for the region.
- **Travel times** - the panel considered the geography of Wales and made it clear that an inclusive trauma system is expected to improve mortality in all geographical regions of South Wales, West Wales and South Powys regardless of the transport time to the MTC. They recognised that irrespective of the location of the MTC, at either Morriston Hospital or UHW, some parts of the population in Hywel Dda and Powys will be a considerable distance from the MTC. This was not an unusual situation and most trauma networks in England supported services that were a considerable distance from the MTC. The panel did not believe that either Morriston Hospital or UHW as a MTC would have any significant advantage over the other in terms of geography. Working as part of a network, most ambulance services in England operated a bypass system of up to one hour. This meant that patients identified as having suffered major trauma by ambulance personnel would be taken directly to the major trauma centre if it were within one-hour travelling time. This time could be extended after advice was taken. Patients with more immediate needs would be transported to a TU and stabilised prior to transfer. Only a small proportion of trauma patients required immediate surgery and this was likely to be achieved more rapidly in the MTC, mitigating any increase in transport times. The wider network model (including trauma units, automatic acceptance at the MTC, enhanced triage

decision making and 24 hours availability of EMRTS) had a key role to play in managing patients who may be further away from the MTC.

Considering all three factors, in March 2017, the independent panel produced a report (see Appendix 11) of their findings making the following unanimous recommendations for consideration by the constituent health boards:

- A major trauma network for South Wales, West Wales and South Powys with a clinical governance infrastructure should be developed quickly.
- The adult's and children's MTCs should be on the same site.
- The MTC should be at University Hospital of Wales, Cardiff.
- Morriston Hospital should become a large TU and should have a lead role for the major trauma network.
- A clear and realistic timetable for putting the trauma network in place should be set.

It is significant that in making recommendations of the development of the wider network, the independent panel recommended that Morriston Hospital should be a large TU. As a large TU, Morriston Hospital is likely to be able to manage some conditions that other trauma units will not, due to the specialist services it already provides. This means that following clinical assessment a more complex patient may not need to be transferred to the MTC (within agreed protocols) and will continue to be managed within Morriston Hospital. This may be different for other TUs in the region, which do not have such specialist services. The term 'large TU' is defined as a TU with specialist services in the remainder of this document for consistency of nomenclature with NHS England.

The panel also specified that Morriston Hospital should take the leadership role in the major trauma network, hence the decision for SBUHB to host the ODN. This follows the model in England where the leadership for the network is often, but not always, provided from a hospital other than the hospital where the MTC is located. A lead hospital is necessary to ensure the trauma network works in a coordinated way and makes sure the patient and the complete patient pathway is the focus rather than the MTC itself.

## **4.6 Public Consultation Process and Recommendations**

The recommendations from the independent panel were reviewed through the Collaborative governance arrangements (Collaborative Executive Group and Leadership Forum) and the benefits for the population of South Wales, West Wales and South Powys associated with developing a trauma network fully considered. Health boards also considered and agreed in principle to the recommendations and for a period of consultation. Whilst the development of the trauma network represented a service change and not a service development, health boards recognised that a period of public engagement and consultation was required to ensure a clear understanding of the role of network and its component parts.

In accordance with this, the NHS Wales Health Collaborative team developed consultation documentation with individual health boards engaging with their local CHC to facilitate the local consultation exercise to seek views on the development of the trauma network and the implementation of the recommendations of the independent panel (see Appendix 12). In doing so, a clear scope was defined for the consultation process and three questions that would be asked of stakeholders:

- Do you agree or disagree that a major trauma network should be established for South Wales, West Wales and South Powys?
- Do you agree or disagree that the development of the major trauma network for South Wales, West Wales and South Powys should be based on the recommendations from the independent panel?
- If we develop a major trauma network for South Wales, West Wales and South Powys is there anything else we should consider?

A detailed stakeholder mapping exercise was undertaken with key groups identified as NHS Wales staff, CHCs, the public, national bodies/organisations, third sector, local authorities and elected members, people with protected characteristics and specialist groups. The consultation started in November 2017 and was completed by February 2018. All documentation including historical work was made available via the Public Health Wales website; consultation documentation was developed and shared with all participating organisations and public engagement sessions were held in each health board (see Appendix 12).

Responses were analysed by the NHS Wales Health Collaborative and themes identified. This information was shared with CHCs to enable production of a formal response. A report was produced which included the findings of the consultation (see Appendix 13). This was considered by health boards in their public board meetings in March 2018.

In relation to the consultation, each CHC provided feedback to their health board in relation to the consultation and whether individual CHCs were in a position to support the recommendations of the independent panel. In general, CHCs were unable to agree or disagree with the recommendations contained in the report. Common themes in the concerns raised by CHCs were:

- A lack of public engagement prior to formal consultation.
- A lack of detailed information about the overall design of the network, including the location of TUs.
- Insufficient financial information and a lack of an assessment of the impact on other services of investing in the network.
- A lack of space and capacity at UHW.
- Arrangements for patient transfer outside the operational hours of the EMRTS.

Despite this and based on the evidence of the positive benefits of a trauma network, in March 2018 all six health boards across South Wales, West Wales and South Powys approved the recommendation to establish the trauma network in line with the independent panel report.

Subsequently, a 'lessons learnt' exercise was held in September 2018, with involvement of CHCs. The network clinical lead and director of the NHS Wales Health Collaborative took the opportunity to meet with CHC Chief Officers on a number of occasions and produced update reports, providing mitigations to the above concerns. At the time of writing, CHCs from two health boards have agreed to the recommendations of independent panel review, with ongoing positive engagement by the health boards with respect to seeking agreement from remaining CHCs. It is anticipated that this dialogue will continue once the network is operational. Furthermore, all of the issues outlined above have been discussed in the context of this Programme Business Case.



## 4.7 Designation of Trauma Units

Having completed the process for designation of the adult and paediatric MTC at UHW, Morriston Hospital as a TU with specialist services and the ODN function being hosted by the SBUHB, a process was established to designate TUs. This process coincided with the establishment of the trauma network board (June 2018) and confirmation that WHSSC would be the principle commissioner for the network.

### 4.7.2 Designation Process

To support health boards to make choices in relation to TU designation, the network board confirmed a process in August 2018, as follows:

- The network board requested that health boards complete a baseline assessment against NHS England quality indicators and service specification for hospitals proposed as 'candidate TUs.' Information was provided as to which indicators needed to be met for day one and which could follow once operational.
- The network clinical lead wrote to directors of planning of each health board requesting meetings to discuss baseline assessments.
- Meetings were held September to October 2018 with all health boards. These meetings were chaired by the network clinical lead, some of which supported by the director of the NHS Wales Health Collaborative. Health board representation included directors of planning or a nominee and clinical and managerial network leads. In addition, the network interim rehabilitation lead provided health boards a useful insight into TU service specification from a rehabilitation perspective.
- The purpose of these meetings was to discuss the baseline assessments against a series of questions:
  - Where gaps exist, how could these be quantified? In the first instance, how could the gap be closed through internal re-organisation? This was used as a starting point for all discussions in relation to quality indicators.
  - Where there is a need for additional resources above what can be achieved through internal reorganisation, what are the implications of this?
  - With additional resources, will it be possible to meet the quality indicators?

These baseline assessments form the basis of the resource requirements set out in Chapters 8 & 9.

- The above questions were used to inform final submissions for all 'candidate TUs,' based on those that could most closely meet the quality indicators. In addition, health boards were asked to indicate whether the 'candidate' TU would be adult and paediatric or adult only, justification for their choice and to consider how patients would be served in regions without a nearby TU.
- Following endorsement by the network board in October 2018, a paper was taken through the WHSSC management structure and to WHSSC Joint Committee to make a recommendation in November 2018, followed by approval of TU designation by each health board in January 2019. In most part, choices were in keeping with the result of the SWP, in terms of future location of emergency departments.
- The network board recognised the need for informing and engaging CHCs with respect to TU designation, recognising that health boards would be principally responsible for this through normal processes, supported by trauma network board members. All health boards confirmed the location of their TUs with their CHCs.

- It was recognised that the designation of TUs would be reviewed after the first year of being operational and national annual trauma peer review.

### 4.7.3 Trauma Unit Locations

The following hospitals were approved as adult and paediatric TUs, following a recommendation by WHSSC Joint Committee and endorsed by health boards:

- UHW, Cardiff – TU function for its own population.
- Morriston Hospital, Swansea – TU with specialist services
- Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the health board)
- Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend.
- Glangwili General Hospital, Carmarthen (section 4.7.4).

In relation to LEHs, the following hospital will be a LEH within the network structure:

- Royal Glamorgan Hospital, Llantrisant.

As described below, Bronglais General Hospital, Aberystwyth and Withybush General Hospital, Haverfordwest will be rural trauma facilities for the purposes of major trauma.

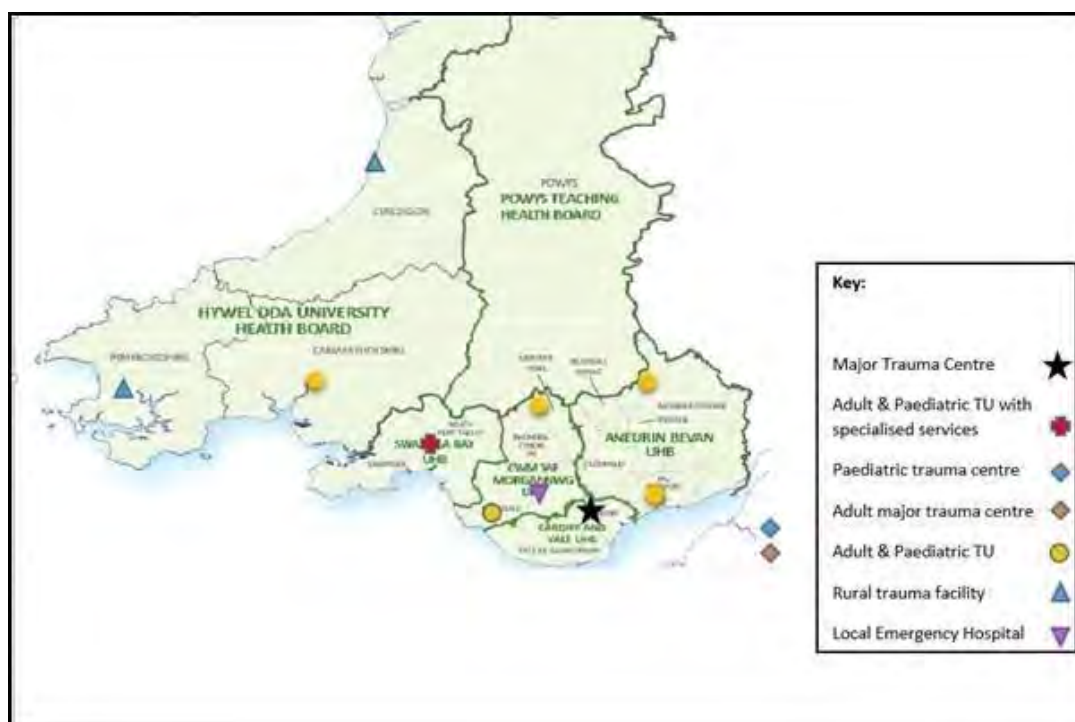
### 4.7.4 Proposed Structure in Hywel Dda University Health Board

Following full public consultation in 2018 as part of its *Transforming Clinical Services Strategy*, the health board confirmed its intentions to develop a new urgent and planned care hospital within the region, which in the future will function as the TU and main emergency department for the health board. In addition, Bronglais General Hospital will be a rural provider of urgent and planned care, including the presence of acute services. Glangwili General Hospital and Withybush General Hospital will become GP led Minor Injury Units alongside community beds and outpatient facilities.

Following a period of public engagement in June and July 2019, the health board has designated Glangwili General Hospital as the TU in the years preceding the development of the new hospital. This, along with the role of the remaining hospitals is being worked through as part of a public engagement process.

With respect to Bronglais General Hospital and Withybush General Hospital, a baseline assessment demonstrated that both hospitals fell significantly short of the quality indicators compared to other TUs, and it was unlikely the 'gap' could be closed easily, even in the presence of additional resources. However, given the rural nature of the catchment areas of both hospitals and concerns in relation to the term LEH it has been proposed that for the purposes of the trauma network, both hospital will be termed rural trauma facilities in recognition of this strategic importance. Whilst as for LEHs there are no specific quality indicators for a rural trauma facility, the Health Board is committed to ensuring these hospitals maintain the ability to assess and treat major trauma patients, given their relatively unique geographical location. In addition, they will need to maintain the ability to rapidly transfer patients to the MTC at UHW, TU with specialist services at Morriston Hospital or the TU in Glangwili General Hospital.

#### 4.7.5 Proposed Map of Trauma Network



#### 4.8 Predicted Change in Patient Flow

Early predictions on the change of flow of moderate and major trauma patients was captured as part of the consultation process in 2017, with an estimated 1,500 moderate and major trauma cases across the region. Historically, basic modelling was also undertaken as part of the EMRTS Strategic Outline Programme using a population-based approach in 2014.

Subsequently, the network board identified the need to undertake a more in-depth analysis of current and predicted activity to inform the planning of the network. A number of strategies have been adopted to achieve this. It was recognised that it would be challenging to solely use baseline data from TARN given the significant variation in completeness and quality across the region. Consequently, the network board enlisted the support of Gareth John, NWIS, and Andrew Nelson, C&VUHB. A detailed presentation of the methodology used, key assumptions and results are presented in Appendix 2.

Essentially, patient episode data for Wales (PEDW) was obtained from NWIS for 2017 to calculate current activity. ICD-10 codes were translated into TARN codes, in order to present a breakdown by ISS. Furthermore, hospital spells were used rather than number of cases, as a more accurate metric for making planning assumptions. A complex modelling algorithm was developed in order to inform the data presented for current activity and this was developed on 5 years of C&VUHB data.

Further analysis was undertaken to predict the change in flow, in line with the assumed current position for South, Mid and West Wales and using the proportions for the English trauma networks (derived from TARN) for 2011, 2012 and 2013, represented as year 1, 2 and 3 respectively below:

ISS	'Patient pathway'	Assumed current position	Year 1	Year 2	Year 3 & steady state
9-15	% direct to MTC	22	25	28	31
9-15	% transfer TU to MTC	0	7	7	8
9-15	% TU only	78	68	65	61
>15	% direct to MTC	32	35	39	42
>15	% transfer TU to MTC	6	25	25	22
>15	% TU only	62	40	36	36

The above table demonstrates that the current position in the region pre-dates that of the year 1 of the establishment of the English trauma networks. Furthermore, the proportion of moderate and major trauma subjected to direct and secondary transfer to the MTC increased and then reached a steady state in year 3. However, the total number of cases reported to TARN continues to rise.

The table below illustrates the predicted change in first spell presentations to the MTC for moderate and major trauma. One hospital spell covers the activity whilst a patient remains within that hospital for a continuous length of time:

ISS 9-15 – moderate	Assumed current position	Year 1	Year 2	Year 3
Direct to MTC	154	206	231	256
Transfer TU to MTC	11	58	58	66
% TU only	660	561	536	503
Total	825	825	825	825
ISS >15 – major	Assumed current position	Year 1	Year 2	Year 3
Direct to MTC	284	306	341	368
Transfer TU to MTC	49	219	219	193
% TU only	542	350	315	314
Total	875	875	875	875

ISS >9 – candidate	Assumed current position	Year 1	Year 2	Year 3
Direct to MTC	438	512	572	624
Transfer TU to MTC	60	277	277	259
% TU only	1202	911	851	817
Total	1,700	1,700	1,700	1,700
Combined Direct to MTC & Transfer TU to MTC	498	789	849	883

Subsequent analyses were undertaken to determine the change in flow for all other receiving hospitals in the region and bed capacity requirements. This included a subgroup analysis for paediatric trauma, bed requirements for patients returning to a 'landing pad' following care at the MTC and further work undertaken within HDUHB. From these, a number of observations can be made:

- The total moderate and major trauma workload of 1,700 spells per year correlates well with earlier predictions.
- In year 1, it is predicted that moderate and major trauma spells will increase by 290 per year once UHW becomes an MTC. By year 3, predicted number of spells will reach a steady state. The main reason for the increase relates to the increase in the proportion of transfers to the MTC of major trauma from TUs. The programme team at UHW have used this data to inform subspecialty specific analyses, ward bed/critical care bed capacity planning and theatre capacity planning.
- It is predicted that all other hospitals in the region will see a fall in admitted moderate and major trauma, owing to increased flows to the MTC. Overall TUs will retain 68% of moderate trauma and 40% of major trauma in year 1. Thus, overall acute bed capacity requirements will fall in these hospitals.
- Approximately 20-34% of patients will return from the MTC and require access to a 'landing pad' in their health board. This largely represents new flow of patients. Requirements will vary from ongoing medical care, hospital care whilst awaiting social care packages, level 2 rehabilitation and a small proportion awaiting specialist rehabilitation. Current practice is that these patients rarely experience timely transfer back their local hospital. For all regions, it is predicted that bed requirements for the 'landing pad' will not exceed the overall fall in acute bed requirements. Thus, the totality of beds required in each hospital (except UHW) will not increase.
- The exception to this is for Glangwili General Hospital, which has been designated a TU. Further local analyses predict a maximum of 1-2 extra patients per week attending the TU acutely from regions served by Bronglais General Hospital and Withybush General Hospital. Furthermore, Morriston Hospital is predicted to see some additional patients acutely due to specialist services provided (e.g. orthoplastics).
- The data have indicated the need for additional ambulance journeys (both for direct and secondary transfers to the MTC) and repatriation. This has informed planning assumptions for WAST (see chapter 6).

- Finally, small increases in moderate and major paediatric trauma will be observed at the MTC.

The work undertaken was reviewed and scrutinised by all health boards and was approved by the network board as a single data source for all health boards/WAST when undertaking service planning and informing additional resource requirements outlined in subsequent chapters.

## 4.9 Summary of Review of Clinical and Operational Service Model

Following the business case submissions from each organisation to inform this programme business case, the following levels of review were undertaken:

- Verbal and written feedback from the NHS Wales Health Collaborative programme team (incl. the network clinical lead). Face-to-face meetings with network board representatives from all organisations with programme team.
- Internal health board scrutiny and review of all submissions.
- A presentation and review of all submissions at the trauma network board in June 2019.
- A professional clinical review of the MTC case, C&VUHB and orthoplastic case, SBUHB by Professor Chris Moran, National Clinical Director, Major Trauma, NHS England on the 2nd July 2019.
- Review of the MTC and orthoplastic business cases by the WHSSC management team.
- Review of the WAST business case by the EASC Management team.
- OGC Gateway review 0 of the entire case 8-10 July 2019.

One of the recommendations of the Gateway review 0 was to undertake a critical scrutiny of all business case submissions in order to close out the gap between the programme team specification of minimum Day 1 requirements and submissions. This include further development of the planning assumptions for each phase to progressively meet quality indicators and service specification.

In response to this, the NHS Wales Health Collaborative organised a one day professional peer review event, bringing together experts from across the UK to undertake a review of the entire system including proposals from WAST, C&VUHB (MTC), SBUHB (specialised services), TUs and the ODN. This also included reviews of the rehabilitation model. A subsequent review of therapy requirements and the spinal trauma case were remotely undertaken and the outcome shared with organisations.

The review was informed by a series of questions generated by an Executive Strategic Group formed following the Gateway 0 review. Following a successful and positively supported event, which took place on 13 August 2019, the Executive Strategic Group generated, a series of recommendations based the discussions that had taken place and these were shared with the network board to consider on 19<sup>th</sup> August 2019. The network board supported in principle recommendations pertaining to the MTC and specialised services, but fully supported recommendations pertaining to WAST, TUs and the ODN. Appendix 14 provides a summary of recommendations made.

Following this, C&VUHB and SBUHB were asked to consider the recommendations in the context of their revised submissions. With the support of an OGC Gateway Assurance of Action Plan review (undertaken on the 9 September 2019), further work was undertaken between these organisations and WHSSC to agree an appropriate position described in subsequent chapters.

## **5 Operational Delivery Network**

### **5.1 Introduction**

The creation of a trauma Operational Delivery Network (ODN) is central to the development of a trauma network for South Wales, West Wales and South Powys. A Trauma ODN involves cross-organisation and multi-professional working through a whole system approach, ensuring the delivery of safe and effective services across the patient pathway. Under an ODN, patient pathways pertaining to trauma are coordinated between providers over a wide geographical area to ensure equity of access to specialist resources and expertise. Its aims align with the key investment objectives outlined in Chapter 2 and 3 in order to improve patient outcomes, patient experience and quality standards from the point of wounding to recovery.

This chapter provides a description of the purpose of the ODN, its phased implementation against service specification and quality indicators and the resource requirements for the ODN management team. Furthermore, it describes the parallel arrangements for the Veterans Trauma Network (VTN). The commissioning and governance arrangements for the ODN are described in the management case (Chapter 12).

Finally, details are provided of the clinical informatics and training and education requirements for ODN using a phased approach.

### **5.2 What is a Trauma Operational Delivery Network (ODN)?**

A Trauma ODN involves cross-organisation and clinical multi-professional working, through a whole system collaborative approach, ensuring delivery of safe and effective services across the patient pathway. Under an ODN, patient pathways pertaining to trauma are coordinated between providers over a wide geographical area to ensure equity of access to specialist resources and expertise. Thus, its aims are to improve patient outcomes, patients experience and quality standards from the point of wounding to recovery.

In September 2018, WHSSC Joint Committee agreed that an ODN will be established to oversee the delivery of trauma services to the population of South Wales, West Wales and South Powys and that a health board should host the ODN; SBUHB was agreed as the host organisation for the ODN.

It was also agreed that the ODN and MTC at UHW will be commissioned by WHSSC. EASC will commission WAST and the EMRTS. Health boards will be responsible for local commissioning of TUs. In addition, existing major trauma commissioning arrangements for BCUHB will be retained.

### **5.3 Purpose of the Operational Delivery Network**

The term 'ODN' was developed in NHS England in 2012, to reflect the shift in the function of some clinical networks to focus on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise. Thus, trauma networks developed as ODNs with a focus on operational delivery. As defined by the service specification below, the network board and WHSSC agreed to the formation of an operational delivery network. In NHS England, provider organisations host Trauma ODNs in order to ensure optimal delivery of the service specification. In keeping with this and aligning with recommendations of the independent panel, a provider, SBUHB, will host the trauma ODN for South Wales, West Wales and South Powys.

The ODN will represent a collaboration between all providers commissioned to deliver trauma care services (both specialised and non-specialised), focused initially on the population of South Wales, West Wales and South Powys. Providers will include the pre-hospital services (WAST and the EMRTS), MTCs, TUs, LEHs and rehabilitation services. The ODN will also have appropriate links to social care and the third sector.

The key responsibilities of the ODN can be summarised as follows (adapted from the Intercollegiate Group for Trauma Standards, 2009):

- A focus on improving functional outcome and patient experience from the outset.
- Ensuring injured patients are delivered to the MTC for definitive care quickly and safely.
- Maintaining patient flow across the region, ensuring timely 'care with treatment closer to home' once specialist care completed.
- Clinical responsibility for a seriously injured patient anywhere in region and ensuring clinicians maintain a responsibility extending outside their traditional health board boundaries.
- Adopting a culture of integrated multi-disciplinary working across health boards through specialist and professional groups.
- Acute and ongoing rehabilitation services to improve outcomes and restore patients back to productive roles in society.
- Adopting a population based approach; in particular developing pathways for trauma in older people (see section 5.4.4).
- A continuous process of system evaluation, governance and performance improvement.
- Develop multi professional training and education across the patient pathway.
- Supports active injury prevention programmes to reduce the burden of injury for the network population.
- Active development of an audit and research programme and support of research into trauma and its effects, to improve outcomes.
- Integration with multi-agency mass casualty planning in the region.

These are expanded further in the next section on service specification and quality indicators.

## 5.4 Phased Implementation

The baseline position is that currently there is no trauma ODN serving the population of South Wales, West Wales and South Powys. Only some aspects of network wide service specification or quality indicators exist.

Two sources have been used to develop the model for the phased implementation of the trauma ODN. Firstly, the NHS England commissioning service specification D15a, Trauma ODN 2012/13. Secondly, the NHS England network quality indicator document, 2013. The rationale for adopting these is presented in chapter 4. The proposed model is further divided into those elements that are essential, desirable and aspirational. Phasing of essential elements has been undertaken including specification and quality indicators that need to be in place before the ODN is operational (i.e. before day 1) and those that will develop in year 1, 2 and 3.



### 5.4.1 Service Specification

All specifications will need to be in place before the ODN becomes operational (i.e. before Day 1) unless indicated below. Each element will be ongoing from the point of implementation, unless otherwise stated.

#### Essential

These aspects are considered essential and are critical to the successful delivery of the ODN and its key investment objectives.

#### *Strategic planning*

- Provide professional and clinical leadership across the network.
- Undertake comparative benchmarking and audit across the network through TARN – supporting the enhancement of data collection.
- Effective linkage into commissioning groups – in this case, WHSC and EASC.
- Hosting a risk register and undertaking risk management across the network.
- Produce quarterly and annual reports – Year 1.
- Develop an annual working plan for the network to deliver against the quality and delivery framework – Year 1.
- Contribute to evaluation of the network – Year 2.
- Develop a longer-term plan going out 5-10 years to ensure new capabilities can be brought into core operations in quickly and efficiently as possible – Year 2.

#### *Operational delivery*

- Develop coordinated patient clinical pathways between services over a wide area to ensure access to specialist major trauma care.
- Develop a comprehensive system of delivery through A) a pre-hospital triage tool and criteria for immediate inter-hospital transfer and transfer within 48 hours of referral; B) Automatic acceptance and repatriation policies; and C) rehabilitation pathways.
- Ensure improved access and equity of access to trauma services – Year 1.
- Responsible for monitoring of day-to-day capacity across the network, agreeing and working to an escalation plan (with agreed thresholds for escalation triggers) both within and across network to monitor and manage surges in demand – Year 1.
- Support capacity planning and activity monitoring for collaborative matching of demand and supply (e.g. through implementing a trauma tracking system) – Year 1.
- Ensure appropriate repatriation for ongoing 'care with treatment closer to home' – Year 1.
- Ensure the quality of the network is monitored and subject to a process of continuous quality improvement through clinical audit – Year 1.

#### *Tactical (local) advice and support to commissioners*

- Provide local information, data and intelligence to support performance monitoring of the network (i.e. TARN clinical reports, process measures, key performance and quality indicators, case-mix standardised outcomes, workforce data) – Year 1.

- Support national annual trauma peer review and assurance of the MTC, TUs/LEHs and pre-hospital services with commissioners – Year 1.
- To provide ongoing programme management of a phased implementation across the network – Year 1.
- Support local implementation of products produced by the national trauma clinical reference group (NHS England) as appropriate – Year 1.

#### *Improved quality and standards of care*

- Develop and implement network protocols for trauma patients.
- Deliver a clinical governance framework with the MTC, TUs, LEHs, pre-hospital services and rehabilitation services including a process for incident reporting with follow up action plans and network morbidity and mortality review. This includes collaborative serious incident investigation.
- Deliver a network-wide training and education programme encompassing the whole patient pathway prioritising key areas (see section 5.6)
- Implement a clinical informatics system for the network – Year 1 (see section 5.5)
- Ensuring on-going service improvements and best practice models are embedded and contribute to improved quality performance (i.e. dashboard measures) – Year 1 and ongoing.
- Monitoring of MTC and TU dashboard measures and provide advice on improvements to clinical services and commissioners – Year 1.
- Use clinical process and clinical outcome measures to compare and benchmark providers – Year 1
- Deliver an annual quality improvement and audit programme – Year 1.

#### *Partnership development*

- Engagement with third sector organisations.
- Linkage with other relevant networks (e.g. North Wales and North West Midlands Trauma Network).
- Embed communication strategy and key communication deliverables – Year 1.
- Monitoring and performance management of active engagement by members in the network to improve performance against agreed outputs – Year 1.
- Participation in relevant national policy or guideline development – Year 2

#### **Desirable and Aspirational**

Some aspects are considered desirable or aspirational. Whilst not critical to the successful implementation of the ODN, they represent future areas of development:

- A research programme focused on all parts of the trauma pathway, as a vehicle for driving improvements in patient outcome and experience. Enhanced profile of the region through sharing knowledge nationally and internationally (e.g. publications and presentations).
- An injury prevention programme in association with Public Health Wales (e.g. knife crime prevention, motorcycle safety, wearing cycle helmets).
- Sharing successful components of the ODN development with other networks, bringing benefits of the programme to other areas of healthcare.

- Utilising local knowledge and experience to support the development of trauma networks in less developed parts of the world.

The programme will consider these opportunities at future points in its development.

## 5.4.2 Quality Indicators

Essential quality indicators for the ODN are presented in the table below. For each quality indicator, a code is assigned, in order to cross-reference (Appendix 3). All quality indicators will need to be in place before the ODN becomes operational (i.e. before Day 1) unless indicated below. Six out of 13 quality indicators are already being met.

Quality Indicator	Currently met/unmet
<b>T16-1C-101 - Network configuration</b> The network structure should be identified in the network operational policy including pre-hospital services, hospitals and rehabilitation services.	✓
<b>T16-1C-102 - Network governance structure</b> A clinical governance structure that includes a network manager, clinical lead and a number of leadership roles, identified in the network operational policy.	✓
<b>T16-1C-103 – Patient transfers</b> Review of patient transfers from year 1 to include the following: <ul style="list-style-type: none"> <li>• The number and proportion of patients transferred directly to MTC, including cases of significant under and over pre-hospital triage.</li> <li>• The number and proportion of patients that have an acute secondary transfer (within 12 hour) from a TU to MTC.</li> <li>• The proportion of urgent transfers that occur within two calendar days.</li> <li>• The number of patients with ISS ≥15 managed definitively within a TU.</li> <li>• The number of patients where repatriation from MTC exceeds 48hrs from when referred.</li> </ul>	X
<b>T16-1C-104 - Network Transfer Protocol from TUs/LEHs to MTC</b> There should be a network protocol for the safe and rapid transfer of patients to specialist care with the following components: <ul style="list-style-type: none"> <li>• A pre-hospital triage tool with specific criteria for triage of patients, based on mechanism, injury pattern and clinical condition to ensure direct transfer to the MTC or nearest TU.</li> <li>• A protocol for the transfer of adult patients specifying that transfers should be carried out by teams trained in the transfer of patients. This standard is already being met by the Designed for Life, Welsh Guidelines for the Transfer of Critically Ill Patients, 2016.</li> <li>• A protocol for the transfer of paediatric patients. This standard is already being met by the Wales and West Acute Transport for Children Service (WATCh) based in Bristol.</li> </ul>	X  ✓  ✓
<b>T16-1C-105 - Teleradiology services</b> There should be teleradiology facilities between the MTC and all TUs/LEHs in the network allowing immediate image transfer 24/7. This standard is already being met.	✓

Quality Indicator	Currently met/unmet
<p><b>T16-1C-106 - Network wide TARN review</b></p> <p>The MTC, TUs and LEHs should participate in the TARN audit, with at least 1 year of back dated baseline data before network operational. Data should meet the following standards:</p> <p>Case ascertainment – patients submitted to TARN compared to expected based on Patient Episode Data for Wales (PEDW) dataset –target of 80% across the network by end of year 1.</p> <p>Case accreditation - this is the proportion of key fields used in this report that are filled in for each patient submitted to TARN –target of 95% across the network by end of year 1.</p> <p>The standards set are to ensure subsequent TARN metrics can be meaningfully interpreted.</p> <p>TARN audit should be discussed at the network audit meeting at least annually and distributed to all constituent members of the network.</p> <p>A working plan has been produced to enhance TARN data collection including appointment of TARN coordinator(s) in health boards where gaps exist.</p> <p>Develop strategies for undertaking TARN PROMS and PREMS in year 1.</p>	<p>Partially met</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>
<p><b>T16-1C-107 – Trauma management guidelines</b></p> <p>There should be network agreed clinical guidelines for the management of:</p> <ul style="list-style-type: none"> <li>• Standardised patient care.</li> <li>• Emergency anaesthesia and emergency surgical airway.</li> <li>• Resuscitative thoracotomy.</li> <li>• Abdominal injuries.</li> <li>• Severe traumatic brain injury.</li> <li>• Open fractures.</li> <li>• Compartment syndrome and vascular injuries.</li> <li>• Penetrating cardiac injuries</li> <li>• Spinal cord injury.</li> <li>• Severe pelvic fractures including urethral injury.</li> <li>• Chest drain insertion.</li> <li>• Pain relief for chest trauma with rib fractures.</li> <li>• CT imaging and imaging for children.</li> <li>• Interventional radiology.</li> <li>• Non-accidental injury in the child.</li> </ul>	<p>X</p>
<p><b>T16-1C-108 - Management of severe head injuries</b></p> <p>All patients with a severe head injury should be managed according to NICE guidance (Head injury: assessment and early management, 2014)</p>	<p>X</p>
<p><b>T16-1C-109 – Management of spinal injuries</b></p> <p>There should be a network protocol for the following:</p> <ul style="list-style-type: none"> <li>• Assessment and imaging of the spine.</li> <li>• Resuscitation and acute management of spinal cord injury linked with a Spinal Cord Injury Centre (SCIC) at the MTC.</li> <li>• Emergency transfer of spinal patients.</li> </ul>	<p>X</p>

Quality Indicator	Currently met/unmet
<b>T16-1C-110 - Emergency planning</b> The network should have an emergency plan for dealing with a mass casualty event that is reviewed and updated annually. The integration of the All Wales Mass Casualty Plans into the network operational policy.	✓
<b>T16-1C-111 – Network rehabilitation director</b> There should be a network lead for rehabilitation with experience in trauma rehabilitation. The director should have an agreed list of responsibilities and time specified for the role. This has been achieved through appointment of the network rehabilitation lead	✓
<b>T16-1C-112 - Directory of rehabilitation services, referral guidelines and education programme</b> To form part of the network operational policy in year 1.	X
<b>T16-1C-113 – Patient transfer policies</b> There should be following network policies in place: <ul style="list-style-type: none"> <li>• Automatic acceptance policy to the MTC for patients who are transferred from scene or arrive in a TU/LEH and need urgent transfer to the MTC.</li> <li>• Automatic repatriation policy ('care with treatment closer to home').</li> </ul> Further detail is provided in chapter 8 which covers the 'landing pad' configuration.	X

### 5.4.3 Collaborative Working with North Wales

In contrast to North Wales, there currently is no trauma network serving the population of South Wales, West Wales and South Powys. Therefore, there is an immediate requirement for an ODN to be established here. As the Network in South Wales is established, every opportunity will be taken to work closely with colleagues in North Wales to share good practice, benchmark and work towards equity of quality of care for the whole population of Wales. The South Wales Network will work with colleagues in the North West Midlands and North Wales Trauma Network to forge strong links and establish regular opportunities to share learning and processes.

### 5.4.4 Specific Patient Groups

#### Trauma in Older People

Given that older people represent the largest group sustaining major trauma (see chapter 2), it is important that the ODN is proactive rather than reactive. In doing so, it will take a population based approach, tailored to the ageing population of South Wales, West Wales and South Powys. Many of the principles of assessment and care are similar to those of existing fractured neck of femur pathways. Furthermore, the NHS England CRG for major trauma has recently introduced standards for the management of trauma in older people.

The development of robust systems will ensure that older people that are appropriate for specialist care will have equity of access to the MTC, whilst the majority could be managed to a higher standard and a better experience in TUs/LEHs, based on comorbidity and frailty. The table below summarises the essential additions to the ODN service specification and quality indicators above, mirroring that of the NHS England and has been approved by the network board:

Quality Indicator	Currently met/unmet
The network will develop a 'silver' trauma triage tool as an addendum to the 'standard' pre-hospital triage tool supported by trauma desk to enhance identification, leading to early senior involvement in Emergency Departments—in place before year 1.	X
Network guidelines on trauma in older people including assessment, specific sections in trauma patient record for documentation of assessment (e.g. cognition/frailty/nutritional status) and care bundle –in place before year 1.	X
Review by a ST3/equivalent or above in orthogeriatric medicine, geriatric medicine or care of elderly medicine as soon as possible and definitely within 72hrs of admission—in place years 3 - 5.	X
Early brief educational/training interventions for WAST/ED (triage nurses/trauma teams/team leaders) as part of initial programme –in place before year 1.	X

Desirable aspects include establishment of a 'silver' trauma working group within the network specifically looking at additional rehabilitation requirements, enhancing outcome assessment and a bespoke educational programme.

### Veterans Trauma Network

The Veterans Trauma Network (VTN) provides a single point of referral for all stakeholders who are concerned about the medical care of a veteran with complex physical injuries, including patients, clinicians (from both physical and mental health services in primary or secondary care), third sector agencies and others. Patients eligible for management by the VTN are ex-service personnel who sustained complex physical trauma due to their service. The VTM is principally concerned with ongoing rather than acute care. Patients will be referred to the VTN when there is concern that the complex nature of their injuries means that the normal pathways in primary, secondary and tertiary care are unable to deliver the appropriate treatment.

To establish the VTN in Wales, the following will be required:

- Creation of a single point of referral for all eligible NHS Wales patients.
- Appointment of VTN clinical lead and deputy.
- Nomination of a Veterans Trauma Centre (VTC). As the MTC for most of NHS Wales, C&VUHB is the natural choice to be the VTC.
- Hosting arrangements for the VTN will be C&VUHB until the trauma ODN is established, at which point it will be hosted within the ODN management structure and SBUHB.
- Infrastructure to allow secure communication between VTN Wales and the VTN in England.
- Referral pathways for the management of identified clinical issues.
- Appropriate linkages between VTN Wales and leads for veteran's affairs in all health boards.
- Suitable governance and reporting structures to be provided by the ODN.
- Communication and stakeholder engagement strategy.

As such, it is anticipated that VTN Wales will deal with less than one patient per month once fully established. Costs of running the VTN/VTC are minimal. There will be some costs to health boards and WHSSC in terms of treatments that will be delivered once issues have been identified. However, these

will all be standard treatment costs for these conditions (or subject to individual patient funding requests if not). The cost to the ODN will be minimal. The lead and deputy will offer their clinical time from their 'military protected time'. Support functions will be absorbed within the ODN management infrastructure. Further details are included in.

## **5.5 Clinical Informatics Model**

Informatics support is essential to improving patient outcomes through both direct support for patient care and indirectly through improving efficiency of the administration of the patient pathway. Making use of existing systems, and harnessing ongoing developments and the future plans of NHS Wales, the informatics programme seeks to reduce the burden of data entry on clinicians and administrative staff, and ensure timely, accurate information is available to patients, clinicians, and management structures, as well as commissioners.

The work stream will seek to work with health boards, trusts, and NWIS to assess the current situation, including mapping information flows relating to major trauma patients, and look at the short, intermediate and long term expectations of the network and how informatics can support this. It will also reach out to the wider UK and internationally to look at best practice and the lessons learned.

In the context of Wales informatics, significant progress has been made recently with the roll out and expansion of national systems allowing cross boundary access to patients records. This provides a unique opportunity to build on existing technologies, and use routinely collected data to track trauma patients in the network.

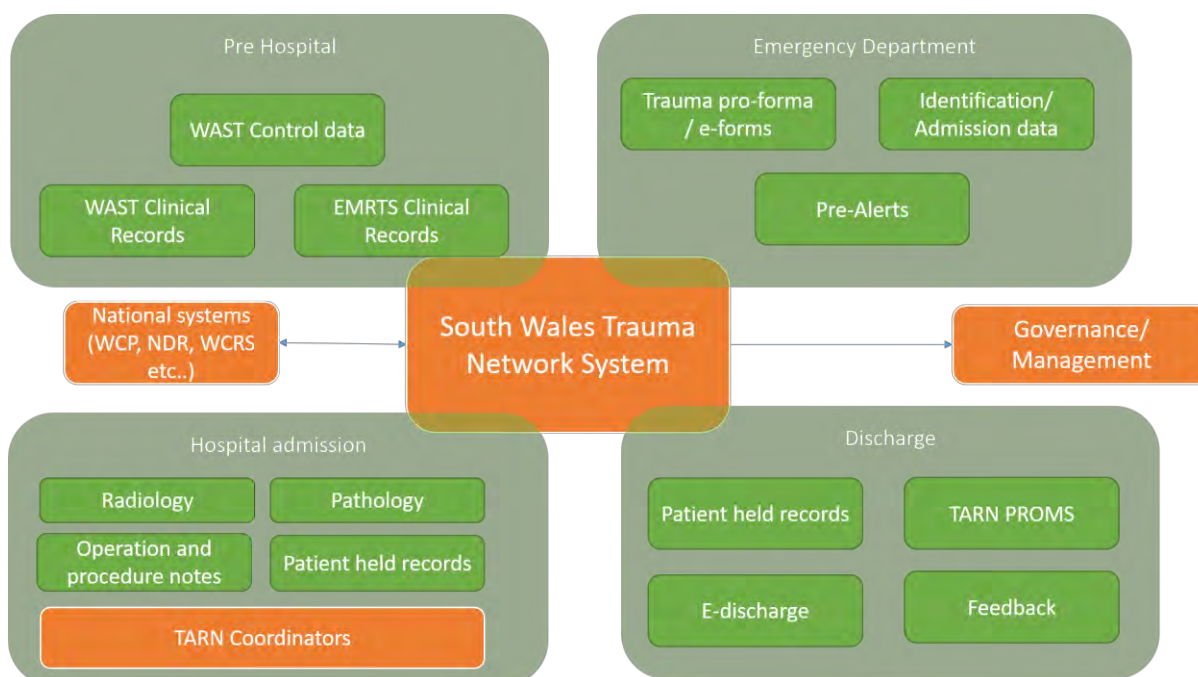
The following areas will be facilitated through the work programme:

- Implementation of a trauma clinical system
- Implementation of a central incident reporting short form, and integration with systems
- Provision of call recording to support governance process
- Development of a network wide information repository / "app"
- Integration of patient held records to support quality discharge
- Supporting training, education, quality improvement and research activities as required.

### **5.5.1 An Overarching Trauma Informatics System**

C&VUHB are developing a bespoke clinical system to improve data collection and aid the tracking of patients across the network pathways. The informatics work programme will seek to implement this across the network, and provide a single point of access for those involved in the care of trauma patients.

A high level overview of the anticipated landscape of the systems is included in the figure overleaf:



It is recognised the work plan is ambitious given the short time frames to ‘go-live’, and ongoing existing work streams in an already stretched informatics landscape. In addition, although important, major trauma makes up a very small proportion of the overall workload in NHS Wales, and will be competing with other established projects which impact far greater number of patients (e.g. introduction of new emergency department systems, implementation of electronic records in WAST).

Thus, a phased approach will need to be taken, and phased over five years. An illustration of the essential and desirable deliverables are included below, subject to change once formally handed over to the ODN.

Year	Essential	Desirable
19/20 (in place for day 1)	<ul style="list-style-type: none"> <li>Data sharing agreements in place</li> <li>Pre-hospital patient reports from WAST &amp; EMRTS to be available to TARN coordinators &amp; Network office no more than 4 weeks following incident</li> <li>WAST/EMRTS to be flagging potential major trauma cases on control systems</li> <li>Up to date pre-hospital operational data available for interrogation and business intelligence dashboards</li> <li>Network information “app” live</li> <li>Trauma tool “app” live</li> <li>All TU’s to upload trauma pro-forma to document management systems that interface with national repository</li> <li>CAV to be using the network trauma information system pro-actively</li> </ul>	<ul style="list-style-type: none"> <li>Patient held records (for rehabilitation prescription) functioning</li> <li>Capture of additional trauma cases in systems that are not TARN eligible, but of interest for injury prevention and service planning e.g. death at scene in HB’s that have capacity (i.e. are already up to date with retrospective data collection)</li> </ul>



	<ul style="list-style-type: none"> <li>• Network incident reporting system short form live and process in place for handling cross boundary/ organisational incidents</li> <li>• Call recording available for non-emergency case discussions/ referrals</li> <li>• All TARN coordinators to have access to national instance of Welsh Clinical Portal</li> <li>• Network data analyst in post (training/ development with stakeholders)</li> </ul>	
20/21	<ul style="list-style-type: none"> <li>• Integration with national systems complete (to include operation notes, emergency department systems, all radiology, pathology results)</li> <li>• Transition to electronic clinical data capture in emergency department (replacement of trauma paper pro-forma) CAV</li> <li>• Patient held records (for rehabilitation prescription) functioning for MTC patients</li> </ul>	<ul style="list-style-type: none"> <li>• Transition of other TU's to electronic data capture</li> <li>• Export of year 1</li> <li>• &amp; year -1 data to SAIL</li> </ul>
21/22	<ul style="list-style-type: none"> <li>• Patient held records (for rehabilitation prescription) functioning for MTC patients + 2 TU's</li> </ul>	
22/23	<ul style="list-style-type: none"> <li>• Patient held records (for rehabilitation prescription) functioning for MTC patients + 4 TU's</li> </ul>	<ul style="list-style-type: none"> <li>• Patient held records (for rehabilitation prescription) functioning for 6 TU's</li> </ul>
23/24	<p>TARN integration</p> <ol style="list-style-type: none"> <li>1 TARN to have direct access to the network trauma information system data including all relevant linked data to complete a TARN submission.</li> <li>2 Network to have direct link to TARN data to augment data already available within NHS held datasets e.g. addition of Ps, ISS etc... in operational dashboards.</li> <li>3 PROMS data to be linked back into welsh systems, and in turn into National data repository</li> <li>4 Export of dataset to SAIL with 3 complete years of network operation, and to include PROMS, and TARN metrics.</li> </ol>	<ul style="list-style-type: none"> <li>• Patient held records (for rehabilitation prescription) functioning for all 8 TU's</li> </ul>

### 5.5.2 Estimated Resource Requirements

An estimate of resource requirements are provided here to aid planning, and is subject to change as the work progresses with formal project management. It should be noted that work is not in established work plans, and crosses multiple stakeholders with complex integration work required in some areas. Each stakeholder may also incur additional resource requirements to complete the work, not detailed here.

## Resource

Estimated resource to implement the 3 year plan are illustrated, and it is anticipated they would start 6 months prior to network go-live.

Resource	WTE	Level	Duration
Clinical Informatics support	0.1	8b	2 years

Further details around the informatics requirements for the network can be found in Appendix 15.

## 5.6 Training and Education Model

The development of the training and education programme for the network is being undertaken in partnership with HEIW. This will provide an excellent opportunity for the network and HEIW to implement an innovative approach to the programme both being new organisations within the landscape of NHS Wales. The principles of developing the training and education models are as follows:

- A focus on multidisciplinary training across health care providers
- The opportunity to support the development of new roles within NHS Wales (e.g. the extended role of allied health care professionals)
- Prioritise training and education in areas of highest risk and acuity
- A blended approach to the delivery of the programme using a combination of ODN led and provider led deliverables
- A strong emphasis on the evaluation of the training and education programme to inform subsequent refinements as the programme evolves

Training has been organised using the main structural elements of a trauma network organisation:

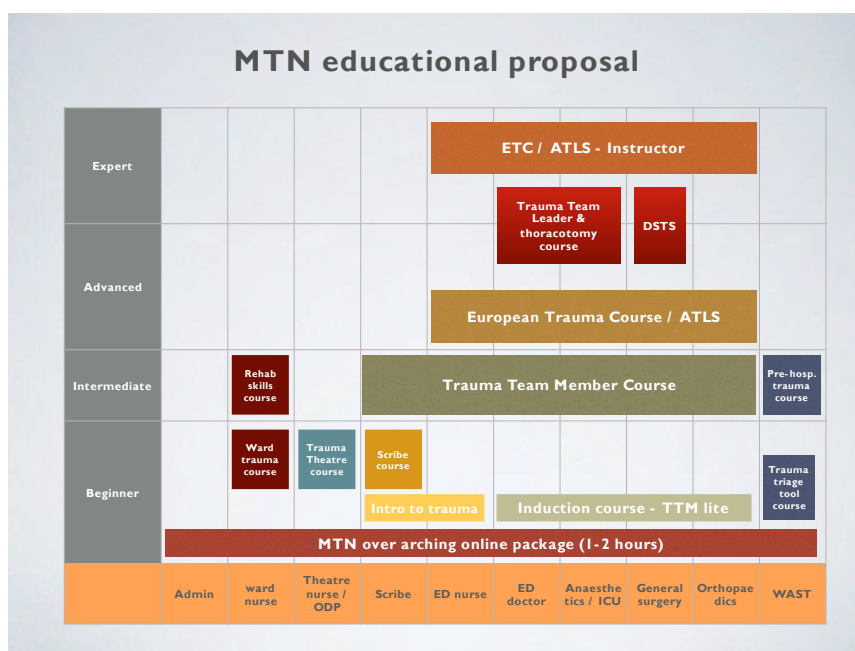
- Prehospital
- Hospital reception
- Definitive care
- Rehabilitation

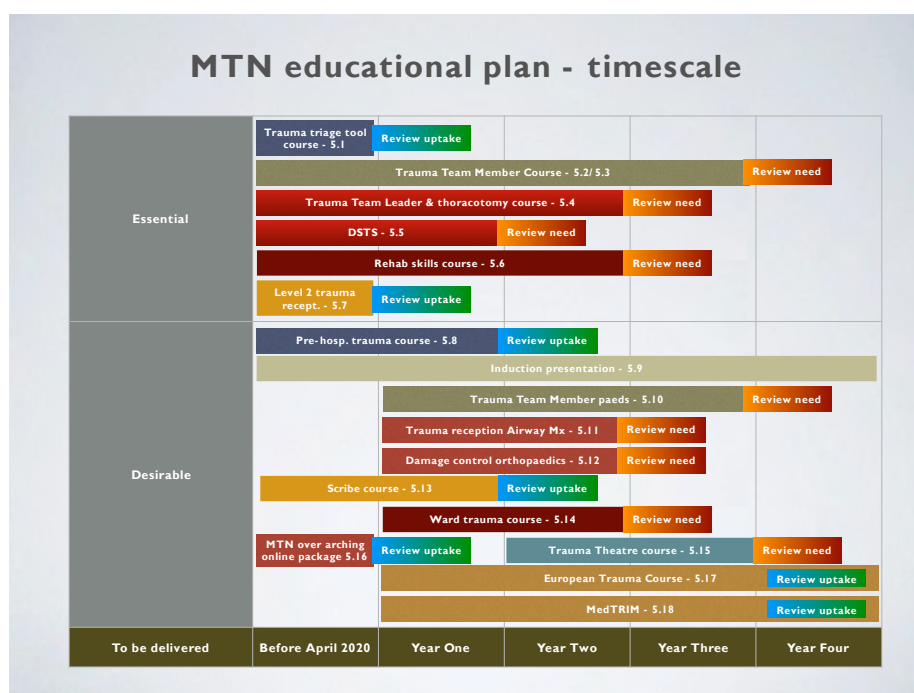
### 5.6.1 Learning Package Summary

Facet		Modality	Description	Governed by	Priority
5.1	Trauma triage tool	On-line learning	Online training package created by onclick	WAST	Essential before April 2020
5.2	Trauma team member course on-line learning environment	On-line learning	On line learning material to support a one day course for nurses and doctors working in trauma reception	Network	Essential before April 2020
5.3	Trauma team member face to face course	Classroom and scenario based learning	One day course format similar to intermediate trauma life support course	Network	Essential before April 2020
5.4	Trauma team leader course	Classroom and hands on learning	One day course to cover human factors and resuscitative thoracotomy	Network	Essential before April 2020
5.5	Definitive Surgical Trauma Skills	Classroom and dissection room course	Two day course to cover elements of damage control surgery for trauma surgeons	Network	Essential before April 2020
5.6	Landing pad course	Classroom based course supported by the on-line learning environment	Course for nurses working in trauma units and local emergency hospitals to aid landing pad arrangements	Network	Essential to start before April 2020
5.7	Level 2 training for nurses working in trauma reception	TNCC and/or APLS	National Trauma Standards recognised courses to fulfil level 2 competencies	To be managed by health boards	Essential to have 24/7 staffing before April 2020 in MTC and TU's
5.8	Trauma skills course for prehospital staff	Classroom and scenario based learning	One day course delivered by WAST. Train the trainers by EMRTS and quality assurance by network	WAST	To start before April 2020 in certain vulnerable areas. To be completed in year one of the network.

Facet		Modality	Description	Governed by	Priority
5.9	<b>Lecture given to doctors at induction</b>	Presentation given to doctors at their induction	To be created by the working group. Delivered to doctors working in trauma reception	Network	Desirable to deliver before April 2020
5.10	<b>Trauma team member course for paediatric staff</b>	Classroom and scenario based learning	A one day paediatric themed trauma intermediate life support course	Network	Desirable to deliver before April 2020. Essential component for year one
5.11	<b>Trauma course for trauma team Airway management</b>	Classroom and scenario based learning	A one day or half day session to support staff intubating patients in the trauma reception environment	Network created. Delivered within HB's	Desirable component for year one
5.12	<b>Trauma course for orthopaedic surgeons working in trauma teams</b>	Classroom and scenario based learning	A one day or half way session to support staff practicing damage control orthopaedics	Network created. Delivered within HB's	Desirable component for year one
5.13	<b>A trauma scribe course</b>	Classroom based learning	A one day or half day session to train HCP's to work as scribes for a trauma team	Delivered by Public Health Wales	Desirable before April 2020 and year one
5.14	<b>A course for ward staff looking after trauma patients</b>	Classroom and scenario based learning	A one day course to support nurses working on the major trauma ward	Delivered by MTC nurse educator with support from the Major trauma nurse practitioners	Desirable for year one and two
5.15	<b>A course for theatre staff looking after trauma patients</b>	Classroom and scenario based learning	A one day course to support theatre staff	Delivered by the MTC with support from the Network	Desirable for year one, two and three
5.16	<b>Overarching package for managers</b>	Online learning	An online course to support management staff	created by the network	Desirable before April 2020
5.17	<b>European Trauma Course</b>	A national gold standard course	A gold standard course	Delivered by the national group and local faculty creation	Desirable for year one onwards

Facet		Modality	Description	Governed by	Priority
5.18	MedTRIM course	Classroom based course	A course to promote resilience of staff working in the network	Delivered by HEIW. With support from the network.	Desirable for year one onwards
5.19	TARN coordinator training	Classroom based course	A course to teach TARN data collection	Delivered by TARN	Essential before April 2020 with ongoing commitment
5.20	Trauma Practitioner training	Classroom and scenario based learning	A course to train TU trauma practitioners	Delivered by major trauma practitioners with support from the Network	Desirable before April 2020 with ongoing commitment
5.21	Therapists / rehabilitation co-ordinator training	Classroom based course	A course to train therapists and rehabilitation co-ordinators	Delivered by the network	To be undertaken before March 2020





The resource requirements for in year, year one and year two will be described in the financial case see chapter 9.

## 5.7 Resource Requirements

In order to deliver the service specification and quality indicators outlined above, there will requirements to establish a trauma ODN management team. This represents a new component within the structure of the network and will be required to be in place in-year (i.e. 2019/20) in order to ensure the following:

- Implementation of a clinical and operational framework across the trauma pathway and work closely with all participating organisations to ensure a state of readiness for delivery of the network within the agreed timelines (see chapter INSERT).
- Suitable governance and reporting structures in place.
- Test clinical and non-clinical policies as indicated above.
- Baseline TARN data collection optimised.
- Quality assurance of key components of the training and education programme.
- Early clinical informatics structures in place to allow appropriate data collection.
- Oversee stakeholder communication and engagement.

The ODN management team will be hosted by SBUHB. Further details in relation to organisational governance are provided in management case (chapter 12). The following table summarises and provides justification for additional resource requirements, which have been developed to align with comparable networks in the UK. It highlights new posts as key enablers for the network and existing posts, where there is currently non-recurrent funding and ongoing resource requirements. In view of the requirements for in year funding of these posts, in line with the timeline for implementation of the network, a proposal has been concurrently submitted for early release of funding through the WHSSC Integrated Commissioning Plan (ICP) prioritisation process.

Role	Purpose	WTE*	Band
<b>Network clinical director (to develop as a national role subject to agreement for ODN taking on a national function)</b>	<p>The network clinical lead is already in place – ongoing resources required to fund this post at point of handover to the ODN.</p> <p>The resource requirement is from August 2020.</p> <p>The purpose of this role can be split up to the following:</p> <p><b>Strategic planning:</b></p> <p>Provide strategic vision and direction to the entire network from a clinical perspective.</p> <p>Provide professional and clinical leadership across the network.</p> <p>Service senior clinical representative (4 Nations and Welsh Government level).</p> <p>Support the phased implementation of the network from a clinical perspective (including the development of an all Wales approach).</p> <p><b>Operational delivery:</b></p> <p>Oversee the co-ordination of patient clinical pathways between services over a wide area to ensure access to specialist major trauma care.</p> <p>Ensure the quality of the network is monitored and subject to a process of continuous quality improvement.</p> <p><b>Tactical (local) advice and support to commissioners:</b></p> <p>Provide leadership in national review and assurance of the MTC, TUs and pre-hospital services with commissioners.</p> <p>Support local implementation of products produced by the National Trauma Clinical Reference Group (NHS England) as appropriate.</p> <p>Advise commissioners on all clinical issues pertaining to major trauma services.</p> <p><b>Improved quality and standards of care:</b></p> <p>Oversee the clinical governance framework with the MTC, TUs, LEHs, pre-hospital services and rehabilitation services.</p> <p>Ensure on-going service improvements and best practice models are embedded and contribute to improved quality performance.</p> <p><b>Partnership development:</b></p> <p>Clinical team development and oversee the activity of network clinical lead positions and health board clinical leads.</p> <p>Partnership working in national clinical policy development.</p>	0.3	Consultant

Role	Purpose	WTE*	Band
<b>Network Manager (to develop as a national role subject to agreement)</b>	<p>There is a requirement to have a dedicated full time operational network manager in place – this post is new and ongoing resources required to fund this post in year to facilitate lead into the ODN. This resource is required in year.</p> <p>The purpose of this role can be split up to the following:</p> <p><b>Strategic planning:</b></p> <p>Lead on the annual working plan for the network to deliver against the quality and delivery framework</p> <p>Undertake comparative benchmarking and audit across the network through the Trauma Audit and Research Network (TARN).</p> <p>Support the phased implementation of the network from an operational perspective (including the development of an all Wales approach).</p> <p><b>Operational delivery:</b></p> <p>Managerial responsibility for the ODN and senior support for network clinical director.</p> <p>Senior responsible officer for monitoring of day to day capacity across the network, agreeing and working to an escalation plan (with agreed thresholds for escalation triggers) for both within and across network to monitor and manage surges in demand.</p> <p>Support capacity planning and activity monitoring for collaborative matching of demand and supply (e.g. through implementing a trauma tracking system).</p> <p>Work with very senior health board management to maintain necessary flow and support to nationally co-ordinated delivery.</p> <p>Development and monitoring of network operational policies.</p> <p><b>Tactical (local) advice and support to commissioners:</b></p> <p>Provide local information, data and intelligence to support performance monitoring of the network</p> <p>Oversee ongoing programme management of a phased implementation across the network.</p> <p>Senior Manager representative for the Network at relevant national commissioning functions</p> <p><b>Improved quality and standards of care:</b></p> <p>Lead for quality and safety.</p> <p>Monitoring of MTC and TU dashboards and provide advice on improvements to clinical services and commissioners. Use clinical process and clinical outcome measures to compare and benchmark providers</p> <p><b>Partnership development:</b></p>	1.0	8C



	Monitoring and performance management of active engagement by members in the network to improve performance against agreed outputs.		
<b>Sessional clinical leadership</b>	<p>These posts are funded non-recurrently until end of March 2020. Ongoing funding required as these roles are critical to clinical governance of the network</p> <p>Clinical lead functions for:</p> <p>Governance – policy development, assess and review all clinical governance issues, provide recommendations to the wider network.</p> <p>Training and education – oversee and evaluate the phased model for multidisciplinary training and education programme across the pathway.</p> <p>Paediatric trauma - policy development, assess and review all clinical governance issues, provide recommendations to the wider network.</p> <p>Quality improvement, innovation and research – improve TARN data collection as a platform for developing a QI and research programme</p> <p>Rehabilitation – oversee and advise on the delivery of rehabilitation services across the pathway including hyper-acute, specialist, local and community based rehabilitation.</p>	0.1 x 5	Consultant
<b>Network administrative support</b>	<p>This post is new and ongoing resources required to fund this post to facilitate lead into the ODN. This resource is required in year.</p> <p>The purpose of this role can be split up to the following:</p> <p>Administrative support, general admin duties (supporting training events, audit, communications activity etc.).</p>	1.0	4
<b>Programme manager</b>	<p>This post is funded non-recurrently until end of March 2020. Ongoing funding required.</p> <p>The purpose of this role can be split up to the following:</p> <p>Business and operational support to network clinical director and operational network roles.</p> <p>Senior manager responsible for line management of admin and TARN co-ordinators.</p> <p>Lead for network communications and engagement, with key deliverables.</p> <p>Lead for financial and budgetary management.</p> <p>Performance management lead.</p> <p>Responsible for all programme and project management relating to major trauma service development in Wales, as part of their phased implementation.</p>	1.0	8B

Role	Purpose	WTE*	Band
<b>Senior Data analyst and service improvement manager</b>	This post is new and ongoing resources required to fund this post to facilitate lead into the ODN. This resource is required in year. Reporting and analysis of all data sets pertaining to trauma across the network (incl. TARN, operational data) for QI, research and commissioning purposes. Production of data sets and necessary development. Enabling of national and local level reporting and self-reporting. Production of routine and targeted data audits. Supporting health boards in the development of and reporting on TARN data.	1.0	7

\*WTE – whole time equivalent

## 5.8 Key Challenges

From the above the following themes have emerged:

- The maintenance of optimal patient flow between the MTC and TUs is critical to ensuring the network can deliver its benefits realisation plan.
- Complex commissioning arrangements with multiple commissioning bodies involved, leading to a lack of accountability across the pathway. There is a risk that no one commissioner has oversight or commissioning influence over the entire patient pathway.
- The inability of the trauma ODN board to hold organisations to account since it will not have a direct commissioning remit and will be acting in a professional capacity in relation to developing responses to clinical and operational governance issues. An inability to be effective at maintaining 'operational delivery', given the complexity of commissioning arrangements and multiple providers.
- The design must recognise that NHS Wales's policy is to follow a route of planning and partnership working instead of incentivisation and an internal market.

## 5.9 Issues Arising for Resolution

- Management of and responsibility for escalation
- Management of and responsibility for interventions
- Management of and responsibility for workforce development
- Provision of coordination, advice and professional steer for workforce related matters
- Management and responsibility for service improvement

## 5.10 Options to the give the ODN Meaningful Operational Authority

In the interim options to give the ODN, operational authority include:

- The ODN (and therefore the 'host' organisation) – has some financial responsibility for contracting and managing aspects of performance or delivery of the pathway in order to maintain authority.

- The ODN Board could, with the correct membership and 'Terms of Reference', discharge an effective commissioning and performance management support function – would require EASC and WHSSC to be appropriately represented and engaged.

Arrangements for the delivery and management of the ODN are described in the management case (see chapter 12).

## **6 Pre-Hospital Care and Transfers**

### **6.1 Introduction**

This chapter sets out the case for improvements in the delivery of pre-hospital care and inter-hospital transfers of major patients, as part of establishing the trauma network. It summarises the service specification and quality indicators in relation to the current position of services.

Building on this, the chapter describes in detail the resource implications for WAST in terms of increased ambulance journeys resulting from direct and secondary transfers to the MTC. The chapter also considers the requirements for ensuring timely repatriation for 'care with treatment closer to home' within this context. The preferred option for online and phased face-to-face training of ambulance service personnel is discussed, expanding on section 6.3.5. Finally, this chapter describes the development of a dedicated trauma desk facility as a key coordinating function within the network structure.

The details provided here in relation to the WAST case have been considered within the context of the professional peer review that took place on the 13th August 2019.

For completeness and information, this chapter also sets out the requirements for 24/7 availability of EMRTS in South Wales aligned with the timeline of the network becoming operational. At the time of writing, EMRTS 24/7 development in South Wales had been approved and recruitment of posts had commenced. Whilst the resource requirements for this are not provided in this case, the delivery of the service is a pivotal development and has the support of the network.

### **6.2 Service Specification and Quality Indicators**


#### **6.2.1 Pre-Hospital Care**

##### **Pre-hospital Trauma Triage Tool**

The introduction of a network pre-hospital triage tool at the scene of incidents will bring about a significant change in triage decision-making by all pre-hospital providers. The purpose of a pre-hospital triage tool is to make informed decisions in relation to disposition, based on the mechanism of injury, injury pattern and clinical condition of the patient. In many cases, this will support providers to bypass the local emergency department and take the patient directly to the MTC at UHW, TU with specialist services at Morriston Hospital, or the nearest TU. Whilst EMRTS currently bypasses local emergency departments and take patients directly to specialist care, there is no mechanism for other providers such as WAST to undertake this consistently. This concept is not new to WAST in other clinical instances given that ambulance crews routinely convey heart attack and stroke patients over significant distances direct to specialist care.

Currently there is no standardised national pre-hospital triage tool available, although work has started to develop one. Current pre-hospital triage tools are all similar in terms of their triage accuracy; however, a key difference is whether a time-to-MTC rule is applied. Using this rule, if a patient is triage tool-positive (i.e. is a 'candidate' major trauma patient) and is within 60 minutes by road from the MTC, the patient is taken there directly. Outside 60 minutes, the patient goes to the nearest TU. The exception to both these rules is if the patient has signs of airway compromise and/or catastrophic haemorrhage. In these cases, the crew will take them to the nearest emergency department. With the development of a national trauma desk facility (see below), there is opportunity to support providers make individualised decisions about the disposition of patients that are less based on the time to MTC rule. For example if a patient is triage positive and 70 minutes from the MTC, logically they should go

direct to the MTC. The copy of the proposed network triage tool is provided below, for which decision-making is supported by the presence of a trauma desk facility:



## South Wales Major Trauma Triage Tool v2.3SM/GL

Applies to South Wales, West Wales and South Powys

Apply this triage tool to all patients suspected to have suffered a significant trauma

**Yes to ANY of the below criteria - contact the trauma desk on 0300##### talk group 442**  
 Any patient with airway compromise or catastrophic haemorrhage – Pre-alert to nearest Emergency Department

<b>1. Measure vital signs.</b>  <small>(Use JRCALC abnormal values for children)</small>  <b>Respiratory rate.</b> <ul style="list-style-type: none"> <li>&lt;10 or &gt;29 breaths per minute.</li> </ul> <b>Systolic Blood.</b> <ul style="list-style-type: none"> <li>Sustained Systolic Blood Pressure &lt;90 mmHg or absent radial pulses.</li> </ul> <b>Glasgow Coma Score.</b> <ul style="list-style-type: none"> <li>Motor score 4 (flexing to pain) or less.</li> </ul>	<b>2. Assess Anatomy of Injury</b>  <b>Penetrating injuries if shocked or requiring haemorrhage control</b>  <b>Significant chest wall trauma.</b> <small>(e.g. Deformity, flail Chest).</small>  <b>Two or more proximal long bone fractures</b> (i.e. femur, tibia and humeral shaft-not neck of femur/humerus)  <b>Crushed/ De-gloved/ mangled/ pulseless limbs.</b>  <b>Amputation above wrist or ankle.</b>  <b>Suspected Major Pelvic fractures.</b> <small>(If active bleeding is suspected from a pelvic fracture following blunt high-energy trauma)</small>  <b>Open or depressed skull fractures.</b>  <b>Base of Skull fractures.</b>  <b>Spinal trauma suggested by new, abnormal neurology.</b>	<b>3. Assess Mechanism of Injury.</b>  <b>Falls.</b> <ul style="list-style-type: none"> <li>Adult &gt; 20 feet (6 metres)</li> <li>Child &gt;10 feet (or 2 x height of child).</li> </ul> <b>High mechanism RTC.</b> <ul style="list-style-type: none"> <li>Significant cabin intrusion.</li> <li>Ejection (partial or complete) from motor vehicle.</li> <li>Death in same passenger compartment.</li> <li>Available information consistent with high risk of injury.</li> <li>Motor Vehicle vs Pedestrian or cyclist &gt; 20mph.</li> <li>Motorcycle crash &gt; 20 mph.</li> </ul> <b>Non motor vehicle incident</b> <ul style="list-style-type: none"> <li>Large animal incident (collision/fall/trampled)</li> </ul>	<b>4. Special considerations.</b>  <b>Older Adults.</b> <ul style="list-style-type: none"> <li>If over 65 complete the <b>Silver Trauma Triage Tool</b> (see reverse).</li> </ul> <b>Children</b> <ul style="list-style-type: none"> <li>Higher potential for injury.</li> </ul> <b>Any clinical concern</b>  <b>Anticoagulation and Bleeding Disorders</b> <ul style="list-style-type: none"> <li>Patients on anticoagulation medication (e.g. Warfarin, Apixaban Rivaroxaban) are at a higher risk and need discussion with trauma desk</li> <li>Head injuries are particularly at risk.</li> </ul> <b>Major Burns</b>  <b>Pregnancy &gt; 20 weeks</b>
--	---	--	--

**No to all above criteria – Convey to nearest Trauma Unit (Local guidelines in Hywel Dda UHB)**  
**Patients ≥65 must have a Silver Trauma Triage Tool assessment**

# ATMIST

Age and sex    Time of Incident    Mechanism    Injuries    Signs and Symptoms    Treatment Given

**Silver Trauma Triage Tool**  
 For patients ≥65 who have suffered trauma

Yes to any of the below then contact the Trauma Desk Clinician on 0330xxxxxx or via talkgroup 442

<b>Physiology</b>  Sustained SBP <110mmHg in the presence of injury (excluding minor injuries)  Anticoagulant medication in the presence of injury	<b>Anatomy</b>  Injury to 2 or more body areas (excluding injuries distal wrist/ankles)  Suspected fracture to shaft of femur  Open fracture to wrist or ankle	<b>Mechanism</b>  Fall down 3 or more steps  Pedestrian vs car/cycle  <i>Caution: Older adults with frailty: low level falls (ground level) might result in severe injury, especially alongside degenerative conditions</i>
--	--	---

**Major Trauma Centre**  
 University Hospital for Wales Cardiff CF 14 4XW  
  
**Trauma Units**  
 Glangwili Hospital Carmarthen SA31 2 AF  
 Morriston Hospital Swansea-SA6 6NL  
 Neville Hall Hospital-NP7 7EG  
 Princess of Wales Bridgend- CF311RQ  
 Prince Charles Hospital Merthyr-CF479DT  
 Royal Gwent Hospital Newport-NP20 2UB  
(The Grange Hospital NP44 2XJ will become the Trauma Unit for Aneurin Bevan health board once completed)

Tranexamic acid should be administered as **soon as possible** following trauma, **ideally within the first hour.**  
  
 The indications for Tranexamic:  

- For all patients aged ≥1 with **Time Critical** injury where significant internal/external haemorrhage is suspected.
- Traumatic cardiac arrest

WAST have developed an adult and paediatric triage tool, which has been approved and will be owned by the ODN. Furthermore, and in keeping with the ODNs aims of adopting a population-based

approach to its design, this includes a triage tool specifically for trauma in older people, otherwise termed a 'silver triage tool.' It is widely recognised that generic pre-hospital trauma triage tools are poor at identifying trauma in older people. By incorporating factors like low mechanisms of injury, differences in vital signs and presence of anticoagulation, a 'silver triage tool' increases identification of major trauma in older people. This has the effect of improving pre-alerting to receiving hospitals and activation of trauma teams, without over triage to the MTC.

All pre-hospital providers will adopt the pre-hospital trauma triage tool across the region (including Search and Rescue Services). As the tool will change patient flow, the tool will come into use at the time the ODN becomes operational and the MTC/TUs are in a state of readiness. In the meantime, familiarisation training for all WAST personnel will commence as described below.

### Quality Indicators

In addition to the above specification, there are a number of essential quality indicators presented in the table below. Each quality indicator has an assigned code in order to cross-reference (Appendix 3). All quality indicators will need to be in place before the ODN becomes operational (i.e. before day 1) unless indicated below. Presently these quality indicators are only being partially met.

Quality Indicator and how met	Currently met/unmet
<b>T16-2A-101 – Pre-hospital care clinical governance</b> The pre-hospital providers should be part of the clinical governance structure for the network and send a representative to the network governance meetings. This will be met through the introduction of the ODN as described in the management case (see Chapter 12)	X
<b>T16-2A-102 – 24/7 senior advice for the ambulance control room</b> There should be an advanced paramedic or a critical care paramedic present in the ambulance control room 24 hours a day. This senior clinician should have 24/7 telephone access to pre-hospital consultant advice. This standard is partially met through the availability of the EMRTS air support desk (ASD) and remote 'Top Cover' consultant support, albeit 12 hours/day. The 'Top Cover' consultant support is limited overnight. As indicated in the WAST case below, plans will be put in place to develop a national trauma desk facility, co-located with the existing ASD. The desk will serve the following roles: <ul style="list-style-type: none"> <li>• Notified by providers of all triage positive and triage equivocal cases to support decision making on assessment, management and disposition.</li> <li>• Interface between providers and receiving hospital for passing pre-alert information.</li> <li>• Retrieval coordination role for all moderate and major trauma transfers.</li> <li>• Major incident/mass casualty coordination.</li> </ul> The ASD Critical Care Practitioner (CCP) and remote EMRTS 'Top Cover' consultant will support the desk. Benefit will come from a national approach, serving both regional trauma networks. The ASD will subsume the trauma desk function overnight as part of the expansion of the EMRTS operational hours	Partially met

Quality Indicator and how met	Currently met/unmet
<p><b>T16-2A-103 – Dedicated enhanced care teams available 24/7</b></p> <p>Enhanced care teams should be available in the pre-hospital phase 24/7 to provide care to the major trauma patient.</p> <p>This standard is already being provided 12 hours/day (8am-8pm) by the EMRTS and ad hoc overnight by voluntary doctors. It has been agreed that the service will be expanded to 24/7 in line with the network becoming operational. The configuration will remain consultant led and delivered, with CCPs responding by air or road from South Wales. Provision will be made for overnight ASD cover to support tasking.</p>	X
<p><b>T16-2A-104 – Clinical management protocols</b></p> <p>There should be protocols in place for the pre-hospital management of major trauma patients which includes:</p> <ul style="list-style-type: none"> <li>• Airway management.</li> <li>• Chest trauma.</li> <li>• Pain management for adults and children including advanced. analgesia options (i.e. ketamine)</li> <li>• Management of major haemorrhage including: the administration of tranexamic acid, application of haemostatic dressings, application of tourniquets and application of pelvic binders</li> </ul> <p>All providers already manage patients who have sustained major trauma in line with national standards (Joint Royal Colleges Ambulance Liaison Committee) and therefore meet all of the above already. However given increased distances over which patients will be conveyed, WAST will be undertaking some refresher training on the above. It should be noted that WAST paramedics do not routinely provide advanced analgesia with ketamine, although this is being identified as an area of development. Currently, EMRTS and voluntary doctors provide this.</p>	✓
<p><b>T16-2A-105 - Hospital Pre-Alert and Handover</b></p> <p>There should be a network wide agreed pre-alert system with effective communication between pre-hospital and in-hospital teams. This should include documented criteria for trauma team activation and patient handover.</p> <p>Although the above exists, delivery is not consistent across the region. The pre-alert communication system will be built into the pre-hospital triage tool function and trauma desk capability. Standard trauma team activation criteria will be developed by the ODN.</p>	Partially met

### 6.2.2 Inter-Hospital Transfers

There will be no change to existing arrangements for inter-hospital transfers. EMRTS or the hospital to transfer team will continue undertake critical care transfers by air or road. These transfers will continue to be monitored and quality assured by EMRTS and the Critical Care Network, respectively. Through the availability of resources from the Critical Care Implementation Group, opportunities exist to develop a non-urgent critical care transfer service as described in Chapter 2. WAST will continue to manage non-critical care transfers and repatriations. Increased ambulance journeys have been reflected in the WAST case below.

The availability of 24/7 EMRTS and trauma desk facility for coordination and delivery of trauma transfers will enhance the quality of these transfers and reduce the pressure on hospital transfer teams.



### 6.3 Welsh Ambulance Service

#### 6.3.1 Context

The internal and wider context for WAST as a critical enabler for the success of the network is described in Chapter 3. However, the ambulance service will be unable to play this leading role within the network unless appropriately resourced. Whilst the anticipated numbers of patients being cared for within this new model are not expected to change from historic numbers, the new clinical model for major trauma will result in the ambulance service making many more ‘new’ journeys; journeys which may often involve significant distance. Existing resources may be taken out of their local area for much longer periods.

These longer journeys will also result, in some cases, patients needing to be cared for by ambulance crews for much longer. This will be a significantly different way of working for WAST staff and they will need support to ensure they can care for their patients to an optimal level. Failure to ensure both these aspects are fully acknowledged and commissioned will ultimately result in the erosion of wider operational performance and patients not being conveyed to the right location first time.

WAST makes ongoing commitments within its integrated medium term plans (IMTPs) to be a full and active partner in supporting the successful delivery of a major trauma network for South Wales, West Wales and South Powys. However, as a commissioned service through EASC current and future plans will stop short of being able to offer assurance on the service being fully funded from an ambulance perspective until all of the elements of the new service have been agreed and funded by the commissioners.

#### 6.3.2 Description of the Clinical and Operational Model for WAST

WAST’s clinical and operational model that will support the major trauma network will be complementary to the organisations nationally agreed clinical model as shown below:



Designed with permission using the CAREMORE® 5 Steps. Copyright, 2017 WAST.

##### Step Two – Answer my call

All calls that the Ambulance receives via 999 are classified as follows:

RED – BLUE LIGHTS	Immediately life-threatening calls	Multiple dispatch Blue light emergency response
AMBER – BLUE LIGHTS	Life-threatening / Serious calls	Blue light emergency response
GREEN 2 and 3– NORMAL ROAD SPEED	All other calls	Face to face response Clinical telephone assessment



The vast majority of major trauma cases will be classified as a red response – immediately life threatening.

### Step Three – Come to see me

Effective pre-hospital decision-making will take place within this step and decisions will be taken about the most appropriate response to send to each case - WAST, EMRTS or both.

This decision process would be facilitated by a trauma desk facility located within the Ambulance Services Clinical Contact Centre and co-located with the EMRTS ASD.

It is the assumption of this business case that EMRTS will be a 24/7 service by the time the trauma network goes live.

### Step Four – Give me treatment

WAST has developed a pre-hospital triage tool in conjunction with the network, which will be used to support pre-hospital decision making at this step with regard to direct transfer from scene to the MTC in appropriate cases. Good discussions have taken place with all stakeholders and refinements have been made to the tool following the professional peer review.

This tool will be supplemented with live clinical decision support of a major trauma desk (see section 6.3.6) for more borderline cases.

### Step Five – Take me to hospital

Decision taken in step 4 guided by the effective use of the two major trauma triage tools will then determine if in this stage patients are conveyed to the nearest TU or directly to the MTC.

## 6.3.3 Phased Implementation

In an approach that is complementary to an underlying principle of the wider trauma network board, WAST is taking a 'phased approach' in regards to support of the network. WAST are committed to ensuring that the network is safe and effective on delivery and that from this point forward the service will be on a trajectory of continued improvement and maturity.

In this respect, a phased approach is outlined below:

	Activities	Why?	Additional Resource Required
<b>Essential in place For Day 1</b>	<ul style="list-style-type: none"> <li>Trauma Triage Tools</li> </ul>	Supports patients being apparently triaged and conveyed to most appropriate location	See section 6.2.1
	<ul style="list-style-type: none"> <li>Online training for staff in relevant geographical areas</li> </ul>	Further supports paramedic triage of patients and convey of patient to most appropriate location	See section 6.3.5
	<ul style="list-style-type: none"> <li>Trauma Support Desk / Expansion of EMRTS Desk to fulfil this function</li> </ul>	Final line of support in triage of patient by offering clinical leadership to on scene paramedics. Ensures	See section 6.3.6

	(including recruitment of relevant posts)	most appropriate on scene car is provided and plays a system co-ordination role	
	<ul style="list-style-type: none"> <li>Agreement on commissioned activity levels for year 1</li> </ul>	Ensures WAST is deploying the most appropriate amount of resources on any given day and that the go live of the network does not destabilise wider WAST operational performance and its ability to attend other non-major trauma cases in the community.	See chapter 12
<b>Essential in Year 1</b>	<ul style="list-style-type: none"> <li>Commencement and completion of 'face to face' staff training</li> <li>Governance structure in place both network wide and internal to WAST (where relevant) to support decision-making.</li> <li>Transfer and discharge service</li> </ul>		See section 6.3.5
<b>Essential in Year 2-3</b>	<ul style="list-style-type: none"> <li>Ongoing data collection</li> <li>Dedicated EMRTS vehicle</li> </ul>		
<b>Essential in Year 4-5</b>	<ul style="list-style-type: none"> <li>Ongoing data collection</li> </ul>		
<b>Desirable &amp; aspirational goals</b>	<ul style="list-style-type: none"> <li>It is desirable for some face to face training to begin prior to go live</li> </ul>		

The following specific governance arrangements have been agreed for training and are reflected in the management case:

Pre-hospital triage tool –the network will 'own' this tool as indicated above:

- Responsibility –WAST will be responsible for developing the tool.
- Accountability –Network board will approve the tool. Monitoring of the tool through the ODN Board on behalf of WHSSC/EASC, however this will require data from WAST on compliance/health board issues.
- Consulted –WAST clinical governance/EMRTS/network governance subcommittee.
- Informed –Providers (online & face-to-face training).

Online & face-to-face training:

- Responsibility –WAST will be responsible for developing both of these elements.
- Accountability –EASC.

- Consulted – WAST learning and development and network training and education lead
- Quality Assure – EMRTS (as preferred provider).
- Informed – Providers.

#### **6.3.4 Additional Resource Requirements for Increased Ambulance Journeys**

WAST have identified that the development of a trauma network will have a significant impact on its resources. In beginning to quantify and understand these implications, a number of existing policies, Welsh Health Circulars and agreed stances of EASC have been considered. These include:

- WHC (2017) 008 NHS Wales Policy for Repatriation of Patients.
- Designed for Life Welsh Guidelines For The Transfer Of The Critically Ill Adult.
- Developing a Once for Wales approach to quantifying the impact of Health Board strategic service changes (26 June 2018).

In noting the documented implications on the Ambulance Service in these papers, it is important to note that it has been necessary to use a number of assumptions over and above those used in the production of the dataset approved by the network board, which is the basis of the whole networks planning.

Individual assumptions used for particular areas are clearly documented in the relevant section of this paper. An executive decision of the organisation was taken that where assumptions need to be used that 'worst case scenario' assumptions should be used.

In light of this, it is highly recommended that after year one of the service when accurate 'actual' activity has been collected that further commissioning discussions are held regarding pre-hospital conveyance, secondary conveyance, repatriations and follow up rehabilitation activity.

#### **Emergency Conveyance Times (job cycle times)**

The implication here derives from the fact that traditional suspected major trauma cases would have been conveyed from scene to the nearest appropriate hospital. The new model will see the patient either conveyed to the nearest TU or direct to the MTC at UHW, Cardiff.

The following assumptions are made:

- NHS Wales is collectively unable to determine exactly where suspected major trauma incidents take place. To mitigate this an assumption has been made that they all happen at the hospital site to which they would have been conveyed under the existing model. This is clearly not reality.
- Because existing incident locations are not known, existing conveyance distances/times have not been able to be deducted to understand the 'new' element of activity.
- HDUHB have engaged with the public on the status of Bronglais General Hospital and Withybush General Hospital within the new model. It has been confirmed that both sites will become rural trauma facilities for the purposes of major trauma. On the basis of this, the WAST submission assumes that the forecast of activity for these hospitals will initially be conveyed to Glangwili General Hospital only.
- It has been agreed between WAST, EMRTS and Office of the Chief Ambulance Service Commissioner that there should be no attempt to split the total activity requiring conveyance between WAST and EMRTS and that instead it is clinically appropriate to model on the basis that WAST will have a role to play in all initial 999 major trauma calls.

### **Secondary Transfers (transfer from TU to MTC)**

The implication for the ambulance services derives from the fact that in some cases it will be appropriate for the patient to be conveyed to the MTC via a TU, for example for stabilisation.

Within the traditional model it would have been unlikely for the patient to have ever been moved from the destination of their first conveyance thus this represents new activity for WAST.

### **Repatriations (back to TU and/or patients local district general hospital (DGH), to specialist rehabilitation, home or home of a carer)**

Whilst repatriations will have been a feature of current service provision there are 'new' implications for WAST in that there will now be a greater number of people in UHW that will need repatriation for 'care with treatment closer to home.'

The following assumptions are made:

- Some data exists to project the proportion of patients who will die as a result of their injuries whilst in UHW and those who will require repatriation or transfer to specialist rehabilitation sites (and thus these numbers are built into modelling).
- No data exists to indicate that when a patient is ready to be discharged home/nursing home/home of carer etc. how they return to these places. It has therefore been assumed that WAST will undertake all of these transfers.
- In addition to the above, existing places of residence and other key data information that determine where patients might need to be conveyed to does not exist. Therefore, modelling is always based on returning to the patient's local DGH. This will not reflect reality.
- A lack of data means it is not possible to understand existing repatriation distances/times and to deduct it in order to understand the 'new' element of repatriation activity.
- Repatriations will be undertaken by the WAST Urgent Care Service and Non-Emergency Patient Transfer Service crews in line with existing NHS Wales policy.

## **6.3.5 Staff Training and Education**

### **Background and Proposed Approach**

The system of major trauma network proposed for South Wales, West Wales and South Powys will require the transport of patients with identified injuries to the MTC. A trauma triage tool (and where appropriate 'silver' triage tool) would be used to identify patients who fall into the major trauma category and these patients would be taken directly to a MTC for optimal care.

This may require WAST Emergency Medical Service staff to manage patients with serious traumatic injuries for longer periods of time. This will require training in the management of trauma patients using the current trauma equipment supplied by WAST. It will also be necessary for staff to undertake training in using the pathway and familiarisation with the trauma network.

Whilst many of the organisations Emergency Medical Service colleagues get 52 hours continuous professional development time, others receive less (it is hoped that this allocation will be standardised across all staff in this group once an internal roster review exercise has been complete). In addition there is a long standing agreement with the organisations trade union partners that only 15 hours of total CPD time is 'directed' by the organisation

The organisation recognises that the annual CPD programme for WAST colleagues would usually be the best option for delivery of such training, however, the directed 15 hours' time for the next year

has been ring-fenced for the Band 6 education process (which has been planned since 2017) and other standard mandatory training which staff are required to undertake.

Mandating staff to also use their CPD hours for the required major trauma training would require detailed conversations with our trade union partners to extend the number of CPD hours which the organisation currently ring-fences. Early discussions with trade union partners have begun but at this moment in time, negotiations are ongoing. This business case is therefore predicated on the assumption that CPD hours cannot be utilised as this represents the worst-case scenario financially for commissioners to plan against.

WAST is the only provider of emergency transport in Wales, operating in a complex environment in terms of geography and topography. Whilst the establishment of the trauma network presents many benefits and opportunities, it should be recognised that it compounds existing service delivery challenges. WAST must ensure that practitioners are fully equipped in terms of decision making and clinical intervention skills to fully support this initiative.

WAST currently operates from 105 sites across Wales meaning that education and training of colleagues is not a straightforward task. It is important that we recognise and utilise the expertise of EMRTS colleagues in relation to trauma in order to ensure quality of learning. Support is therefore required from EMRTS colleagues in relation to delivering “train the trainer” sessions for our staff and quality assurance of our delivery.

Potential delivery options have been reviewed in collaboration with the network clinical lead and network training and education lead and the preferred option is set out below:

- All colleagues complete the eLearning module (1 hour) before the network goes live. This learning will be provided in workbook format for those colleagues who require it.
- EMRTS have agreed to carry out ‘Train the Trainer’ training and quality assurance for WAST as part of their business as usual. Following this colleagues will then receive a 1-day (7.5 hours), face-to-face trauma network training session delivered by the recruited trained WAST tutors. These roles will need to be filled on a secondment basis, as the existing small education and training delivery team in WAST is fully committed to a challenging workforce/training plan. Additionally, there will be a need to recruit a trauma network lead tutor to oversee delivery, recording and reporting.

The team would comprise:

- 1 x lead tutor (responsible for overseeing project delivery and reporting and delivery of training) – 12 month secondment at band 7.
- 3 x tutors (responsible for delivery of training) – 3 x 7 month secondments (delivery of South Wales training) and 3 x 5 month secondments (delivery of Mid and North Wales training) all at band 7.

WAST recognises that whilst the face-to-face training is a one-off cost it will still represent a significant investment from the wider system which commissions Ambulance Services in Wales. Detailed conversations have taken place not only internally but also with the network board, commissioners and through the external peer review exercise as to the most appropriate way to roll out this training.

Discussions allowed three options to be considered:

- Do nothing – have no face-to-face training.

- Conduct face-to-face training of all staff during 2020/21 with a prioritisation of staff in the most geographically important areas of Wales during quarter 1.
- Phase training over three years with a prioritisation of staff in the most geographically important areas of Wales during 2020/21.

Option one was immediately discounted because of the significant impact of quality of service provision and the wider implications this would have for the success of the network.

A SWOT analysis of options two and three were subsequently undertaken. This has resulted in option 2 being the preferred option.

#### **Benefits of this approach:**

- Timely delivery
- High quality training
- Appropriately skilled workforce
- Existing training plan is not adversely affected – ensure business continuity
- Enhanced trauma management skill set for colleagues across Wales
- Fully supports the Trauma Network initiative.

#### **Online Training**

The preferred supplier is Onclick, as WAST is already using this company for other eLearning. Onclick is building a good portfolio of eLearning packages and remains competitive in this field. The eLearning will include design and development of interactive major trauma triage tool, for installation on the WAST Learnzone. It will include instructional design and copywriting of content, custom graphic design and eLearning build. There will also be a bank of multiple choice questions, case study-based assessment to be built within a learning platform, with certification on successful completion. Further signposting and resources to be embedded within WAST Learnzone. A scheduled report to be set up for WAST and South Wales Trauma Network. The duration of eLearning will be 1 hour. Back fill costs will be required for this.

#### **Face-to-Face Training**

The total number of staff requiring training is 1434 including:

- Paramedics (band 6): 949.
- Advanced Paramedic Practitioners (band 7): 19.
- Advanced Emergency Medical Technician / Emergency Medical Technician (band 5): 92.
- Emergency Medical Technician 1 / Emergency Medical Technician 2 (band 4): 374.

Costs are provided in the financial case for one lead tutor (band 7), three tutors (band 7) and backfill costs for staff. Equipment costs are also presented here for the training sessions.

#### **Risks, Issues and Dependencies**

This training requires the full support of WAST operational teams and resource departments to ensure staff attendance to maximise educator-to-student ratio. Support is required from EMRTS in terms of “train the trainer” delivery and quality assurance. Support from area managers (WAST) is required in relation to accessing suitable teaching spaces at existing WAST sites. Success is dependent on availability of funding and allocation in a timely manner. The model requires full support of WAST

operations directorate to release four colleagues to facilitate this training (lead tutor and tutor roles) on a secondment basis. Full support from the clinical and medical directorate is required, in terms of provision of advice, guidance and support from health board clinical leads/consultant paramedics. Support from and collaboration with trade union partners is also required, as well as engagement from staff.

### **6.3.6 Trauma Desk Facility**

In order for step two of our clinical model to operate as effectively as possible in the context of major trauma, new arrangements within WASTs Clinical Contact Centres are required and an effective major trauma desk is an absolute requirement from day one of a live network.

A field visit was made in 2019 to the West Midlands Ambulance Service Trauma Desk, who have been supporting their major trauma networks for five years. That visit has enabled us to see how best a major trauma desk is configured for the Welsh context.

Options considered included:

1. The status quo. No changes to existing practices and should paramedics on scene have queries regarding a patient's suitability for conveyance to the MTC then dialogue directly with on-call MTC consultants takes place.
2. There is suitable expansion of the EMRT Air Support Desk (ASD) in order for this service to co-ordinate the pre-hospital element of the network.
- 3a. The creation of a separate 'WAST' major trauma desk which works conterminously with the existing EMRTS ASD, is staffed by a band 7 clinician and operates 24/7.
- 3b. As above but with reduced operational hours. 14/7 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS ASD out of hours.
- 4a. The creation of a separate 'WAST' major trauma desk, which works conterminously with the existing EMRTS ASD, staffed by an additional allocator band 5 role and operates. 24/7.

Here the clinical decision-making would rest with the EMRTS Critical Care Practitioner on the desk with the band 5 freeing up the CCP to make the clinical decisions, rather than undertaking non-clinical communication duties.

- 4b. As above but with reduced operational hours. 14/7 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS desk out of hours.

Option 3b has been identified as the preferred option.

The creation of a separate 'WAST' major trauma desk which works conterminously with the existing EMRTS ASD, is staffed by a band 7 senior paramedic and operates 14/7 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS ASD out of hours.

EMRTS have confirmed that they are supportive of this preferred approach and it is recognised that the working relationship with the ASD staff is vital to the success of the desk.

To support the operation of the WAST Trauma Desk it is essential that the clinicians maintain their clinical skills within a face-to-face role. Therefore, to facilitate this rotation between the Trauma Desk and operational setting, it is vital to create capacity in the clinician's roster hours to enable patient

contact and the maintenance and development of clinical skills. Therefore, whilst draft versions of this business case have shown a necessity for 3.48 WTE this has been scaled up to 4 WTE to allow the aforementioned rotation.

### **6.3.7 Transfer and Discharge Model**

With many more journeys relating to Major Trauma taking place across South Wales, West Wales and South Powys the establishment of a function to effectively and efficiently co-ordinate these journeys will be critical.

An expanded additional call handler/dispatcher resource will provide the required capacity to ensure the safe delivery of journey co-ordination. However, the need for an effective and efficient co-ordination of journeys function is not limited to the changes planned for major trauma. It will play an equally critical role in the success of other strategic developments across NHS Wales such as the opening of the Grange University Hospital in Aneurin Bevan University Health Board.

In recognising this both the WAST and EASC IMTPs make the commitment to develop a proposal for All Wales Transfer and Discharge service within 2019/20. The creation of the trauma network has been identified as being the ideal 'spring-board' for the potential creation of this test service that can be trialled and evaluated prior to wider rollout across Wales. A wider piece of work is being taken forward by WAST, EASC and Health Boards to determine what the preferred model could look like. However, for the purposes of this business case an assessment has been made as to what funding maybe required supporting transfer and discharging service for major trauma. The figure represented in the business case for this part of the service represents the additionality in activity that is forecast to be created by the network.

## **6.4 Emergency Medical Retrieval and Transfer Service (EMRTS)**

This section provides an outline of a review undertaken to allow the phased 24/7 development of the EMRTS. It is referenced here for completeness and for information only, as the first phase of expansion has already been approved and the service model and timeline is congruent with the network development. There is a key dependency on service expansion and the network development as illustrated by the above quality indicators. This case does include the financial case for the service expansion as this has been considered separately by EASC.

The purpose of this review was to explore the options for the proposed expansion of the EMRTS in response to the Welsh Government Gateway Review in May 2017 and correspondence from the Chief Executive Officers, NHS Wales in June 2018.

This review provided comprehensive information on the establishment of the EMRTS in April 2015, an organisation overview and details of the current service model. Following discussion with stakeholders, it was agreed that the scope of the project would include:

- Extension of EMRTS operating hours.
- The ASD to operate in line with EMRTS operating hours.
- Options that address the main peak of unmet demand.

The key investment objectives, agreed with stakeholders, align with those of the network and describe what the project was seeking to achieve and provide a basis for post-project evaluation.



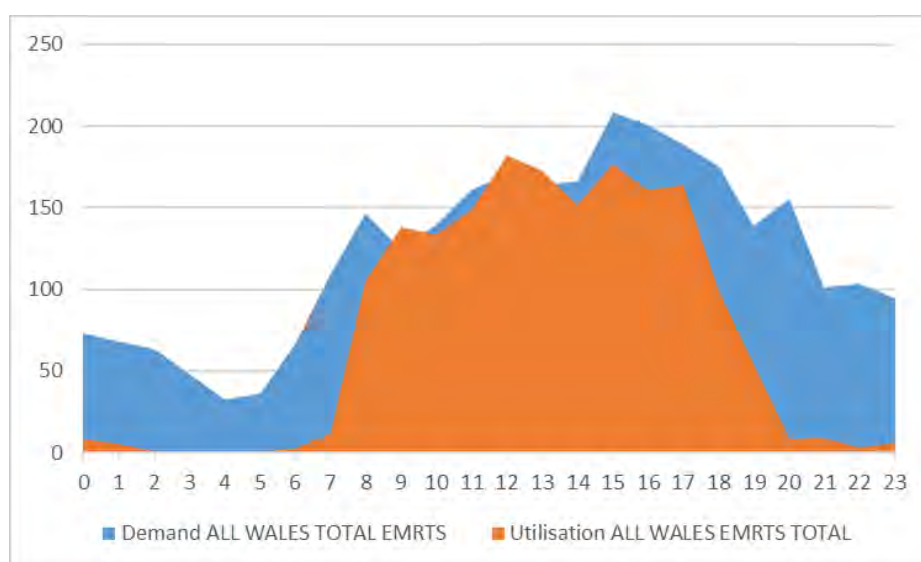
A three-year evaluation report builds on this work and will be published in 2019. This will provide a detailed analysis of the benefits delivered by EMRTS against the benefits set out in the relevant Strategic Outline Programme and Business Justification Cases and set out an approach for the robust management of benefits going forward. The three-year report will provide a more robust assessment, analysing three-years of data and supported by established data linkages.

Key strategic drivers for the expansion of the EMRTS are described along with details of how the project both aligns with and enables them. Key drivers are to address:

- Unmet critical care need in the target population in uncovered and existing operating hours.
- The critical care and time critical transfer needs created by key service changes such as the development and requirements of the major trauma network and other national and regional planning initiatives.

The unmet need data provided indicated that, with the current 12-hour service model, EMRTS is reaching 70% of the predicted demand for pre-hospital critical care, and 63% of demand for time-critical transfers for the whole 24-hour period. This is not just exclusive of major trauma, but also includes medical emergencies.

The analysis utilised data from multiple sources and suggests unmet need of 1,796 cases (meeting EMRTS service specification and appropriate for EMRTS intervention per annum across 24 hours. 991 cases were during the 2000hrs - 0800hrs period (when EMRTS is not currently operational) and 805 cases relate to current EMRTS operating hours of 0800hrs – 2000hrs. These latter cases related to the main peak of demand from early afternoon when there are insufficient EMRTS assets to cover demand. The overall level of unmet need was greater than anticipated. The graphic below shows the total demand compared to EMRTS activity over a 24-hour period (April 2017 – March 2018):



TYPE	0800-2000hrs	2000-0800hrs	Total
Time Critical Transfers	n/a	82	82
Trauma	668	497	1,165
Medical	137	412	549
Total	805	991	1,796

Further analysis was carried out, broken down by health board.

In addition, key principles and implications of air and road response for night operations were developed. It was clear that, due to the additional risks and restrictions, air response would be utilised less at night and the reliance on road response would be even greater. For this reason, it was confirmed that, whilst details relating to both air and road responses and the respective population coverages were provided, the options appraisal process utilised road response figures due to this increased role at night.

From the analysis the following conclusions were reached:

- The main peak of unmet demand was between 1500hrs and 0000hrs, and was most significant in the South East Wales area. A twilight rapid response vehicle shift was therefore explored as a key part of the option appraisal.
- The bases at Caernarfon and Welshpool airports have relatively poor population coverage and that any option that only included a base at Welshpool airport or Caernarfon airport or an option that only provided a combination of them would not provide equity in terms of effective population or geographical coverage.
- No single base could provide the required national population coverage and that at least two bases would be required overnight to provide the required population and geographical coverage within agreed response times thereby ensuring equity.
- The preferred option would include a base in North Wales and a base in South Wales. This would ensure an equitable and effective air and road responses and maximise health gain.
- Road responses would continue to forward-locate to central locations close to key road links in order to maximise population coverage and peaks in activity in order to ensure greater equity and health gain.

It should also be noted that the ASD would need to be extended to provide this important support and coordination function across all operational hours.

An options appraisal defined the scope of the project, main benefits, risks, constraints, dependencies and assumptions, and was agreed with stakeholders. Members of the trauma network board gave input to this process. A long list of options was reduced to a short list of options using key indicators. A shortlist of five options was carried forward to the economic appraisal to evaluate in further detail. The 'Do Minimum' and 'Do Maximum' options were also included for reference.

A number of factors relating to the agreed investment objectives were used to determine the preferred option including capital, revenue and transitional costs, cost per case, unmet demand and population coverages for each option.

The preferred option was then presented as follows:

- 2000hrs – 0800hrs: Consultant and CCP at a South Wales base with a rapid response vehicle (RRV).
- Double pilot crew and aircraft available at the South Wales base to support either.
- 2000hrs – 0800hrs: Consultant and CCP at Caernarfon airport with a RRV.
- RRV including a Consultant and CCP operating 1400hrs - 0200hrs along the M4 corridor to meet the main peak of unmet demand.

The preferred option includes three operational rotas and indicative implementation timelines were developed as set out below:

Project Phase	Year 1	Year 2	Year 3
Introduction of first 24/7 base in South Wales and 24/7 ASD coverage	Phase 1		
Introduction of second operational rota		Phase 2	
Introduction of third operational rota			Phase 3

The year 1 implementation has commenced and has an indicative timeline of April 2020 to be operational.

## 7 Major Trauma Centre

This chapter provides an overview of the extensive work undertaken by Cardiff and Vale University Health Board (C&VUHB) and the network board in developing a comprehensive and robust business case for the adult and paediatric Major Trauma Centre (MTC) at University Hospital of Wales, Cardiff (UHW). The position described here follows a number of internal and external reviews, including feedback received from a recent professional peer review. The principles are supported by commissioners. The approach to the reviews is described in Chapter 4.

The complete MTC business case is presented in Appendix 16. Where references are made to sections in the MTC business case, these are stated below.

### 7.1 Overview

The MTC business case seeks to demonstrate the need for investment in services for seriously injured adults and children for the population of South Wales, West Wales and South Powys. Investment will be crucial across full pathways of care for those patients treated at C&VUHB in order to establish an MTC for the South Wales Trauma Network and realise the improvements in outcomes and quality of care for this diverse and complex group of patients. The establishment of the MTC is pivotal to the development of the trauma network.

The MTC business case sets out a compelling case for change and identifies areas where investment will be required in order to deliver timely and improved quality of care. The investment required aligns to meeting national adult and children's MTC quality indicators/service specification and/or a predicted activity uplift.

The case has been separated between adult and paediatric MTCs to highlight the requirements for both. Where possible, proposed models combine investment across both adult and paediatric patients in order to minimise the cost impact.

The MTC business case provides an overview of each core specialty in the patient pathway identifying current models of care and a proposed model based on meeting the relevant MTC quality indicators over years one and two, as well as meeting the predicted activity uplift. This is in keeping with a phased approach to the establishment of the network, but, in line with MTCs in NHS England, requires some considerable frontloading, in order to demonstrate maximal benefit.

The case for increased provision should be considered in relation to delivery of the MTC quality indicators/service specification and the totality of major trauma activity. Where there are requirements to increase service provision relating to activity only, this has been clearly identified in the specific sections of the MTC business case. Furthermore, both capital and revenue costs are outlined in each section of the MTC business case and a schedule detailing workforce and associated costs provided as an Appendix to the business case submission (see Appendix 16).

Finally, C&VUHB demonstrate a positive approach and contribution to collaborating with the wider network across the patient pathway as evidenced below.

### 7.2 National Major Trauma Quality Indicators

The development of the trauma network aligns itself with a number of national drivers as summarised in Chapter 2.

More specifically, there are clear links between the establishment of an MTC and C&VUHB Strategic Goals in its 'Shaping our Future Wellbeing Strategy 2015-2025.' The Strategy sets out objectives that link directly with the delivery of an MTC:

- Reduce Health inequalities.
- Have an emergency care system that provides the right care, in the right place, first time.
- Be a great place to work and learn.
- Work better together with partners to deliver care and support across care sectors, making best use of our people and technology.
- Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives.

## 7.3 Case for Change

The overarching investment objective of a trauma network can be summarised by the network's mission statement '**Saving Lives, Improving Outcomes, Making a Difference**'.

Furthermore, key investment objectives defined by Welsh Government are referenced throughout this business case with added value that could be delivered. These include:

- **Health gain:** improving patient experience and outcomes.
- **Equity:** where people of highest health needs are targeted first.
- **Clinical and skills sustainability:** reducing service and workforce vulnerabilities and demonstrating solutions that are flexible and robust to a range of future scenarios.
- **Value for money:** demonstrating the least costly way of generating the anticipated benefits.

These investment objectives align with C&V UHB strategic vision to deliver the MTC for the South Wales Trauma Network.

### 7.3.1 Investment in MTC Services in Wales

The investment in services proposed in the MTC business case for patients from across the Network from day 1 would deliver:

- A designated adult and paediatric MTC to serve the region of South Wales, West Wales and South Powys, providing patients with direct access to specialist teams and state-of-the-art equipment to ensure that they receive immediate treatment, 24 hours a day, seven days a week.
- A single point of access into UHW as a specialist centre for major trauma cases.
- A Consultant led service for the reception and resuscitation of patients 24/7 allowing for immediate senior decision making and consultant led care from the outset.
- Multispecialty trauma teams including dedicated paediatric trauma teams and mobilisation of supporting departments and services such as transfusion, radiology and surgery.
- Enhanced capacity in the emergency unit to allow for access to effective and timely lifesaving interventions.
- Enhanced capacity in theatres to ensure timely access for a variety of complex injuries.

- Improved capacity in the critical care unit at UHW.
- A dedicated ward where multiply injured patients are managed and cared for as a cohort.
- A designated consultant available to contact seven days a week who has responsibility and authority for the hospital trauma service and leads the multidisciplinary team care.
- Availability of hyper-acute rehabilitation for seriously injured patients.
- Provision of a rehabilitation plan/prescription for all seriously injured patients.
- Consistent and coordinated care with a named member of staff and clear communication with seriously injured patients and their families/carers and ongoing care provider.
- Improved information and communication of discharge and enhanced repatriation and transfer of patients to their local hospital following specialist treatment to avoid unnecessary delays for patients awaiting care with treatment closer to home.
- An MTC Directorate to oversee and drive the governance agenda.
- Enhanced audit data submission into the national audit (TARN) to be met within 25 days from discharge.
- A multidisciplinary approach to governance, quality improvement, research and audit.
- A Network wide approach to training and education including rotational posts for the network through the MTC.

In addition to those benefits detailed in the case for change section of the network programme business case, the expected quality benefits extended to those attending the MTC are as set out below:

- Patients will receive a service that delivers the highest possible quality of care for patients 24 hours a day, seven days a week
- Reduction of 20% in preventable deaths as measured by the National Trauma Audit Research Network (TARN).
- Improved functional outcomes
- Improved patient and carer experience through increased coordination of care and communication around expected pathway and ongoing care plan.

## 7.4 Workforce Summary

The full national major trauma quality indicators are provided in Appendix 3.

### 7.4.1 MTC Indicators

An analysis has been undertaken reviewing current C&VUHB services against the agreed national quality indicators for MTCs. There are 52 adult indicators and 46 Children's indicators in total. The analysis has shown that a number of indicators are currently achieved by C&VUHB as a regional specialist centre. Those not met are listed below and form the basis of the required investment.

There are 20 key indicators that are not currently met:

1. T16-2B-101/201 – 24/7 Consultant Trauma Team Leader
2. T16-2B -103/203 - Emergency Trauma Nurse

3. T16-2B-107 – CT reporting
4. T16-2B -113 - 24/7 Access to Consultant Specialists
5. T16-2B-115/213 Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries
6. T16-2B-118/216 - 24/7 Specialist Acute Pain Service
7. T16-2C-102 Major Trauma Service (Consultant)
8. T16-2C-103 /202 Major Trauma Coordinator Service
9. T16-2C-104/203 Major Trauma MDT Meeting
10. T16-2C-105 Dedicated Major Trauma Ward or Clinical Area
11. T16-2C-110 /209 Management of Musculoskeletal Trauma
12. T16-2C-113 /212 Management of Maxillofacial Trauma
13. T16-2C -118/215 Specialist Dietetic Support
14. T16-2C-121/218 - Patient Experience – Trauma Audit Research Network (TARN) PROMS and PREMS
15. T16-2D-101/201 Clinical Lead for Acute Trauma Rehabilitation
16. T16-2D-103 /203 Rehabilitation Coordinator
17. T16-2D-105/205 Keyworker
18. T16-2D-106 /206 Rehabilitation Assessment and Prescriptions
19. T16-2D-102/202 Specialist Rehabilitation Team
20. T16-2D-109 Clinical Psychologist for Trauma Rehabilitation

The ability to meet the above will place CAV UHB in a strong position to deliver the benefits as outlined in chapter 4 of this programme business case.

Similar to MTCs in England, there are a number of indicators of the 20 above that will not be met on day 1. They are as follows:

1. T16-2B-201 – Paediatric 24/7 Consultant Trauma Team Leader
2. T16-2B -203 – Paediatric Emergency Trauma Nurse
3. T16-2B-107 – CT reporting, this will be monitored during year 1
4. T16-2B-118/216 - 24/7 Specialist Acute Pain Service

This case clearly indicates relevant MTC quality indicators throughout the pathway service specification and how plans will ensure these are met over the first 2/3 years of MTC launch.

#### **7.4.2 Trauma Unit indicators**

A review of TU standards demonstrates that C&V UHB already meets 86% of the national TU standards. Those that are not met are as follows:

1. T16-2C-301 Major Trauma Lead Clinician
2. T16-2C-303 Major Trauma Coordinator Service

3. T16-2D-301 Rehabilitation Coordinator
4. T16-2D-303 Rehabilitation Prescriptions

A plan has been developed to meet the above indicators as a part of the local UHB IMTP process for 2019. The additional resource requirements for this are outlined in Chapter 8.

Note: Resources for plastic surgery are not included in the MTC business case.

## 7.5 Predicted Activity Uplift

Appendix 1 details the current and expected trauma activity that has been used as a basis for service planning. This was taken from an agreed set of data assumptions commissioned by the trauma network and signed off at the network board in February 2019. This modelling utilised NWIS and TARN data as well as observed changes in English network flows to provide a predicted model for use in planning.

In relation to CAV UHB, current activity is modelled at 385 Major Trauma patients and 164 moderate trauma. The first year predicts an overall uplift of 294 candidate major trauma patients. This can be broken down into 193 Major Trauma patients with an additional 101 patients classified as 'overtriage' in the first year after go live. Overall, this equates to a 50% uplift in Major Trauma patients with a 35% 'overtriage' rate.

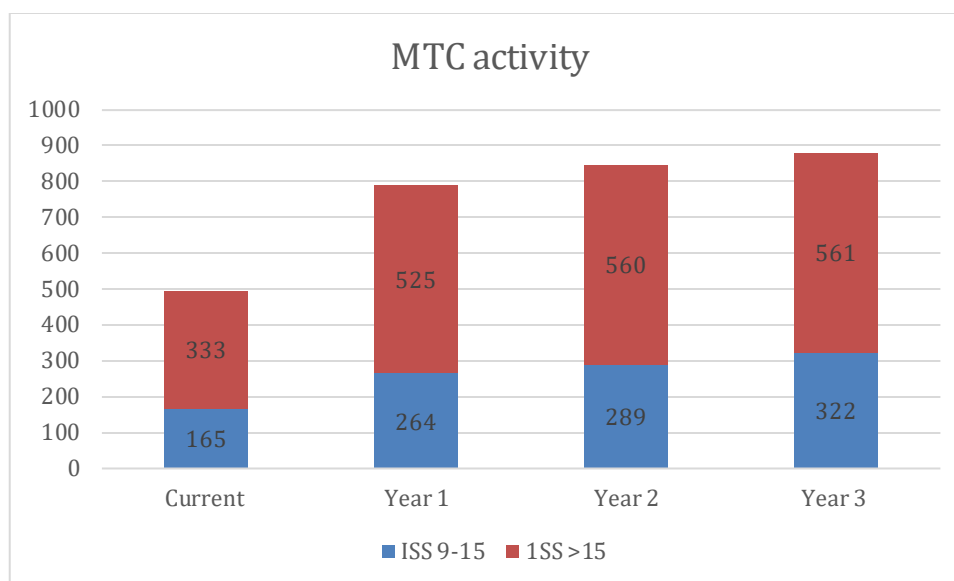
'Overtriage' is a term used to describe patients who arrive directly at the MTC from scene, who otherwise could have been treated locally. It is recognised that an element of 'overtriage' is acceptable to avoid missing major trauma cases that could benefit from the MTC; however, the exact rate for the network cannot be predicted at this stage. The effectiveness of the trauma desk should enhance triage decisions and will be evaluated in year one.

Further specialty level activity modelling has been challenging to obtain due to the complex nature of the clinical injuries and pathways for this patient group and lack of TARN data submitted across all of the Health Boards.

### 7.5.1 Activity Assumptions and Profile

CAV UHB currently receives and treats around 40% of all major trauma (Injury Severity Score (ISS) >15) patients within the network region. This equates to approximately 300 cases, with a further 200 cases treated who are moderately injured (ISS 9-15). Network modelling suggests that in its first year as an MTC, C&V UHB will treat 54% more patients, an additional 294 candidate trauma patients. These candidate major trauma patients can be broken down into two categories, Major Trauma (ISS >15) and moderate trauma (ISS 9-15) which is often described as 'false positive' or 'overtriage'. Year 2 and 3 data modelling suggests a smaller incremental increase in activity:





Predicted activity increase to the MTC Years 1 – 3

Network data analysis shows changes in network flow in the first three years, with the number of patients bypassing directly to the MTC rather than transferring increasing as the network develops:

<u>ISS 9-15 – moderate</u>	<u>Assumed current position</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Direct to MTC	154	206	231	256
Transfer TU to MTC	11	58	58	66
% TU only	660	561	536	503
Total	825	825	825	825
<u>ISS &gt;15 – major</u>	<u>Assumed current position</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Direct to MTC	284	306	341	368
Transfer TU to MTC	49	219	219	193
% TU only	542	350	315	314
Total	875	875	875	875
<u>ISS &gt;9 – candidate</u>	<u>Assumed current position</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Direct to MTC	438	512	572	624
Transfer TU to MTC	60	277	277	259
% TU only	1202	911	851	817
Total	1,700	1,700	1,700	1,700
<u>Combined Direct to MTC &amp; Transfer TU to MTC</u>	<u>498</u>	<u>789</u>	<u>849</u>	<u>883</u>

Predicted change in activity flows for network, predicted data activity for the trauma network

Due to the complex nature of the clinical pathways and the lack of TARN data submitted across all of the health boards it is difficult to predict the predominant specialty of patients with multiple trauma, including impact on specialties in terms of workload in theatres. Discussions (supported by Professor Moran) with other MTCs in England and benchmarking against Nottingham and Bristol MTCs show that this increase is variable but that a large percentage of the increased workload impacts on Trauma and Orthopaedics. This is reflected in the case and will be reflected in the theatres utilisation plan.

### Paediatric MTC Activity

The predicted uplift in paediatric Major Trauma cases is shown as a 'sub set' of the above data and is shown below:

	<u>Assumed current position</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
ISS 9-15	22	27	30	33
ISS >15	53	55	56	60

Predicted data activity for the Wales Trauma Network 2019

There are significant problems with the paediatric data captured in TARN in relation to:

- Capturing all paediatric trauma cases.
- The injury severity score (ISS) is an adult tool that fails to accurately reflect the pattern of paediatric injuries.

We can therefore assume that activity may be more than predicted, as reflected by experiences within the Bristol Royal Hospital for Children, and shared at the professional peer review panel. During the first year, an analysis of TARN data will be undertaken by both the network and MTC to assess both under and overtriage of patients for transfer to the MTC. This will provide an indication of whether activity modelling in the planning phase was accurate, and allow further planning for year two.

### Additional Factors Impacting on MTC Activity

It is important to highlight that there has been an increase in major trauma activity in UHW since the establishment of the EMRTS. The one-year evaluation demonstrates that this has helped improve equity and timeliness of access to definitive specialist trauma care for patients brought to UHW. During this time, 58% of patients were transferred directly to specialist care. Nonetheless, this change in flow has impacted on C&VUHB services.

An estimated additional 64 patients with major and moderate trauma were predicted to flow to UHW per annum. Since the launch of this new service there has been no investment in critical services such as Emergency Unit, Theatres and ward capacity in relation to the care of seriously injured patients, this is expected to increase by a further 100 patients upon the extension of the service next financial year.

## 7.5.2 Capacity Requirement Assumptions – ward beds, theatre sessions and critical care beds

Following the overarching network data modelling, further local data analysis was undertaken to identify capacity requirements for year one. This was based both on total numbers but used a number of local data sources including Ward Watcher, TheatreMan and a number of specialty specific clinical databases (e.g. Neurosurgery, Maxillofacial Surgery) plus some specific clinical reviews of health board TARN data.

Due to the variable nature of unscheduled care activity, modelling has necessarily taken account of not only average attendances but peaks in flow (particularly for the emergency unit and theatres) and also current delays for major trauma patients accessing theatres.

### Ward Beds

The table below shows the modelled current and predicted bed occupancy relating to major trauma patients. The number of beds by percentile, shows the number of beds needed for major trauma patients for that percentage of days of the year. For example, it is modelled that, for current activity levels, 30 dedicated beds would be enough for major trauma patients 50% of the time and that 38 beds would be enough 95% of the time.

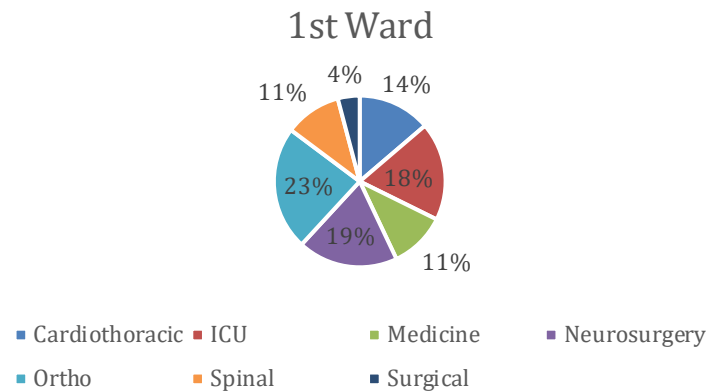
Modelled current and predicted bed occupancy (LOS $\geq$ 3days)												
	<u>Beds Occupied -</u>			<u>Year 1</u>			<u>Year 2</u>			<u>Year 3</u>		
	5%ile	50%ile	95%ile*	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile
University Hospital Of Wales	23	30	38	42	47	53	45	50	56	46	52	58

Predicted data activity for the Wales Trauma Network 2019 – excludes critical care beds.

Comparing the beds required for Year 1 suggests an increase of between 15 (5th centile) and 19 beds (95th centile) in Year 1 with a further 3 beds in Year 2. Note that this has been based upon current LOS for all ISS >9 patients at UHW. Published evidence shows that a reduction in length of stay (LOS) was not seen in the English MTCs post MTC launch and introduction of an automatic acceptance and repatriation system. Overall median length of stay in acute care was unchanged from initially 10 (IQR 5–21) to finally 9 (5 to 19) days (Moran *et al*, 2018). Therefore, a reduction has not been factored into bed calculations at UHW based on MTC status.

One should not consider length of stay in isolation, the impact of repatriation within and outside the network will play an important role in determining the efficacy of the polytrauma unit. There is an All Wales Repatriation Policy currently in place and the issues around operationalising the policy are well recognised. Whilst it is recognised that work is ongoing at network level to improve repatriations, this falls outside of the sole remit of C&VUHB and cannot be relied upon to have any definite impact upon length of stay until it is realised and understood. It is important to note, therefore, that the 14 beds modelled on an 18 day length of stay are the minimum requirement to admit seriously injured patients to an appropriate location in a safe and timely manner.

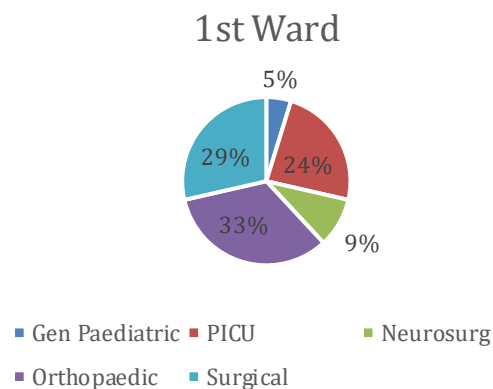
The largest uplift in patients is expected to occur in the first year particularly as EMRTS has been approved to extend to 24/7 cover in line with the MTN go live. It is anticipated that the uplift in beds and critical care capacity will be needed for day one. An analysis of the 2018 UHW dataset from TARN provided a baseline for where seriously injured patients are currently being treated in UHW:



2018 adult UHW TARN data, first ward

Around 20% of the current major trauma patients treated at UHW have significant multiple injuries and require polytrauma unit care, this equals six beds. As highlighted, it is a challenge to accurately predict activity by specialty. It would not be sensible to apply the percentage uplift to all specialties, for example, as UHW currently receives the large majority of major trauma patients requiring neurosurgical intervention. After discussion with MTCs in England, it is assumed that UHW will predominantly see an increase in patients with multisystem injuries requiring multispecialty input as well as an increase in those patients with severe isolated orthopaedic injuries. Therefore, from a total expected uplift (based on 50th percentile) of 17 beds a pragmatic approach has been taken for year 1 to start with 14 beds and that these be placed together to collocate care on the adult polytrauma unit.

Paediatric TARN data shows a large proportion of orthopaedic and surgical patients with a much smaller percentage of patients care for under neurosurgical wards. Due to the smaller number of patients predicted in year 1, it is not expected this percentage split will change dramatically, but this will be audited:



2018 Paediatric UHW TARN data, first ward

### Theatre Sessions and Critical Care Beds

It was recognised within the network data paper that further analysis would be required in relation to impact on critical care and theatres. This was undertaken following a health board review of Ward Watcher.

The table below shows the modelled requirements for current major trauma activity at UHW and compares it to the modelled requirements in year one and year two.

		Current	Year 1	Increase	Year 2	Increase
		Predicted Median	Predicted Median	Increase on 2017-18 (Median)	Predicted Median	Increase on 2017-18 (Median)
Theatre time (weekly)	Cases (patients)	7.8	12.6	4.4	13.0	5.2
	Hours operating	26.7	43.7	14.4	43.8	17.2
CriticalCare	Total Beds	3.0	5.8	2.8	6	3

Local UHB data review April 2019

The modelling suggests that on average an additional 14.4 hours of theatre sessions (median) will be required based on average operating for theatre cases. A review of the range between 5th percentile and maximum from current shows a range of between 6.39 and 9.24 sessions. A total of 9 sessions has been planned to account for increased activity and to protect existing theatres during peak times of activity.

There will be further work required to review where the sessions will be timetabled and against which specialty.

Critical care modelling has estimated an uplift by 3 beds. The sections on theatres and critical care, which follow, explain what has been planned for in these areas.

## 7.6 Workforce Summary

Based on both meeting the quality indicators/service specification and the uplift in predicted activity, an additional 191 staff will be required to establish CAV UHB as an MTC in April 2020, with the largest groups being Nursing, Healthcare Support Workers and Medical Staff. This has reduced substantially from the first submission of the MTC business case, following internal and external reviews. Whilst MTC status should attract and help to retain staff, it is recognised that this is a significant challenge to the delivery of the MTC by April 2020. There is a recruitment strategy being developed led by the head of workforce and detailed planning work underway at a specialty level. A full time recruitment support post has been recruited to, supported by the head of workforce and OD to drive the recruitment strategy and ensure Clinical Boards are supported fully throughout the recruitment process.

An overview of this is presented in the MTC case in Appendix 16.

Staff Group	WTE
Medical Staff	29.5
HCSW	37.65
Registered Nurses	85
AHPs, Scientists & Techs etc.	27.5
Admin and Clerical	11
<b>Total</b>	<b>191</b>

In addition, CAVUHB recognises the potential impact upon recruitment and retention of staff in other health boards and thus is committed to collaboration as part of a network to ensure that skills and development of staff can be maximised within the network. There is a network workforce group

supporting development of recruitment principles/plans and this will include a number of cross health board joint appointments and rotational posts to ensure that skills and training can be maximised across the network (see Chapter 13).

## 7.7 Benefits and Risks

The networks benefits realisation plan provides a robust foundation to evaluate the effectiveness of the MTC and will be considered in the context of data collection and analysis in year one.

There are a number of risks in relation to both the delivery of the network and MTC. These include significant risks related to workforce and capacity detailed in the MTC business case (Appendix 16) and in the network risk register.

In considering this case, the risks to go live should be carefully considered against the benefits that have been highlighted.

## 7.8 Planning and Assurance Process

### Planning Process for Specialties

This case has been developed with strong involvement from all core specialities. Service planning templates have been completed by each of the specialties at C&V UHB along with face to face meetings with the MTC project team. This has supported the Directorates to review their current service and supported planning against:

- The expected increase in activity following Network 'go live.'
- The relevant national MTC quality indicators/service specification.

The planning templates completed covered both adult and paediatric indicators. However, a separate template was completed by the paediatric team and signed off by Women and Children's Clinical Board for indicators specific to paediatric major trauma.

### Internal Assurance and Approval

In order to provide assurance to the Network Board, WHSSC and Welsh Government that the MTC components of this programme business case have been internally scrutinised, the following were agreed and have taken place:

- Clinical Board sign off

Completed templates have been signed off by the relevant Clinical Board. By signing, the Board provided assurance that due diligence has been undertaken in completion of the template, and that the revenue implications of the pathways are understood and relate solely to the national MTC quality indicators for the totality of major trauma patients and/or uplift in major trauma activity.

- C&V UHB Executive Assurance panel

A panel was convened to ensure overarching assurance of Clinical Board elements of the business case before the full case is submitted to an internal major trauma business case approval group.

- MTC Business Case Approval

Final internal signoff of the business case at combined Major Trauma Project Board/ Business Case Approval Group meeting.

- Further Business case revisions based on external feedback

A number of external reviews of the case have now taken place and all feedback has been considered by Clinical Boards and submitted for discussion at an Executive UHB panel. The changes following feedback are highlighted in green in the financial tables of the case.

- Executive Scrutiny Panels

There have now been three panels convened who have reviewed each round of revisions to the case and provide any further challenge and scrutiny as well as discussions around assurance and risks to revisions and reductions to areas of the MTC case.

## 7.9 Financial Summary

### Revenue Costs

A detailed financial schedule is provided in the MTC business case, with a summary provided in financial case (Chapter nine).

The health board believes that the costs identified represent the minimum current investment that is required to allow the health board to deliver the additional modelled volumes and standards expected of an MTC.

It is expected that the costs within the case will present a loss when reviewed against income comparisons from NHS England. This is comparable to other MTC designations. Two similar combined adult and paediatric MTCs in Oxford and Southampton both confirmed they launched with a gap between costs required to go live as an MTC and the expected income through activity and Best Practice Tariff.

This is also evidenced in standalone paediatric MTCs where incidence of major trauma are small and therefore income related to this, not sufficient to support the delivery of MTC standards.

### Efficiencies

The modelling within this document is based on current efficiencies and working practices. Further opportunities to deliver improvements in productivity and efficiency within the major trauma patient pathway through new ways of working and streamlined patient pathways have been reviewed and it is agreed that there has been significant work undertaken by the health board to date and any further efficiencies may not be realised immediately.

Anecdotally, there is recognition that other MTCs in England have delivered improvements in efficiency, such as theatre times and, in some specific patient groups, length of stay. It should be noted that these improvements have been realised five years post implementation of networks and as systems develop and improve.

A review of length of stay efficiencies was undertaken as part of a review of the proposed Polytrauma Unit. Published evidence shows that a reduction in LOS was not seen in the English MTCs post MTC launch and introduction of an automatic acceptance and repatriation system (C Moran, 2018). Therefore, starting with a bed base that is lower than the modelled 50th percentile is a risk for MTC capacity upon go live and agreements for increase in bed capacity in year will be required.

The design and delivery of service improvements will form a fundamental part of the on-going clinical governance of the MTC. Service improvements will be informed by and defined at a network level. Post implementation service efficiency and productivity will also be reviewed via benchmarking with other Centres.

### **Capital Costs**

In line with a phased implementation approach there are developments within the current timelines that are an absolute requirement for operational readiness and those that can be safely enabled once the MTC is operational; the former are listed below:

- Sufficient adult resuscitation capacity
- Additional theatre capacity
- Poly Trauma Ward capacity
- Uplift in Critical Care capacity

Accepting that not all the capital and estates timelines are aligned to an April 2020 'go live', an assessment of alternative solutions to each of the absolute requirements for operational readiness has been discussed at the MTC Project Board, UHB Management Executive and Network Board.

It has been agreed that the solutions proposed for all workstreams are acceptable in principle, as an interim solution for year one starting April 2020. With this in mind there will be a requirement for a release of funds 'in year' in order to begin the capital works. Along with these, equipment costs have been identified, and together these are detailed in the finance case and in the Appendix 16.

### **Year 2**

In order to ensure sufficient operating capacity, a capital business case is being developed, alongside a programme of work for vascular services, to deliver a new theatre from April 2021. This will deliver a dedicated operating space to ensure that Major Trauma cases can be treated safely in a timely manner as the activity increases, and to meet all national guidelines and standards. The timescales for the case is as follows:

- February 2020 – OBC
- September 2020 – FBC
- Construction completion – June 2021

There will be further requirement to expand the polytrauma ward to meet standards including IP&C. A separate business case will be submitted to Welsh Government in year 1.

The estimated future capital requirement for the MTC theatres at the time of publication is in the region of £20-25m. Note that this is an integrated capital scheme which includes the vascular hybrid theatres.

## **7.10 The Major Trauma Centre Role within the wider Network and Opportunities for Collaboration**

As a part of its role within the network, it is crucial that the MTC effectively collaborates with all other organisations within the trauma network system in order to ensure benefits for patient's right across the pathway.



Experience in England has demonstrated that Trauma Units (TUs) have, over time, become deskilled in major trauma. This is a situation that the South Wales Trauma Network is keen to avoid and the role of the MTC will be important in supporting and developing the network as it matures. The MTC's key role and responsibilities are set out in the 2013 Major Trauma Service Specification (D15/S/a) and in relation to support and collaboration within the wider network include:

#### **Clinical Advice & Leadership Roles**

The MTC will provide clinical advice to other providers within the network. This will include; in pre-hospital stage and whilst patients are awaiting transfer to the MTC for definitive treatment or following acute care when the patient is discharged to on-going specialised or local rehabilitation services.

There are a number of roles within this business case that will be key enablers to ensure that effective advice and support is available 7 days a week. These include, Trauma Team Leaders, Advanced Nurse Practitioners and Rehabilitation Consultant, Consultant AHP and Coordinators. The MTC recognises the value of sharing experience across the Network and is committed to the provision of posts which allow for rotation through both TUs and the MTC. There are clear opportunities within the Rehabilitation posts for providing outreach and support to TUs.

#### **Training, Audit & Quality Improvement**

The MTC will commit to being actively engaged and contributing to the Trauma Network, particularly in operational requirements, training, governance and audit. The MTC has a role to ensure that all organisations within the network are actively engaged and supported as a part of an effective trauma Quality Improvement programme.

There are a number of opportunities for the MTC to act as a hub for training provision within the network, working with the Network lead for training. This will be vital to minimise impact of deskilling in local Trauma Units over time.

This includes the development of leadership and faculty for key 'in house' training programmes including Trauma Team Leader and Trauma Team member, nursing and scribe training as well as ward skills and rehabilitation. There is also an opportunity to develop outreach programmes to deliver training locally and host annual events similar to those delivered by other MTCs within England and Scotland.

Trauma Team Leaders working as a part of a network model, will also be key to the continued development of trauma team skills within trauma units. These shifts within the MTC will provide clinicians working in TUs with regular exposure to trauma cases (see below).

#### **Rotational Posts & Joint Appointments**

Joint appointments in key areas will be considered in order to ensure the development of the MTC does not destabilise other Health Boards services and this is aligned with the principles of workforce recruitment into the MTC. This will bring benefits to the wider network, which C&VUHB is committed to as part of its critical role in the network.

There is also an opportunity for rotational posts within the Polytrauma Unit. This would include staff employed both within C&V UHB and within Trauma Units to ensure expertise can be spread to the network. The Polytrauma Unit will be key in providing delivery of training and up skilling staff in the definitive care of seriously injured patients.

The ability for Major Trauma Practitioners and Rehabilitation coordinators from around the region to spend time in the MTC will ensure that good links can be made between teams that will support the effective flow of patients within the Network

### **Audit and Quality Improvement**

The additional TARN coordinator roles within the business case will support the timely and quality entry of a large percentage of network data into the National Audit. In turn, this will be key for developing an audit programme for the centre, which develops in collaboration with the network and organisations within it. There is also a role for TARN coordinators at the MTC to support colleagues within the network in relation to training and development.

### **Rehabilitation**

The MTC will provide early/hyper acute rehabilitation as well as a managed transition to rehabilitation and the community. Key roles within this case such as the rehabilitation consultant, Consultant AHP, lead therapist and nurse for Major Trauma as well as psychologists will integrate into the network to support wider programmes of quality improvement, training and education.

### **Collaboration with other Specialist Services**

There are a number of interdependent services and specialties required to work in partnership to deliver seamless and high quality care. In particular, the services delivered for Major Trauma patients with orthoplastic requirements will need close joint working between C&VUHB and SBUHB to ensure the care delivered is to an excellent standard regardless of where the patient is treated. It is proposed that one of the Major Trauma Practitioners will be recruited with an interest in Orthoplastics to ensure a strong link with the Regional Centre for Burns and Plastics in Morriston and enabling collaborative rotational working, training and education between the two centres.

### **Patient Flow and Access to Services**

The MTC is committed to ensuring that patient flow is maximised to ensure that the quality benefits set out in section 6 of the case can be realised. This includes commitment to an automatic acceptance policy ensuring 24/7 access to specialist services. It is essential this is aligned with an automatic repatriation/transfer of care policy.

The MTC also supports a network approach and its role in the delivery of care closer to home following completion of the MTC phase of treatment. This includes clear and timely information to both health boards, patients and their families as well as a clear point of communication including escalation so that patient flow can be maintained, pull back to the originating HB is promoted and patient experience is maintained.

The MTC will take part and lead in governance around this which includes collecting accurate and timely data so that this can be utilised to inform governance and recognises the importance of the ODN having operational authority in the escalation processes and that commissioning will support this in a timely way.

## 8 Local Health Board Configuration

### 8.1 Introduction

In 2018, health boards undertook a process of confirming Trauma Units (TUs) and Local Emergency Hospitals (LEHs) as part of defining the network structure.

The following hospitals were approved as adult and paediatric TUs, following a recommendation by WHSSC Joint Committee and approval by health boards:

- Cardiff and Vale University Health Board: University Hospital Wales (UHW), Cardiff – TU for its own population.
- Swansea Bay University Health Board: Morriston Hospital, Swansea – TU with specialist services
- Aneurin Bevan University Health Board: Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the health board)
- Cwm Taf Morgannwg University Health Board: Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend.
- Hywel Dda University Health Board: Glangwili General Hospital, Carmarthen (subsequently confirmed following a period of public engagement)

In relation to LEHs, the following hospital will be a LEH within the network structure:

- Royal Glamorgan Hospital, Llantrisant.

As described below, within Hywel Dda University Health Board, Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest, will be rural trauma facilities for the purposes of major trauma.

This chapter sets out the requirements for health boards by providing an outline of baseline assessments against the agreed quality indicators and service specification, in order to illustrate those that are already being met, those that could be met through internal re-organisation and those that require additional resources. A description is also provided of the configuration of local and community based rehabilitation and requirements for the 'landing pad' for patients returning from the MTC for 'care with treatment closer to home.' This follows on from developing a more phased approach to implementation of quality indicators and service specification over five years following the recent Gateway review.

Furthermore, a summary is provided of each health board business case against this phased model, outlining additional resource requirements.

Although Powys Teaching Health Board does not have a TU itself, the health board's model and resource requirements are also described here.

Finally, an outline is given of the clinical and operational models for specialist services supporting the MTC (i.e. orthopaedic surgery, spinal trauma surgery, thoracic trauma surgery and pelvic trauma surgery).

## 8.2 Overview of the Model

The composition of health boards in the context of the trauma network will include TUs, LEHs, rural trauma facilities (in Hywel Dda University Health Board only) and community-based rehabilitation. The latter will require close working with social care.

All 'candidate TUs' are already managing moderate and major trauma patients. In the trauma network, TUs will continue to provide initial assessment, imaging and treatment of trauma patients. TUs will be optimised to provide definitive care and admit major trauma patients. However, they will also enhance existing systems to rapidly move the most severely injured to specialist centres that can manage injuries. In doing so, TUs will develop an effective quality improvement programme. By day one, all TUs will have undertaken the requisite level of medical and nursing training and education (supported by the network programme) and embedded network policies within their systems. Organisational governance structures will be established, consisting of an operational manager (from an existing directorate), clinical lead, major trauma practitioners, rehabilitation coordinators and TARN coordinators. There will be a named executive lead. The team will work closely with the equivalent team in the MTC and the trauma ODN management team. These roles are considered key enabling roles in-year.

Major trauma practitioners and rehabilitation coordinators will be new roles in the health boards and will be vital in ensuring seamless care of major trauma patients and key points of contact for patients returning from specialist care to the TU or community. In particular, rehabilitation coordinators will provide a link to community resources, allowing early notification of individuals who require support, facilitating discharge and managing patient and family expectations. They will be seen as the 'flight controllers' of the system. This will be augmented by the availability of a consultant in rehabilitation medicine operating in each health board on a weekly basis, playing key roles in coordinating the team, managing complex patients and facilitating discharge.

In years two and three, there will be an enhancement of core therapy roles as well as some specialist roles (e.g. neuropsychology), providing both in-reach and outreach services within the health board. Opportunities will exist for these specialist therapy roles to work across neighbouring health boards.

For complex patients who return from specialist care (e.g. traumatic brain injury, spinal injuries), the network will develop a training and education programme for medical and nursing staff caring for these patients. Thus, the skill set of the rehabilitation multidisciplinary team based at the TU will be identical to the skill set of that based at the MTC.

This model will not just benefit major trauma patients returning to TUs and the community, but also those admitted locally and other patients groups with complex rehabilitation requirements. It will lead to the establishment of TUs as level two rehabilitation facilities and an enhancement of a level three community based rehabilitation response. By ensuring health boards are appropriately prepared and supported, they will be in a position to provide an optimised 'landing pad' for patients returning from specialist centres (e.g. the MTC). This timely repatriation of patients from specialist care has been termed 'care with treatment closer to home' or CWTCH by the network.

Within the network there will be one LEH as indicated above. This hospital will not routinely receive acute trauma patients; however, they will retain processes to ensure that, should this occur, there is appropriate initial management and transfer to the MTC or nearest TU. Given the proximity to the MTC and TU, this will be a rare occurrence. In Hywel Dda University Health Board, Bronglais General Hospital and Withybush General Hospital will be termed rural trauma facilities. Whilst, as for LEHs, there are no specific quality indicators for a rural trauma facility, the health board is committed to ensuring these hospitals maintain the ability to assess and treat major trauma patients, given their

relatively unique geographical location and distance from the MTC and nearest TU. Furthermore, the health board's organisational structure will need to ensure appropriate oversight of clinical and operational governance activities in these hospitals. The TU team described above, together with an enhancement in therapists and consultants in Rehabilitation Medicine will have a key role in supporting these rural trauma facilities.

Finally, a key risk of establishing the network, as evidenced in NHS England, is deskilling hospitals outside the MTC in acute and ongoing care of major trauma patients. The risk of this will be mitigated in several ways including a commitment of the network to deliver quality improvement equitably across the region and evidence of collaboration of the MTC with the wider network.

## 8.3 Quality Indicators

As part of the TU designation process, each health board undertook a baseline assessment against essential quality indicators. Quality indicators for TUs and a summary of the baseline assessments are presented in the table below. For each quality indicator, a code is assigned, in order to cross-reference to Appendix 3. The table also indicates where quality indicators could be met through internal re-organisation or network support (indicated in *italics*) and where additional resource requirements are needed. Furthermore, an indication of phasing of quality standards is provided (i.e. in place for Day 1, year 1 – 3) as agreed by the network board.

Essential Quality Indicator	Currently met/unmet/partially met
<b>T16-2B-301 – Trauma team leader – in place for Day 1</b>	
There should be a trauma team leader of ST3 or above or equivalent non-consultant career grade doctor (NCCG), with an agreed list of responsibilities available within 5mins, 24/7 – in TUs where this cannot not be entirely achieved through Emergency Medicine, a trauma team leader could be sought from Intensive Care or a surgical specialty.	<b>Partially met and could be fully met through internal re-organisation</b>
There should also be a consultant available in 30 minutes.	<b>Met</b>
The trauma team leader should have been trained in advanced trauma life support (ATLS) or equivalent – this could be achieved through existing in house training and network training and education programme.	<b>Partially met and could be fully met as described</b>
There should be a clinician trained in advanced paediatric life support (APLS) available for children's major trauma – this could be achieved by ensuring paediatric registrar or consultant on call on paediatric trauma team.	<b>Partially met and could be fully met through internal re-organisation</b>

Essential Quality Indicator	Currently met/unmet/partially met
<p><b>T16-2B-302 – Emergency trauma nurse/allied healthcare professional (AHP) – variable timeline</b></p> <p>In place for Day 1 - All nursing/AHP staff caring for a trauma patients should have attained the competency and educational standard of level 1. In units that accept paediatric major trauma, this should include the paediatric trauma competencies (as described in the National Major Trauma Nursing Group guidance) –overlapping with Royal College of Nursing competencies and supported by network training and education programme.</p> <p>End of Year 1 plan and deliver Year 2 – 3 - There should be a nurse/AHP available for major trauma 24/7 who has successfully attained or is working towards the adult competency and educational standard of level 2 as described in the National Major Trauma Nursing Group guidance –phased approach and supported by network training and education programme.</p> <p>In units that accept children: there should be a paediatric registered nurse/AHP available for paediatric major trauma 24/7 who has successfully attained or is working towards the paediatric competency and educational standard of level 2 as described in the National Major Trauma Nursing Group guidance - phased approach and supported by network training and education programme.</p> <p>(It is acknowledged that recruitment of paediatric nursing staff can be difficult. If the emergency department does not have a paediatric nurse with Level 2 equivalent trauma training available 24 hours a day, then it is suggested that a senior paediatric ward nurse bleep holder could attend all paediatric trauma calls.</p> <p>Note that APLS has been recognised as Level 2 compliant, as well as the Advanced Trauma Nursing Course (ATNC), the Trauma Nursing Core Course (TNCC), the European Trauma Course (ETC).)</p>	<p><b>Partially met and could be fully met as described</b></p> <p><b>Unmet and could be fully met as described</b></p> <p><b>Unmet and could be fully met as described</b></p>
<p><b>T16-2B-303 – Trauma team activation protocol – in place for Day 1</b></p> <p>There should be a trauma team activation protocol – all health boards agreed to follow network trauma team activation protocol aligned with major trauma and ‘silver’ trauma triage tools.</p> <p>The trauma team should include medical staff with recognised training in paediatrics and paediatric trained nurses with experience in trauma –this could be achieved by ensuring paediatric registrar or consultant on call on paediatric trauma team and by nursing competencies outlined above.</p>	<p><b>Met but will be required to adopt network protocol</b></p> <p><b>Partially met and could be fully met through internal re-organisation</b></p>
<p><b>T16-2B-304 - Network Transfer Protocol from TUs/LEHs to MTC – in place for Day 1</b></p> <p>The TUs/LEHs should agree the network protocol for the transfer of patients from trauma unit to MTC – all health boards agreed to follow this protocol.</p>	<p><b>Will be fully met with network protocol</b></p>

Essential Quality Indicator	Currently met/unmet/partially met
<p><b>T16-2B-305 - 24/7 CT Scanner Facilities – in place for Day 1</b></p> <p>There should be CT scanning available within 60 minutes of the trauma team activation.</p> <p>Whilst 24/7 access to MRI is not a pre-requisite for TUs, it will be desirable that all health boards move towards having this provision by year 2 to support the spinal clinical service model.</p>	<p><b>Met</b></p> <p><b>Unmet</b></p>
<p><b>T16-2B-306 – CT reporting – in place for Day 1</b></p> <p>There should be a protocol for trauma CT reporting that specifies there should be a provisional report within 60 minutes.</p>	<p><b>Met</b></p>
<p><b>T16-2B-307 – Teleradiology facilities –in place for Day 1</b></p> <p>The TU should have an image exchange portal that enables immediate image transfer to the MTC 24/7.</p>	<p><b>Met</b></p>
<p><b>T16-2B-308 – 24/7 access to surgical staff – in place for Day 1</b></p> <p>The following staff should be available within 30 minutes 24/7:</p> <ul style="list-style-type: none"> <li>• A general surgeon ST3 or above, or equivalent NCCG.</li> <li>• A trauma and orthopaedic surgeon ST3 or above or equivalent NCCG.</li> <li>• An anaesthetist ST3 or above or equivalent NCCG.</li> </ul>	<p><b>Met</b></p>
<p><b>T16-2B-309 - Dedicated orthopaedic trauma operating theatre – in place for Day 1</b></p> <p>There should be dedicated trauma operating theatre lists with appropriate staffing available 7 days a week. The lists must be separate from any other emergency operating.</p> <p>In TUs that run 5 days a week, a 7 days a week service could be achieved by prioritising trauma cases on the emergency theatre list as is practiced in some English TUs.</p>	<p><b>Partially met and could be fully met through internal re-organisation</b></p>
<p><b>T16-2B-310 - 24/7 access to emergency theatre and surgery – in place for Day 1</b></p> <p>There should be 24/7 access to a fully staffed and equipped emergency theatre.</p> <p>Patients requiring acute intervention for haemorrhage control should be in an operating room or intervention suite within 60 minutes.</p>	<p><b>Met</b></p>
<p><b>T16-2B-311 - Trauma management guidelines – in place for Day 1</b></p> <p>The TU should agree the network clinical guidelines specified in T16-1C-107</p> <p>The TU should include relevant local details.</p> <p>These are listed in Chapter 5 and health boards agreed to implement guidelines</p>	<p><b>Unmet and will be fully met as described</b></p>

Essential Quality Indicator	Currently met/unmet/partially met
<b>T16-2B-312 - Transfusion protocol – in place for Day 1</b>  There should be a protocol for the management of massive transfusion in patients with significant haemorrhage.	Met
<b>T16-2B-313 - Administration of tranexamic acid – in place for Day 1</b>  Patients with significant haemorrhage should be administered tranexamic acid within 3 hours of injury and receive a second dose according to CRASH-2 protocol - network protocol to be followed. Evidence now points to administer within 1hr, thus, this has become a pre-hospital care standard. WAST carry tranexamic acid and have a protocol for administration.	Met
<b>T16-2C-301 – Major trauma lead clinician – in place for Day 1</b>  There should be a lead clinician for major trauma, who should be a consultant with managerial responsibility for the service and a minimum of 1-programmed activity specified in their job plan - network board provided sample job description and personal specification. Achieved across health boards through programme resource.	Partially met and ongoing resource requirements from April 2020
<b>T16-2C-302 – Organisational governance structure – in place for Day 1</b>  The TU should have a trauma group that meets at least quarterly - all health boards have established health board trauma project groups with a template terms of reference provided by the network board. This will form a TU committee once operational.  The TU should have a lead executive and named operational manager (from a suitable directorate overseeing the service and TU team)	Met  Could be met through nominations by each HB
<b>T16-2C-303 - Trauma coordinator service – in place for Day 1</b>  There should be a trauma coordinator service available Monday to Friday for the co-ordination of patients; this will be provided by major trauma practitioners (suggested 1.5 whole time equivalent (whole time equivalent)/TU)  The coordinator service should be provided by nurse or allied health professionals.  Network board provided sample job description and personal specification. New key enabling roles in the health boards and will have the following responsibilities: <ul style="list-style-type: none"> <li>• Developing a structure/strategy for identifying all patients treated within health boards (including those transferred to and from an MTC).</li> <li>• Coordinate care for this patient group, identify and highlight gaps in care.</li> <li>• Act as the key point of contact for patients and their families and be an advocate for patients (incl. issues such as safeguarding).</li> </ul>	Not met and requires additional resources



<ul style="list-style-type: none"> <li>• Deliver information for patients appropriately incl. ensuring that the patients are provided (if appropriate) with a rehabilitation prescription and that this is updated prior to discharge and on return from the MTC.</li> <li>• Work with major trauma practitioners in the MTC to support patients transferring back from the MTC to ensure timely, safe and smooth transfer of care.</li> <li>• Promote and highlight this patient group across the health board with relevant specialities and staff groups and alongside clinical and managerial leads act as a champion for this patient group developing improved pathways and care.</li> <li>• A core member of the TU committee.</li> <li>• Take an active role in governance for this patient group, highlighting possible cases for review and taking part in morbidity and mortality meetings. Support the TARN coordinator(s) with life case identification for TARN and TARN PROMS/PREMS.</li> <li>• Support relevant training and education (formal and informal) across staff groups linking with national and network initiatives.</li> </ul>	
<p><b>T16-2C-304 – Management of spinal injuries – in place for Day 1</b></p> <p>The TU should agree the network protocol for protecting and assessing the whole spine in adults and children with major trauma.</p> <p>There should be a linked Spinal Cord Injury Centre (SCIC) for the MTC which provides an out-reach nursing and/or therapy service for patients with spinal cord injury within 5 days of referral.</p>	<p><b>Will be fully met with network protocol</b></p> <p><b>See section 8.12.2</b></p>
<p><b>T16-2C-305 - Management of multiple rib fractures – in place for Day 1</b></p> <p>There should be network agreed local management guidelines for the management of multiple rib fractures including:</p> <ul style="list-style-type: none"> <li>• Pain management including early access to epidural.</li> <li>• Access to surgical advice.</li> </ul>	<p><b>Will be fully met with network protocol and thoracic trauma clinical service model</b></p>
<p><b>T16-2C-306 – Management of musculoskeletal trauma – in place for Day 1</b></p> <p>There should be guidelines for:</p> <ul style="list-style-type: none"> <li>• Isolated long bone fractures.</li> <li>• Early management of isolated pelvic acetabular fractures.</li> <li>• Peri-articular fractures.</li> <li>• Open fractures.</li> <li>• The guidelines should include:</li> <li>• Accessing specialist advice from the MTC.</li> <li>• Imaging and image transfer.</li> <li>• Indications for managing on site or transfer to the MTC.</li> </ul>	<p><b>Will be fully met with network protocols and orthopaedic/pelvic trauma clinical service model</b></p>
<p><b>T16-2C-307 - Designated specialist burns care – in place for Day 1</b></p> <p>Burns care should be managed through a designated specialist burns network.</p> <p>There should be a clinical guideline for the treatment of burns. This should include the referral pathway to the specialist burns centre.</p> <p>This is already in place in conjunction with the regional burns centre at Morriston Hospital</p>	<p><b>Met</b></p>

Essential Quality Indicator	Currently met/unmet/partially met
<p><b>T16-2C-308 - Trauma unit agreement to the network repatriation policy – in place for Day 1</b></p> <p>The TU should agree the network repatriation policy There should be a protocol in place for identifying a specialty team to accept the patient. The protocol should include the escalation process in the event of there not being access to a specialty team.</p>	<p><b>Will be fully met with network protocol</b></p>
<p><b>T16-2C-311 - The trauma audit and research network (TARN) – variable timeline</b></p> <p>In place for Day 1- The TUs and LEHs should participate in the TARN audit, with at least 1 year of back-dated baseline data before network operational. Data should meet the following standards: Case ascertainment – patients submitted to TARN compared to expected based on Patient Episode Data for Wales (PEDW) dataset –target of 80% across the network by end of year 1. Case accreditation - this is the proportion of key fields used in this report that are filled in for each patient submitted to TARN –target of 95% across the network by end of year 1. The standards are to ensure subsequent TARN metrics can be meaningfully interpreted.</p> <p>TARN audit should be discussed at the network audit meeting at least annually and distributed to all constituent members of the network. A working plan has been produced to enhance TARN data collection including appointment of TARN coordinator(s) in health boards where gaps exist.</p> <p>In year 1 - Develop strategies for undertaking TARN PROMS and PREMS.</p> <p>New TARN coordinators required. Network board provided health boards a sample job description and personal specification. As a guide, 1 day per week of a TARN coordinators time is required per 100 expected cases per annum. Network board provided approximate whole time equivalents.</p>	<p><b>Partially met and could be fully met with additional resources</b></p>
<p><b>T16-2C-310 - Discharge summary – in place for Day 1</b></p> <p>There should be a discharge summary which includes:</p> <ul style="list-style-type: none"> <li>• A list of all injuries.</li> <li>• Details of operations (with dates).</li> <li>• Instructions for next stage rehabilitation for each injury (including specialist equipment such as; wheel chairs, braces and casts.</li> <li>• Follow-up clinic appointments.</li> <li>• Contact details for ongoing enquiries.</li> </ul> <p>Electronic discharge record already in place, enhanced through clinical informatics development and patient held record.</p>	<p><b>Partially met and could be fully met through clinical informatics development</b></p>

Essential Quality Indicator	Currently met/unmet/partially met
<p><b>T16-2D-301 - Rehabilitation coordinator – in place for Day 1</b></p> <p>There should be a rehabilitation coordinator who is responsible for coordination and communication regarding the patient’s current and future rehabilitation including oversight of the rehabilitation prescription. Service provided Monday to Friday.</p> <p>This rehabilitation coordinator should be a nurse or allied health professional (suggested 1.5 whole time equivalent/TU), maybe split role between therapists, with some clinical commitment.</p> <p>Network board providing sample job description and personal specification. New key enabling roles in the health boards and will have the following responsibilities:</p> <ul style="list-style-type: none"> <li>• Responsibility for the rehabilitation planning process for TU patients and review for patients who are repatriated from the MTC maintaining ‘pull.’</li> <li>• To provide advice and work as part of the MDT to ensure appropriate management of TU patients and those repatriated from the MTC.</li> <li>• To develop and maintain links with the MTC and TUs across the network incl. the network rehabilitation lead.</li> <li>• Develop links across neighbouring health boards.</li> <li>• To continue developing a map of other relevant services in the region, including early links with acute, community resource, primary healthcare and social care services and agencies, ensuring the rehabilitation requirements of discharged TU and MTC patients are being met.</li> <li>• To provide training, education and advice within the MDT in relation to the development of the rehabilitation plan.</li> <li>• To work closely on service development and evaluation with the clinical lead for the TU, Major trauma practitioner(s) and TARN coordinator(s)</li> <li>• To be a member of the therapy teams working within the TU service and work closely with rehabilitation consultants providing outpatient reviews and outreach services in the health board.</li> </ul>	<p><b>Unmet and requires additional resources</b></p>
<p><b>T16-2D-302 - Access to rehabilitation specialists – Year 2-3</b></p> <p>There should be the following allied health professionals with dedicated time to support rehabilitation of trauma patients:</p> <ul style="list-style-type: none"> <li>• Physiotherapist.</li> <li>• Occupational therapist.</li> <li>• Speech and language therapist.</li> <li>• Dietician.</li> <li>• Psychologist</li> </ul>	<p><b>Unmet and requires additional resources</b></p>

<p>Balanced teams are required between the above therapies as traumatic injuries present with an extensive range of conditions. Therefore the therapeutic expertise required needs to be comparable with that of the MTC. This includes complex cognitive and communicative assessment and multiple limb injuries. It is unlikely that traumatic injuries as an isolated speciality will provide the necessary expertise and it will be essential for teams to provide cover for neurological conditions to ensure that the expertise necessary is provided within the team. This model will support the repatriation of other complex neurological conditions for 'care with treatment closer to home.'</p>	
<p><b>T16-2D-302 - Access to rehabilitation specialists</b></p> <p>In place for day 1 - Availability of a consultant in Rehabilitation Medicine providing outreach in all TUs, including interest in spinal- and neuro-rehabilitation (including telephone advice to rehabilitation coordinators and therapists)</p> <p>Key roles include:</p> <ul style="list-style-type: none"> <li>• Management of complex conditions in adults of working age.</li> <li>• Special interest in musculoskeletal, amputee medicine, spinal injury and neurological rehabilitation.</li> <li>• Manage risk and facilitating complex discharge.</li> <li>• Coordinate the team goals working with physiotherapy, occupational therapy, psychology, speech and language therapists, nutrition team, orthotists, prosthetist etc.</li> <li>• Assess capacity and managing behavioural issues after injury.</li> <li>• Usual to link with many specialities – including palliative care.</li> <li>• Provide community support including benefits and advice around home adaptations.</li> <li>• Vocational rehabilitation support.</li> <li>• Support specialist nursing home placements.</li> </ul> <p>Rehabilitation consultants will provide 4 sessions support for the TUs. This will consist of a ward round, a multidisciplinary team meeting, outpatient clinic with time to support relatives and relevant SPA. HDUHB, SBUHB, CTMUHB and ABUHB will require 4 sessions each. PTHB will require support within outpatient services as no inpatient facility. C&amp;VUHB TU to be met from within MTC rehabilitation service. This equates to 17 additional sessions for TUs. 10 sessions would be provided from the additional appointment and 7 sessions from reorganisation of existing sessions. There is currently one trainee and HEIW have agreed to support the proposal to appoint an additional trainee. It is anticipated that trainees would rotate between the specialist rehabilitation units and the TUs. Additionally, North Wales currently has no dedicated rehabilitation facility and expansion of trainees may provide trained consultants for development of this model.</p> <p>This would strengthen support to the trauma units and provide a variety of expertise.</p>	<p><b>Unmet and additional resources required</b></p>

Essential Quality Indicator	Currently met/unmet/partially met
<p><b>T16-2D-302 - Access to rehabilitation specialists – in place for Day 1</b></p> <p>Directory and referral guidelines for rehabilitation services (to be provided locally and supported by network) including:</p> <ul style="list-style-type: none"> <li>• Pain management.</li> <li>• Psychology/neuropsychology.</li> <li>• Mental health/psychiatry.</li> <li>• Specialised rehabilitation.</li> <li>• Specialised vocational rehabilitation.</li> <li>• Surgical appliances.</li> <li>• Orthotics and prosthetics.</li> <li>• Wheel chair services.</li> </ul>	<p><b>Unmet and will be fully met through network protocol</b></p>
<p><b>T16-2D-302 - Access to rehabilitation specialists – Year 2 – 3</b></p> <p>Input of psychology/neuropsychology providing both an in-reach and outreach service to patients in the Health Board.</p> <p>It is accepted that psychological support for patients and families is a core component of a major trauma service for adults and children and that it is essential that it be embedded within the team rather than a standalone service. The network requires a visible psychological model of care and a component of the care should provide support for the staff within the service. There is an established network of peer support for psychology across the region and this should provide a solid platform on which to develop psychological services within the trauma units. The support for patients and families after trauma requires expertise across a wide clinical field from Post-Traumatic Stress Disorders to detailed neuropsychological assessment. It is essential that the relevant expertise be contained within the network to cover the broad range of psychological presentations. Linking with local rehabilitation services is essential to achieve the breadth and depth of complexity expertise required to support all patients and families affected by trauma. This service will add value to wider presentation other than major trauma. The need for psychological support was integral to the aftermath of a number of mass casualty events in the UK over the last few years.</p>	<p><b>Partially met and could be fully met with additional resources</b></p>
<p><b>T16-2D-303 – Rehabilitation plan – in place for Day 1</b></p> <p>All patients should receive a rehabilitation assessment including barriers to return to work. Where a plan is required, this should be completed within 72 hours.</p> <p>The plan should be updated prior to discharge and a copy given to the patient</p> <p>All patients repatriated from the MTC should have their plan reviewed and updated at the trauma unit.</p> <p>Requires additional resources (i.e. rehabilitation coordinators and therapists). Standardised plan being developed by rehabilitation working group.</p>	<p><b>Unmet and could be fully met through network protocol and additional resources</b></p>

Essential Quality Indicator	Currently met/unmet/partially met
<p><b>Additional standard – Orthogeriatric review – Year 3 - 5</b></p> <p>Review by a ST3/equivalent or above in orthogeriatric medicine, geriatric medicine or care of elderly medicine as soon as possible and definitely within 72hrs of admission.</p> <p>In keeping with the case for change, health boards have been asked to consider how this could be achieved (e.g. reviews undertaken by major trauma practitioners under supervision of care of the elderly consultant, given shortage of orthogeriatric workforce).</p>	<p><b>Unmet and could be fully met by additional resources</b></p>

## 8.4 Additional Service Specification

### 8.4.1 'Care with Treatment Closer to Home' (CWTCH)

A key early priority for the network board is the development of 'care with treatment closer to home' (CWTCH). As described in the case for change, timely repatriation of patients to an appropriate environment remains an issue in NHS Wales. Without adequate patient flow out of specialist centres, the MTC at UHW and TU with specialist services at Morriston Hospital will struggle to automatically accept new patients. The constraints to timely repatriation were considered as part of a patient flow workshop. The next steps are described below which will need to be in place for Day 1 (unless otherwise stated):

- Acceptance of the principle that origin health boards are responsible for their patients, irrespective where they are being treated. Automatic acceptance will be treated in the same way in both directions.
- Early communication between major trauma and rehabilitation coordinator services across the system, giving notification of patients that need repatriation and their requirements. Single point of access for repatriations. Thus, helping to create a 'pull' rather than a 'push' model.
- Use of clinical informatics to enhance patient held records (e.g. discharge and rehabilitation plan) and trauma tracking (Year 1).
- A simple, easy-to-use policy with escalation measures, in which the ODN is given operational authority, augmenting any revisions undertaken to the All Wales Repatriation Policy. The network policy will require endorsement by the Chief Executive Officer of each health board.
- Building confidence in medical and nursing staff accepting patients back from specialist care, through creation of an appropriate 'landing pad' as described below. This will form the basis of a further workshop in 2019.

If the above package of interventions is successful in delivering timely repatriation whilst ensuring the highest level of patient outcome and experience, its principles could be scaled up to other areas where repatriation is currently a problem.

### 8.4.2 'Landing Pad' Configuration

The 'landing pad' describes the environment to which major trauma patients will return once their specialist care is complete (e.g. at the MTC). It includes the structures in place to support and enhance the confidence of medical and nursing staff in managing patients in the recovery, rehabilitation and

re-enablement phases of their journey. This will include patients who return to a local hospital or community. A small group of patients with complex conditions will return from the MTC to the 'landing pad' whilst waiting for specialist rehabilitation and once specialist rehabilitation is complete.

In deciding the location of the 'landing pad,' the programme team (including the network rehabilitation lead) have undertaken a number of meetings with all health boards and have provided the following guidance on the requirements for a 'landing pad':

- Inpatient beds with appropriate medical and surgical ward cover including out of hours. Surgical input to include availability of orthopaedic and general surgical review. Input from other specialties may also be required (e.g. ENT, ophthalmology and urology). Access to input from care of the elderly services will be essential.
- Access to diagnostics (e.g. CT and MRI), to aid detection of complications.
- The presence of the multidisciplinary team as indicated above supporting the 'landing pad' including consultants in Rehabilitation Medicine, major trauma practitioners, rehabilitation coordinators and balanced therapy teams.
- Network led training and education for medical and nursing staff in tracheostomy management, spasticity management, bowel and bladder care and management of behavioural disorders. Face-to-face training augmented by online delivery.
- A low stimulation environment is important to consider, with an ability to dim lighting and nurse in a low-level bed. This environment can reduce the need for additional nursing support.
- A meeting space for multidisciplinary team/family meetings.
- Appropriate wheelchair provision for short-term loans.

In considering the 'landing pad,' health boards were asked to consider the following points:

- In most cases and based on the specification for a 'landing pad' provided above, health boards were asked to consider that their TU(s) become the 'landing pad' for the health board. If not, consideration needed to be given to suitability of an alternative location in line with the guidance already provided, with appropriate mitigations. Whilst the aspiration is to have a single ward for these patients, allowing a concentration of expertise, this is unlikely to be possible by year one.
- In accordance with the All Wales Repatriation Policy, patients should already be returning to health boards (except a few with complex conditions); therefore, these do not represent new patients in the system and does not necessarily represent new capacity. Of course, this needs to be carefully balanced against the unprecedented pressures on unscheduled and social care, and the impact on capacity.
- Most TUs will see fewer patients in totality (as the number of acute patients from health boards to MTC will exceed the number of patients returning from the MTC to the health boards). Therefore, in most cases there will be no requirement for new capacity. There are some exceptions to the above, but uplift in these health boards should be proportionate to the need.
- The data presented in Appendix 1 on the bed requirements for the 'landing pad' represents a worst-case scenario. This represents the maximum number of beds required at the landing pad within existing TU capacity. Most patients will go for specialist rehabilitation from the MTC, so transfers of these patients from the MTC to the 'landing pad' will be minimum. A minimal number of patients may also go from specialist rehabilitation to the 'landing pad.'

- The true size of the 'landing pad' could be accurately quantified at this stage of the programme to determine any additional infrastructure and nursing requirements but in year one, the picture is likely to become clearer.

Based on the above, a phased approach to the development of a 'landing pad' has been agreed, where's health boards identify beds within key admitting specialties (e.g. care of the elderly, stroke, neurology, and trauma and orthopaedics), with the multidisciplinary team providing outreach. In year one, accurate data will be collected to objectively quantify the need for a single 'landing pad' and this will be subject to future planning (see Appendix 17).

### **8.4.3 Paediatric Rehabilitation**

With respect to specialist paediatric rehabilitation, this is described in the MTC case. It consists of multidisciplinary team led by a neurologist with an interest in rehabilitation at the Noah's Ark Children's Hospital of Wales, Cardiff. This team supports admissions requiring complex rehabilitation and works closely with neurology, paediatric intensive care and general paediatrics. Rehabilitation for children with non-neurological injuries at UHW is less formalised and is led by either therapy services, general paediatricians or trauma and orthopaedics. The function of this rehabilitation model will be reviewed in year one to assess whether additional resources may be required. Currently there is no capacity for organised outreach and this is recognised as a service need. However, most children will be repatriated home from the MTC and not the hospital 'landing pad.' Additional resources for consultants in rehabilitation medicine will allow outpatient reviews as part of the outreach service, linking in with the specialist paediatric rehabilitation team in Cardiff.

Children will be repatriated to local paediatric services and supported by existing community paediatric services. The additional rehabilitation support planned for TUs will support transition of affected children in the TUs back to the community. The coordinator role will be important here. In year one and two as new therapists are introduced, health boards will develop a broader skill mix with these therapists to manage children with specific rehabilitation requirements.

## **8.5 Summary of Quality Indicator Assessment and Information Requests**

As part of the TU designation process, an initial summary of key gaps against quality indicators and service specification was provided to Chief Executive's in November 2018, at the WHSC Joint Committee.

From the analysis, a number of quality indicators are already being met by the TUs or could be met through the provision of network policies and internal re-organisation of resources. Where additional resources are required as indicated above, these resources will be introduced using a phased approach. The analysis revealed that there was commonality between all TUs with respect to additional resource requirements.

Following the Gateway review, a phased introduction of additional resources is summarised below, with details provided in Appendix 18:



In place for Day 1	Year 1 – business case development (implemented years 2 – 3)	Year 2 – business case development (implemented years 3 – 5)
health board trauma clinical lead – already in place	Balanced therapies: Physiotherapy Occupational therapy Speech and language therapy Dietetic Podiatry Orthotics	Orthogeriatric review
Major trauma practitioner(s) - Band 7 - 1.5 WTE/TU (5 day service)	Psychologist/neuropsychologist	
Rehabilitation coordinator(s) – Band 7 - 1.5 WTE/TU (5 day service)	Level 2 training requirements for nurses	
TARN coordinator(s) – Band 4 – 1.0 WTE/TU		
Additional rehabilitation consultant for network (4 sessions/HB/week, PTHB – 1 session/week)		

Subsequently, all health boards were asked to develop their submissions for the Programme Business Case and any associated cases based on the above.

In order to provide assurance that the TU components of the Programme Business Case were internally scrutinised, the programme team provided written and verbal feedback on initial submissions from health boards, followed by further challenge at a network board meeting on 24 June 2019. Following the Gateway review, face-to-face meetings were held with all health board network board members to discuss and agree the key enabling requirements and approach to the 'landing pad.' Subsequent to each meeting, a summary of the discussion was sent to each health board. It was agreed that health boards would consider and provide a written response to the proposals and to confirm their intentions to appoint in-year to the key enabler roles to include in 2020/21 and subsequent Integrated Medium Term Plans (IMTPs) and to address in year resourcing.

At the time of writing, all health board network board members have confirmed their support for the key enabling requirements and approach to the 'landing pad' and discussions are underway in relation to inclusion in IMTPs and in year resourcing.

## 8.6 Cardiff and Vale University Health Board

The following is a summary of the health board's resource. The health board's TU is the University Hospital of Wales. The resource requirements set out here are because UHW already meets most of the TU quality indicators and service specification outlined above, through existing resources and staffing.

0.1 whole time equivalent clinical lead from March 2020 (consultant) for TU capability
0.5 whole time equivalent major trauma practitioners (band 7)
0.5 whole time equivalent rehabilitation coordinators (band 7)
Landing pad – UHW, no new additional resources for day 1

## 8.7 Swansea Bay University Health Board

The following is a summary of the health board's resource. The health board's TU is Morriston Hospital. Specialist services are considered in section 8.12.

0.1 whole time equivalent clinical lead from March 2020 (consultant)
1.5 whole time equivalent major trauma practitioners (band 7)
1.5 whole time equivalent rehabilitation coordinators (band 7)
1.0 whole time equivalent TARN coordinators (band 4) in addition to 0.5 WTE (band 4) already in place
0.4 whole time equivalent rehabilitation consultant
Landing pad – Morriston Hospital, no new additional resources for day 1

## 8.8 Aneurin Bevan University Health Board

The following is a summary of the health board's resource requirements. The health board's TUs are the Royal Gwent Hospital and Nevill Hall Hospital. The health board is taking a pragmatic approach ahead of the planned centralisation to a single TU site with the opening of the Grange University Hospital in 2021.

0.1 whole time equivalent Clinical lead from March 2020 (consultant)
1.5 whole time equivalent major trauma practitioners (band 7)
1.5 whole time equivalent rehabilitation coordinators (band 7)
1.0 whole time equivalent TARN coordinators (band 4)
0.4 whole time equivalent rehabilitation consultant – the requirement for consultant rehabilitation resource will be considered as part of the second phase review of clinical models including the overarching rehabilitation model and therefore not included here
Landing pad – Royal Gwent Hospital and Nevill Hall Hospital in the interim, no new additional resources for day 1

## 8.9 Hywel Da University Health Board

The following is a summary of the health board's resource requirements. The health board's TU is Glangwili General Hospital (GGH).

0.1 whole time equivalent Clinical lead from March 2020 (consultant)
1.5 whole time equivalent Major trauma practitioners (band 7)
1.5 whole time equivalent Rehabilitation coordinators (band 7)
1.0 whole time equivalent TARN coordinators (band 4)
0.4 whole time equivalent Rehabilitation consultant
Landing pad – GGH, no new additional resources for day 1 (although the health board aspires to develop a 10 bedded dedicated landing pad in future years)
In addition for day 1, the health board aspires to provide an additional 1 session for clinical leadership, 2.5 whole time equivalent physiotherapists (band 6) and 1 extra theatre session/week in anticipation of the increased flow to GGH within the health board

Bronglais General Hospital and Withybush Hospital have been designated rural trauma facilities by the health board and within the context of the network, some of which will be patients from Powys. These facilities will need to maintain the ability to assess and manage major trauma patients. Given their rural geographical location, the following measures will be put in place once the network is operational:

- A network pre-hospital triage tool to guide decision-making and trauma desk facility to provide remote support and prioritisation of face-to-face training for ambulance personnel operating in these regions. The pre-hospital triage tool will provide a safety net that patients with airway compromise or catastrophic haemorrhage will be taken to the nearest Emergency Department. Nonetheless, the above measures will support ambulance personnel taking some patients, where appropriate, to the TU at GGH.
- Confirmation of 24/7 availability of EMRTS, providing pre-hospital critical care, supporting local trauma teams and retrieval of patients to the MTC at UHW or TU with specialist services at Morriston Hospital.
- Remote telemedicine to guide management of trauma teams in rural trauma facilities ahead of arrival of EMRTS.
- An operational policy between the TU and rural trauma facilities, forming part of the network operational policy.

It is anticipated that rural trauma facilities will have a vital role to play in the network. With the above measures in place, it is expected providers will be supported and major trauma patients will receive a higher standard of care than they do currently.

## 8.10 Cwm Taf Morgannwg University Health Board

The following is a summary of the health board's resource. The health board's TUs are Prince Charles Hospital and Princess of Wales Hospital. Additional resource requirements for the two TUs have been combined below.

0.1 whole time equivalent Clinical lead from March 2020 (consultant)
3.0 whole time equivalent Major trauma practitioners (band 7)
3.0 whole time equivalent Rehabilitation coordinators (band 7)
1.0 whole time equivalent TARN coordinators (band 4)
0.4 whole time equivalent Rehabilitation consultant
Landing pad – Royal Glamorgan Hospital - no new additional resources for day 1

## 8.11 Powys Teaching Health Board

Powys Teaching Health Board has no acute hospital. All of the health board's major trauma cases will be managed by an MTC or TU outside of the health board's geographical catchment area. The health board's contribution to maintaining the trauma network will be through enabling repatriation of trauma cases for rehabilitation. Rehabilitation services in the health board are currently geared towards the elderly and those with chronic diseases. Trauma rehabilitation requires a subtly different approach and holistic organisation, which may not be best served by managing trauma patients alongside elderly and chronic disease patients. The health board may well be seeking to commission a 'landing pad' from neighbouring health boards, albeit patient numbers will be small. This remains a work in progress.

In relation to community-based rehabilitation, the health board has identified the following additional resources, augmenting existing services.

0.5 whole time equivalent Rehabilitation coordinators (band 7)
--

0.1 whole time equivalent Rehabilitation consultant
---

## 8.12 Specialist Services Support to the Major Trauma Centre

The following specialist services have been considered within the context of Morriston Hospital, as a TU with specialist services and the role it will play within the network to support the MTC to meet specific quality indicators.

### 8.12.1 Orthoplastic Surgery

The Welsh Centre for Burns and Plastic Surgery is located at Morriston Hospital. Currently there is no routine provision of emergency surgery by a plastic surgeon at UHW. A number of major trauma patients taken to the MTC will require the input of plastic surgeons. This is in keeping with requirements of a consultant plastic surgeon to be available for emergency cases within 30 minutes of the patient's arrival (T16-2B -113). Furthermore, the MTC should provide a comprehensive musculoskeletal trauma service and facilities to support all definitive fracture care and allow joint emergency orthoplastic management of severe open fractures as specified in British Orthopaedic Association Standards for Trauma and Orthopaedics (BOAST 4) guidelines (T16-2C -110).

In summary, the quality indicators indicate that for open fractures:

- A combined orthopaedic and plastic surgical approach should be undertaken for the initial debridement of the wound and stabilisation of the fracture.
- Heavily contaminated wounds require immediate debridement. Within 12 hours for isolated high energy, open fractures. Within 24 hours for all other low energy, open fractures.
- Definitive soft tissue closure or coverage should be achieved within 72 hours of injury if it cannot be performed at the time of debridement, again using a combined orthopaedic and plastic surgical approach.

Performance against these standards is monitored by TARN. In response to this, both UHW and Morriston Hospital have worked collaboratively to develop and agree a clinical service model, supported by the network board:

- Multi-system trauma patients with concurrent orthoplastic requirements – will be taken to the MTC (direct as informed by the pre-hospital triage tool or transferred from TU/LEH). Recommendations made following the professional peer review indicated that the provision for a plastic surgical presence at the MTC was an absolute day 1 requirement.
- Patients with isolated crush injury/ mangled limb/ partial or complete amputation (above wrist or ankle)/ major degloving – will be taken to Morriston Hospital (direct as informed by the pre-hospital triage tool or transferred from TU/LEH).
- Patients with isolated open lower limb (tibia/ankle/foot) fracture – recommendations derived from the professional peer review indicated that this element of the pathway could be phased for the following reasons:
  - In year 1 – the current pathways will be maintained and there will be no change in patient flow. The transfer of isolated open lower limb fractures will not be included in the pre-hospital triage tool. The reasons for this include that whilst this is an important patient

group, they are not major trauma patients and the provision of plastic surgical input into multi-system trauma patients at the MTC takes priority. Furthermore, historically, English trauma networks phased this aspect of service development. A significant proportion of isolated open lower limb fractures are transferred to Morriston Hospital already either directly or by secondary transfer.

- End of year 1 – consideration will be given to additional resource requirements to allow direct transfer of significant isolated open lower limb fractures direct from scene to Morriston Hospital. This will take into consideration any capacity released through the increased major trauma workload at the MTC, which would previously have been undertaken at Morriston Hospital.

Activity data was used to determine the resource requirements to deliver a plastic surgical presence at the MTC. Based on population data, the level of orthoplastic surgery cases requiring admission to the MTC is likely to be approximately 24 cases +/- six per annum. However, as evidenced by other MTC's there may be wider plastic surgical input once the service is established. Hendrickson *et al* (2016) demonstrated that 14% of MTC cases required plastic surgical input. Furthermore, of 227 patients an average of 3.7 procedures were carried out per admission. Given the wider benefit of establishing a plastic surgical service at the MTC it is likely that the number of cases predicted above is underestimated.

Initially the presence of a plastic surgeon will be provided for 5 days per week for 12 hours per day, in order to undertake combined orthoplastic cases, multidisciplinary team meetings and complex fracture clinics. It is accepted that this provision does not meet the quality indicators; however, out of hours and at weekends, the orthopaedic surgeon at the MTC will discuss all cases as appropriate with the plastic surgeon on call at Morriston Hospital. Patients requiring soft tissue closure or coverage either will receive this at the MTC or be transferred to Morriston Hospital, based on their clinical presentation.

The resource requirements to establish the plastic surgery service at the MTC is 4.0 WTE consultant plastic surgeons and 5.0 WTE middle grades as assessed by the professional peer review process.

### 8.12.2 Spinal Trauma Surgery

Currently there are three hospitals that provide spinal surgery: UHW, Morriston Hospital and the Royal Gwent Hospital. Following discussions between the three sites, a clinical service model for spinal trauma surgery was agreed as summarised below:

- All patients with suspected or confirmed spinal trauma and new neurology (paralysis) – direct or transfer from TU/LEH to the MTC (Spinal Cord Injury Centre). This is being addressed through the MTC case.
- Spinal fractures that require operative fixation with no neurology:
  - UHW – refer to respective spinal team locally for operative fixation.
  - Morriston Hospital and Royal Gwent Hospital – refer to respective spinal teams at Morriston Hospital and Royal Gwent Hospital.
  - Patients in Hywel Dda University Health Board hospital – refer to Morriston Hospital spinal team (transfer within 48hrs from initial admission).
  - Patients from Cwm Taf Morgannwg Health Board hospital – refer to UHW spinal team (transfer within 48hrs from initial admission).

The only change in current flows will be to Morriston Hospital. This is reflected in the Swansea Bay University Health Board case and opens up the opportunity to improve the emergency provision of

spinal surgery as a whole for South West and West Wales, which is supported by the network board and will further decompress the UHW, for non-traumatic spinal emergencies that it is otherwise currently expected to manage.

### **8.12.3 Thoracic Trauma Surgery**

The current provision of thoracic surgery is split across Morriston Hospital and UHW. Following an independent panel review and public consultation in relation to the future provision of thoracic surgery across the region, it was concluded that Morriston Hospital should be a single site for thoracic surgery. This decision post-dated the designation process for the MTC in Cardiff and questioned the ability for the standard to be met that a thoracic surgeon to be available within 30 minutes for an emergency case at the MTC (T16-2B -113). There are a number of clinical scenarios, which may require the input of a thoracic surgeon. WHSSC have agreed an interim solution (see Appendix 16) and this will ensure adequate thoracic surgical presence at the MTC for emergency cases, as the MTC is likely to be operational prior to the centralisation of thoracic surgery. Now a decision has been reached on this provision, the network board will work with both health boards to develop a clinical service model for emergency, urgent and subacute cases. Within this, consideration will be given as to the model for rib fixation and referral for complications of thoracic trauma.

### **8.12.4 Pelvic Trauma Surgery**

Current provision of urgent (i.e. next day) definitive fixation of the pelvis across the region is limited. UHW (based on self-assessment) have two surgeons with interest in pelvic surgery. Morriston Hospital has one with recognition that recruitment has been challenging. None of the other health boards has dedicated pelvic surgeons. The network board has recommended that all urgent isolated pelvic and acetabular fractures as referred to the MTC and the MTC accepts transfers as clinically appropriate for definitive fixation, noting that most of these will be next day referrals. The additional resource requirements have been confirmed in the MTC case.

## 9 Financial Case

### 9.1 Introduction

The purpose of this section is to set out the totality of costs (revenue and capital) and proposed funding arrangements to enable NHS Wales and Welsh Government to assess the total amount required, as well as the phasing of the service and supporting capital requirements. The section sets out the required investment in work towards meeting the quality indicators and service specification standards for major trauma, as well as the uplift of activity at the Major Trauma Centre (MTC).

### 9.2 Context

The Welsh Government issued clear planning guidance and financial direction to all health boards in a report to the NHS Wales Executive Board in December 2018. This formed part of the financial settlement from 2019/20 onwards, as outlined below:

#### Welsh Government directions:

- It is our expectation that the NHS in Wales will view the establishment of a trauma network and MTC as a significant priority. As such, we will be expecting Health Boards to invest strategically in this service. We are aware that provision has not been made so far within the WHSSC prioritisation for the recurrent revenue funding requirements for the service. The Health Boards have been provided with an uplift in their funding from 2019/20 and it is the expectation that this uplift will enable the implementation of strategic service developments such as major trauma to be supported.
- To aid the development of this work, we have established an internal Welsh Government policy board to facilitate cross department working, scrutiny and challenge. We are conscious there are significant time and resource constraints in relation to the delivery of this project and we expect the internal policy board to be utilised to provide collective advice and scrutiny to assist the trauma network as it develops its programme business case, policies etc. We do of course accept that it will not be possible to deliver the entirety of the project by 2020 and we will look to work with NHS colleagues to agree a sensible programme, which can deliver benefits to patients in a phased way.
- We have provided advice to the trauma network on the structure and business case process to deal with both the capital and revenue consequences arising from the Major Trauma programme. There is an expectation that an overall programme business case will be developed setting out the case for change, as well as the high-level service and revenue consequences. This does not negate the need for individual health boards to develop any individual capital business cases required to support local implementation – where known, these are reflected within the programme business case; these should be flagged with capital and estates officials within Welsh Government, as soon as possible, in line with normal processes including within health board IMTPs.
- There is an expectation set out in the national audit programme that all Health Boards should submit data to the Trauma Audit Research Network (**TARN**). Historically, Health Board participation rates in the audit have been variable. Participation in this audit is vital to the successful implementation of the trauma network. As such, Welsh Government will be paying much closer attention to this audit and we expect all health boards to review their participation and make the improvements necessary to ensure their full participation.

- The trauma network and MTC must be developed within the NHS Wales **policy context** and as such, account must be taken of existing and emerging policies such as the national work on transfers for critically ill patients. This will avoid duplication of effort within the project.
- It is also important that any service development relating to the trauma network such as investment in rehabilitation services be considered in the **wider service context** such as the development of neuro-rehabilitation and services to support patients with a prolonged disorder of consciousness.
- Finally, we understand there have been discussions about the future commissioning model for major trauma services in South Wales, West Wales and South Powys. The NHS in Wales operates as a planned healthcare system, and it would be **inappropriate for an internal market approach** such as tariffs to be used to support this development. Any commissioning mechanisms or framework must therefore work within the NHS Wales context and should not be unnecessarily bureaucratic.

### 9.3 Phasing

In assessing the need for investment in the development of the network, significant consideration has been given to the need for phasing, for both financial and operational reasons.

There is a difference between the MTC and the TUs in terms of phasing. Investment in the MTC needs to be more frontloaded, because of the need to achieve quality indicators and meet the service specification at an early stage, in order to provide the maximal benefit to the most seriously injured patients, the majority of whom will go to the MTC. By contrast, the TU resource requirements will reflect a much more phased approach, where subsequent business cases may be required, where appropriate, to meet quality indicators and elements of the service specification that cannot be met from day one.

The frontloading of resources at the MTC is also a reflection of the shift in learning and evidence base, from trauma systems nationally and internationally. This includes the need from day 1 for 24/7 trauma team leadership in the MTC, the presence of a poly trauma unit and hyper acute rehabilitation. C&V UHB will also be providing a combined adult and paediatric MTC, thus there are two sets of quality indicators to be met, with some areas of overlap and others requiring distinct resources.

It is evident that in the seven years since the establishment of the English trauma networks, there has been a substantial increase in pressure on unscheduled care. Thus, the financial case presented here is a reflection of a system already under strain, where demand often outstrips resources, leading to resources being depleted to undertake existing work.

Within the MTC case there is phasing for workforce against incremental changes in predicted activity. This is not reflected in the totality of the network revenue implications, as after year one, WAST revenue costs fall significantly.

Finally, all health boards (except C&V UHB as the MTC) will see less moderate and major trauma in totality. Whilst it is difficult to quantify releasable workforce, it is possible for health boards to consider releasable Emergency Department admissions, ward bed days, theatre sessions and critical care bed days, in terms of accepting the financial position.



## 9.4 Revenue Costs

### 9.4.1 Summary of Revenue Costs

Following the provision of information against the agreed phasing of clinical and service standards, Health Boards prepared an estimate of revenue costs and these are summarised in the table below:

**Summary of Revenue Costs**

	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
MTC Costs	£922	£10,579	£11,222	£11,222	£11,222
Specialist Services Costs	£150	£910	£910	£910	£910
Trauma Unit costs	£287	£1,278	£1,278	£1,278	£1,278
Operational Delivery Network Costs	£119	£496	£508	£513	£515
Pre-Hospital Care	£58	£1,201	£635	£640	£640
<b>Total</b>	<b>£1,536</b>	<b>£14,465</b>	<b>£14,553</b>	<b>£14,562</b>	<b>£14,564</b>

The revenue implications are further broken-down below:

<b>Summary Revenue Costs of Network</b>					
	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
Aneurin Bevan (Trauma Unit)	£51	£205	£205	£205	£205
Cwm Taf Morgannwg (Trauma Unit)	£103	£471	£471	£471	£471
Cardiff and Vale Major Trauma Centre	£922	£10,099	£10,594	£10,594	£10,594
Cardiff and Vale Major Trauma Paediatrics	£0	£481	£629	£629	£629
Cardiff and Vale (Trauma Unit)	£0	£69	£69	£69	£69
Hywel Dda (Trauma Unit)	£62	£247	£247	£247	£247
Swansea Bay (Trauma Unit)	£62	£247	£247	£247	£247
Swansea Bay Operational Delivery Network	£119	£496	£508	£513	£515
Swansea Bay Specialist Services	£150	£910	£910	£910	£910
Powys (Repatriation and Rehabilitation Facility)	£10	£40	£40	£40	£40
WAST	£58	£1,201	£635	£640	£640
<b>Total NHS System Revenue</b>	<b>£1,536</b>	<b>£14,465</b>	<b>£14,553</b>	<b>£14,562</b>	<b>£14,564</b>

The above costs have been derived through an iterative process of reviewing the gap between commissioning expectations and provided costs. It is important to stress that the TU costs presented do not include all of the costs associated with moving in a phased manner to full TU compliance with quality indicators and all aspects of the service specification. Such additional costs, which are not currently known, will need to be subject to additional TU specific business cases over the period of implementation.

The local trauma unit costs for Hywel Dda UHB reflect the key enabling posts for Day 1, however the Health Board aspires to invest in an additional clinical leadership session, 2.5 whole time equivalent physiotherapists and an additional theatre session per week to meet an anticipated demand upon GGH. Further rehabilitation investment has also been identified. The Health Board are looking to develop 10 landing pad beds, which will be phased in year 1 and year 2. The revenue costs that the Health Board have identified locally for staffing of these additional rehabilitation and landing pad staffing costs over and above the costs in the case is £8k in 2019/20, £268k in 2020/21 and £1,457k in 2021/22.

Furthermore, SBUHB have confirmed that the ongoing cost for expanding the South West Wales Spinal Service will be managed between HDUHB and SBUHB.

The above costs include recurring funding already released in-year (as part year costs) during 2019/20 for key enabling posts and preparation for Day 1. This funding, as shown below, has been approved in two tranches through the WHSSC Joint Committee process (therefore signed-off by all Health Board Chief Executives):

<b>Tranche</b>	<b>2019/20 part year funding (£000s)</b>	<b>Full year funding from 2020/21 (£000s)</b>
Tranche 1	675,000	1,993,000
Tranche 2	441,000	3,006,000
<b>Total</b>	<b>1,116,000</b>	<b>4,999,000</b>

\* Released subject to approval of the programme business case to allow recruitment processes to commence in the meantime

The preferred MTC model also creates the potential for further efficiencies to be delivered at the trauma units who will in future be transferring current activity to the MTC. Further work will be undertaken by the finance group to assess how such opportunities can be realised in practice. Possible opportunities include reduced in patient stays and reduced front door activity. It will be important that health boards have systems in place to capture these potential benefits as they will need to re-deploy resources internally into improved landing pad activities to enable timely repatriation from the MTC.

## 9.4.2 Summary of Revenue Funding Arrangements

The finance sub group agreed that the figures in the sub section above would form the basis of the initial distribution, subject to further work to determine if there was an appropriate direct contribution to the MTC costs in relation to the C&VUHB's own trauma unit costs. The distribution would then be subject to review in the light of actual utilisation patterns experienced in year one and beyond and the subsequent application of the agreed risk sharing principles for regional services.

### 9.4.3 Benchmarking

The costs of the MTC were benchmarked against real world finance and activity data from the flow of the North Wales population to the Stoke MTC. The method to determine this benchmark used detailed actual charges for a complete financial year for a whole population in order to base it on a reliable and representative case mix. The charges included in the comparator included the full costs of critical care, all procedure costs from core specialty activity and the best practice tariff charges payable under the English PBR system. All charges were at 2018/19 prices and reflected national tariff rules together with any variation needed for local prices. The resulting dataset only included those cases that ultimately attracted major trauma best practice tariffs to ensure a like for like comparison. The dataset comprised 105 cases which included 45 for MTC level 1 and 60 cases for the higher severity level MTC level 2. The average unit prices were £23,576 per case for MTC level 2 (ISS>15) and £12,083 per case for MTC level 1 (ISS 9<15) with an overall average of £18,650 per case. These benchmark units' costs have been applied to business case activity as follows to illustrate a range of expected values:

<u>ISS 9-15 – moderate</u>	<u>Assumed current position</u>	<u>@ Average Tariff Cost £</u>	<u>Year 1</u>	<u>@ Average Tariff Cost £</u>	<u>Year 1 Additional Cases</u>	<u>Additional Cases @ Average Tariff Cost £</u>	<u>Year 2</u>	<u>@ Average Tariff Cost £</u>	<u>Year 3</u>	<u>@ Average Tariff Cost £</u>
Direct to MTC	154	1,860,782	206	2,489,098	52	628,316	231	2,791,173	256	3,093,248
Transfer TU to MTC	11	132,913	58	700,814	47	567,901	58	700,814	66	797,478
<b>Total</b>	<b>165</b>	<b>1,993,695</b>	<b>264</b>	<b>3,189,912</b>	<b>99</b>	<b>1,196,217</b>	<b>289</b>	<b>3,491,987</b>	<b>322</b>	<b>3,890,726</b>
<u>ISS &gt;15 – major</u>	<u>Assumed current position</u>		<u>Year 1</u>				<u>Year 2</u>		<u>Year 3</u>	
Direct to MTC	284	6,695,584	306	7,214,256	22	518,672	341	8,039,416	368	8,675,968
Transfer TU to MTC	49	1,155,224	219	5,163,144	170	4,007,920	219	5,163,144	193	4,550,168
<b>Total</b>	<b>333</b>	<b>7,850,808</b>	<b>525</b>	<b>12,377,400</b>	<b>192</b>	<b>4,526,592</b>	<b>560</b>	<b>13,202,560</b>	<b>561</b>	<b>13,226,136</b>
<u>ISS &gt;9 – candidate</u>	<u>Assumed current position</u>		<u>Year 1</u>				<u>Year 2</u>		<u>Year 3</u>	
Direct to MTC	438	8,556,366	512	9,703,354	74	1,146,988	572	10,830,589	624	11,769,216
Transfer TU to MTC	60	1,288,137	277	5,863,958	217	4,575,821	277	5,863,958	259	5,347,646
<b>Combined Direct to MTC &amp; Transfer TU to MTC</b>	<b>498</b>	<b>9,844,503</b>	<b>789</b>	<b>15,567,312</b>	<b>291</b>	<b>5,722,809</b>	<b>849</b>	<b>16,694,547</b>	<b>883</b>	<b>17,116,862</b>

The new MTC will be delivering the full range of activities across ISS 9<15 and ISS>15 and hence both should be taken together in comparing to expected costs for the MTC. In making a like for like comparison with the MTC business case the following also needs to be taken into account:

- The existing cost base for the MTC at UHW. Including baseline costs for trauma, emergency care department costs and critical care.
- The majority of isolated neurosurgery cases will be dealt with as per the current pathway under the neurosciences contract.
- The major trauma pathway from the Stoke centre includes agreed standards for appropriate discharge back to local services within the BCUHB area. Patients with an ISS>15 had an

average length of stay of 10.9 days (non-neurosurgery cases excluding critical care). Critical care length of stay averaged 4.0 days.

- The new UHW MTC will be meeting the requirements for increased activity which is anticipated to rise each year. The value of additional activity delivered over the period would be equivalent to circa £5.7m to year 1 (+291 cases); £6.8m to year 2 (+291+60 cases); and £7.5m to year 3 (+291+60+34 cases).
- The new UHW MTC total activity including baseline will deliver activity valued at £15.6m (year 1 - 789 cases); £16.7m (year 2 - 849 cases), £17.1m (year 3 - 882 cases).

### Unit Costs

The costs forecast for the MTC, Specialised Services and ODN components of the business case total £11.984m in year 1, £12.640m in year 2 and £12.645m in year 3. Activity is forecast to increase to 789 cases by year 1, 849 by year 2 and 883 by year 3. Resulting incremental units costs are therefore £15,189 for year 1, falling to £14,888 for year 2 and £14,320 by year 3. These incremental costs are within the comparator derived from the costs of the benchmark service of £18,650 per case. However, inclusion of baseline costs set out below are likely to take the gross overall unit cost to above the benchmark level.

The baseline contracting currencies used by CVUHB to contract for major trauma lack detail, vary between health boards and it is difficult to match TARN activity data retrospectively to contracting data. Hence it has not been possible for CVUHB to place an accurate value on the current baseline. However, the following baseline unit cost data is useful in comparing the above incremental cost of the MTC to the benchmark comparator:

- CVUHB current non elective trauma unit prices average at £3,960 per case.
- CVUHB critical care unit prices average £1,935 per day with a marginal rate of £1,225 per day.
- Emergency unit contracts are on a block basis hence no unit cost data is available.

### 9.4.4 Financial Risk Sharing

The financial risk share arrangements for the Major Trauma Centre, Swansea Bay Specialist Services and Wales Ambulance Services NHS Trust are based on WHSSC standard formula, the impact of which is outlined below:

Health Board	Risk Share
Cardiff and Vale UHB	20.77%
Swansea Bay UHB	18.44%
Cwm Taf Morgannwg UHB	17.23%
Aneurin Bevan UHB	25.36%
Hywel Dda UHB	16.80%
Powys THB	1.40%
<b>Total</b>	<b>100.00%</b>

The required revenue funding from each health board on the risk share basis, plus all currently known local costs for the development of the TUs is reflected below:

<b>Summary of funding of Trauma Network by Health Board</b>					
<b>Reflects local Trauma Unit / Rehabilitation costs plus share of Major Trauma Centre, Specialist Services and WAST Pre-hospital care</b>					
	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
Aneurin Bevan	£353	£3,549	£3,571	£3,573	£3,574
Cwm Taf Morgannwg	£308	£2,743	£2,758	£2,759	£2,760
Cardiff and Vale	£247	£2,808	£2,826	£2,828	£2,829
Hywel Dda	£262	£2,462	£2,477	£2,479	£2,479
Powys	£27	£225	£226	£226	£226
Swansea Bay	£281	£2,678	£2,695	£2,696	£2,697
WAST (2019/20 funded by Welsh Government, year 1 onwards by Health Boards)	£58	£0	£0	£0	£0
<b>Total NHS System Revenue</b>	<b>£1,536</b>	<b>£14,465</b>	<b>£14,553</b>	<b>£14,562</b>	<b>£14,564</b>

EASC have confirmed that the funding for the 2019/20 costs for the WAST business case will be funded by Welsh Government. The risk share calculations are assumed to be the same as WHSSC. Year 1 revenue implications are being considered within the context of this programme business case.

#### 9.4.5 Outstanding Issues Impacting on Revenue Costs and Apportionment

The costs and funding shares above do not take account of the several factors outlined below, as sufficient information is not yet available:

- Increased RTA income to C&VUHB resulting in lower net costs, offset by equivalent reduced RTA income to other health boards. This has no net overall effect to NHS Wales, but does result in a change to the financial impact on each health board. The planned approach to reflect this is to monitor changes in RTA income during 2020/21 by the health board, and adjust net costs and commissioning flows to reflect the changes identified.
- The impact of the planned earlier repatriation of patients from the MTC to TUs/'Landing Pads' for repatriated patients is taken account of in the business case in respect of the projected additional patients triaged to the MTC, but is not taken into account in respect of earlier repatriation of existing major trauma patients treated at UHW. Therefore, if the implementation of the repatriation protocol and pathway is fully successful, there would be a reduction to bed requirements within the MTC from that assumed in the business case. Conversely, if earlier repatriation is not achieved, there would be an increase in the bed requirement. The level and timing of repatriation will be monitored during year one, and consideration given whether the bed planning and associated resourcing plans need to be amended in year two.
- The phasing of costs is based on a 1 April 2020 implementation, with all additional year 1 staffing being in place by this date. It is inevitable that there will be a degree of slippage which will reduce year 1 costs to some extent. Tracking of the additional costs during year 1 will be put in place until all staff and associated costs are being incurred, and only actual costs incurred will be funded.
- The costs do not include capital charges associated with capital expenditure (see also below). It is assumed that these will be funded directly by the Welsh Government as with all capital schemes.
- There are areas within the MTC business case where further review of detailed staffing plans and costs is still being undertaken (largely around ED consultant numbers). These could

potentially impact year 2, but would not impact on year 1. The final outcomes of this review will then be reflected in the year 2 costs.

- There may be further operational efficiencies resulting from the introduction of the Paediatric TU which could reduce local beds requirements within UHW. It is important that these potential further efficiencies are tracked and benefits shared appropriately.
- The costs included in the SBUHB case for specialised services include the significant overhead of locating up to four plastic surgeons at the MTC. In practice, in order to fully utilise this resource, there is likely to be a change the balance of activity undertaken at the current SBUHB plastic surgery service and at the MTC. This may result in an offset in costs from a reduction in activity and cost at the SBUHB service, but this cannot be accurately determined at this time until the actual case mix of the MTC activity becomes clearer.
- The SBUHB specialised services business case includes the cost of five middle grades at 100%, assuming no deanery funding. This has not been approved in principle by WHSSC Joint Committee at this point, but is included for planning purposes.
- The Cardiff MTC case reflects additional revenue costs of £352k that are expected to arise following submission of the capital case to Welsh Government. These figures have not been approved in principle by WHSSC Joint Committee at this point but are included for planning purposes.

## 9.5 Contracting Arrangements

WHSSC, working with the finance sub group of Health Boards, will continue to develop contracting arrangements that will determine an appropriate contracting and funds flow model that will replace the current trauma income flows into C&VUHB. A system will be designed which will continue to provide baseline income which is not duplicated by the addition of the MTC business case funding. This will be a complex process as there is significant uncertainty as to the value of current income flows and the overlap of these with MTC designated activity.

## 9.6 Capital Costs

### 9.6.1 Summary of Capital Costs

Strategic capital funding of £6,414m through Welsh Government (rather than locally funded through discretionary capital) is outlined below:

Programme Capital Requirements	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
MTC Cardiff & Vale (MTC Construction and Equipment)	£5,426				
Hywel Dda Trauma Unit (West Wales General)			£1,252		
<b>Capital Total</b>	<b>£5,426</b>	<b>£0</b>	<b>£1,252</b>	<b>£0</b>	<b>£0</b>

C&VUHB has identified the following 2019/20 capital requirements for estate and equipment:

#### Cardiff & Vale Capital Requirements 2019/20

	Construction	Equipment	Total
	£000s	£000s	£000s
Emergency Unit - Resus Bay Equipment Costs	£0	£134	£134
Extension, resus, streaming and triage bay refurbishment	£436	£0	£436
Room alterations to provide additional minors capacity	£150	£0	£150
Interim refurbishment of Poly trauma Unit (PTU) 14 beds	£1,109	£383	£1,492
Critical Care bed expansion – Equipment only	£0	£194	£194
Theatres – Capital equipment inc plastics	£0	£1,100	£1,100
Theatres - Image Intensifier	£0	£120	£120
Replacement scanner for Emergency Unit	£600	£1,200	£1,800
	<b>£2,295</b>	<b>£3,131</b>	<b>£5,426</b>

Further C&VUHB capital requirements for the construction and equipping of a major trauma theatre are being developed by the Health Board. The expected timeline for submission of these detailed cases is reflected in the timetable of business cases. The estimated future capital requirement for the MTC theatres at the time of publication is in the region of £20-25m. Note that this is an integrated capital scheme which includes the vascular hybrid theatres and this will be considered within a full business case submission by C&VUHB.

Hywel Dda University Health Board has identified £1,252k for the development of a 10 bedded 'landing pad' in year 2 (2021/22) at Glangwilli Hospital, Carmarthen. However, it is envisaged that the year 1 approach will be in keeping with all other Health Boards, with consideration given to a dedicated 'landing pad', as appropriate, following a period of evaluation of actual activity.

### 9.6.2 Capital Charges

C&VUHB has indicated that there will be a summary of capital charges once the Capital, Estates and Facilities Division of Welsh Government has confirmed the final capital award. C&VUHB expect that there will be Welsh Government funding for these capital charges.

## 9.7 Timetable of Future Business Cases

The timetable of future revenue and capital business cases that will be prepared by the appropriate organisations is outlined below and is further considered in the management case chapter. Whilst at this stage it is difficult to quantify, this gives an indication of the potential cases that would need to be considered as part of the phased network development.

[illegible]



## 10 Economic Case

### 10.1 Introduction

There are two sections in this Economic Case, the first describing the costs effectiveness and value for money of establishing a trauma network for South Wales, West Wales and South Powys, based on evidence from comparable systems. The second section of this chapter summarises the range of options considered as part of the historical work undertaken to develop a preferred operational model for achieving the stated investment objectives, offering the best value for money, based on both qualitative and quantitative analysis. This was undertaken in accordance with HM Treasury guidance. Within the context of this, a 'do nothing' option was considered.

More recently, it is important to note that in relation, to developing the stated clinical service model, the approach has been based largely on phasing of pre-defined quality indicators and service specification over a period, rather than considering a range of options per se. This is mainly because the development of quality indicators and service specification lends itself better to a phased approach rather than an options appraisal. Furthermore, as decisions were taken in March 2018 to proceed with the development of the network and decisions were then taken in relation to the location of the MTC, it was not possible to consider a 'do nothing' option moving forward.

Nonetheless, the programme has where possible, looked at options in the context of individual business case submissions. Examples of this include considering a range of options in terms of developing a consultant trauma team leader rota at the MTC (see Appendix 16), plastic surgical provision at the MTC and SWOT (strength, weakness, opportunity, threat) analyses in relation to the configuration of trauma desk function and face-to-face training by the Welsh Ambulance Service.

Thus, this chapter sets out the case based the best available evidence and both current and historical options appraisal of operational and clinical modelling.

### 10.2 Evidence from Established Trauma Systems

Major trauma networks in England have resulted in an 18% increase in the probability of surviving trauma for the 54 million population of England. This equates to around 500 additional survivors per year. Pre-hospital triage and transfer protocols have resulted in a significant increase in patients treated at an MTC from 13,358 in 2011 to 26,486 in 2016. Networks have also facilitated rapid dissemination of evidence-based practice. Independent, socioeconomic analysis has calculated the cost effectiveness of the system at £2,500 per Quality Adjusted Life Year (QALY).

With enhanced investment across the trauma pathway (including rehabilitation), there is evidence of improvements in functional outcome, a reduction in ongoing healthcare requirements and improving ability to return to work. Gabbe *et al* (2015) demonstrated that 10 years after introducing the Victorian State Trauma Service, there was a cost saving per case of \$633,446 in 2010-2011 compared with 2001-2002, owing to increased disability-free years.

Taylor *et al* (2012) demonstrated that Helicopter Emergency Medical Services working within the context of a mature trauma system resulted in a reduction in hospital mortality leading to a cost per life saved of \$1,566,379 in all patients: \$533,781 in patients with serious injury and \$519,787 in patients with traumatic brain injury. The cost savings are not related to just additional patients who survive, but to all patients who survive. With improvements in rehabilitation, enhancements in functional recovery will be seen across a wide group of patients.

Furthermore, there are a number of studies demonstrating cost effectiveness of rehabilitation interventions. Wood *et al* (1999) demonstrated an estimated lifetime saving in the cost of care of over £1 million for each patient receiving neuro-rehabilitation with good functional outcome. The same trend has been demonstrated in other studies related to the provision of neurorehabilitation.

With an estimated 14 additional lives saved across the network per year, this is likely to equate to a cost per life saved of approximately £17 million, with the economic benefits from improving functional outcomes to be quantified as part of the benefits realisation plan.

A critical question that the network board has considered is whether the establishment of the network will be a cost effective intervention and bring value. Given the required additional investment to improve quality of care through meeting higher standards of care, this is an important question to consider. This issue can be considered through two distinct, but related, lenses:

- For a given investment, what is the likely return on that investment?
- For a given investment, what is the value that the network will bring?

In demonstrating the above, it is important to demonstrate how these elements will be measured in the context of major trauma.

### 10.3 Cost Effectiveness

In relation to the return on investment, there is consistent national and international evidence indicating that the establishment of trauma networks is cost effective.

Durham *et al* (2006) evaluated the cost effectiveness of mature trauma system in Florida, and demonstrated costs per lives saved comparable to or lower than other major public health expenditures.

Rotondo *et al* (2009) demonstrated a similar experience. It is important to note that these early studies focused on the economic benefit of lives saved and not necessarily on the whether those patients that survived had a poor functional outcome and therefore increased the burden of disease. However, it is clear from more recent evidence that survival does not necessarily increase the disability burden. With enhanced investment across the trauma pathway (incl. rehabilitation), there is evidence of improvements in functional outcome and therefore, reducing ongoing healthcare requirements and improving ability to return to work. Gabbe *et al* (2015) demonstrated that after 10 years of introducing the Victorian State Trauma Service, there was a cost saving per case of \$633,446 in 2010-2011, compared with 2001-2002, owing to increased disability free years.

If the focus turns to an MTC, within a mature trauma system, then investment in the MTC in itself is cost-effective, with evidence of a 5 to 15 fold return on investment for each patient successfully returned to work. In terms of cost per life year saved, regionalised MTC care costs significantly less than the provision of renal dialysis, breast cancer treatment or the percutaneous or surgical management of coronary artery disease and is cost-effective when compared with the provision of other medical interventions (Mackenzie *et al*, 2010, Seguin *et al*, 1999, Zarza *et al*, 2010). Mackenzie *et al* prospectively demonstrated cost effectiveness of MTC's in the United States with a Quality Adjusted Life Years (QALY) of \$36,961 (US system costs).

Whilst mature international systems give a clear signal towards cost-effectiveness, the challenge remains of how comparable are they with trauma systems in the UK, which will be more similar to the South Wales Trauma Network. A recent UK based study sheds some light on this issue. An NHS England economic evaluation of regional trauma networks was published in 2013. Over the period of the study, there was an increase in the number of patients surviving major trauma and QALY increased as a

result. It also noted that, on average, the NHS investment appears to range between £5,241 - £5,679 per additional QALY gained. This suggests that the introduction of English trauma networks has been cost effective, given that it is significantly under the NICE QALY threshold for cost effectiveness of £20,000. Based on the expected number of 'candidate' major trauma patients (2,112) across the entire South Wales Trauma Network, the investment is significantly below the NICE QALY threshold of £20,000 (£6,896 per additional QALY gained), comparable with other interventions (e.g. hip and knee replacements). Whilst comparison with NHS England is challenging, given differences in how healthcare is commissioned, there is a clear signal that, by applying the NHS England quality indicators and service specification, to a comparable level of costs effectiveness in NHS Wales based on the NICE QALY threshold could be achieved.

It should also be noted that, in the 7-9 years that have elapsed since the English trauma networks have been developed, there has been ongoing investment and incentivisation of the system, based on lessons learnt. These investments have been slow to progress, but started in rehabilitation and TUs. There have been further enhancements in standards (e.g. Orthogeriatric assessments, poly-trauma wards). It is clear that with investment planned across the pathway for the South Wales Trauma Network, it is predicted that there will be a greater gain in terms of returning survivors to higher levels of function and this will allow them to contribute positively to the economy. Therefore, the cost effectiveness demonstrated in England is likely to be further enhanced. There is also a range of benefits to wider rehabilitation services as the investments and raising of standards in rehabilitation, driven by the establishment of the South Wales Trauma Network, will positively impact a wider range of patients and services.

As discussed in chapter three and based on experience of enhanced survival in NHS England, approximately an extra 14 lives will be saved per year, over and above the current position. For the given investment, this would equate to a cost of lives saved of approximately £17 million per year. Thus, the service will pay for itself in terms of economic benefit. What is more challenging to understand, is the totality of improvement in functional outcomes for all survivors with investment across the pathway, and how this could lead to cost avoidance in long term rehabilitation and social care. Whilst predicting that the network will be cost effective, how this could be objectively measured needs further consideration.

With investment across the pathway and the requisite clinical informatics requirements, development of the South Wales Trauma Network presents a unique opportunity to evaluate the cost effectiveness of the whole system and not just its component parts in isolation. The development of a research programme, not just including TARN and TARN PROMS/PREMS data, but longer term outcomes, will give the network an opportunity to identify reductions in health and social care utilisation, leading to a broader evaluation of economic value. Material links with academic centres such as Swansea University already exist, through the Secure Anonymised Information Linkage (SAIL) Databank, and network opportunities with the Victorian State Trauma Service (above), present attractive opportunities for the network. Of course, some key aspects need to be in place in order to be able undertake a long-term evaluation of any system. Firstly, a strong appetite for research, with a robust platform for collecting high quality data, secondly, time for a stable and mature system to develop and finally, getting the building blocks in place for the system to work collaboratively and in synchrony. These are key aims of the network and align with key investment objectives.

## **10.4 Value of the Network**

Linked to cost effectiveness of the network, value will come from realising benefits, which form a significant part of chapter three and has been developed further in the management case, into a

comprehensive benefits realisation plan. Whilst it is imperative that the network focuses on the key investment objectives of improving survival and functional outcomes, one of the areas that will be measured are the wider system benefits. This will focus on the enhancing and adapting of existing and new roles within the workforce, cross health board working arrangements, the development and deployment of highly specialised posts and natural improvements in other areas of healthcare (e.g. spinal surgery, plastic surgical capability, and rehabilitation of non-traumatic complex neurological problems). It is helpful that there will be a fundamental shift in the way networks operate in Wales, with the opportunity for others to benefit from the learning that will take place during the lifetime of the programme and beyond. Whilst difficult to quantify, qualitative analysis of these benefits will be undertaken to demonstrate wider value.

## **10.5 Options in Developing the Operational Model**

### **10.5.1 Development of options/recommendations for the location of the Major Trauma Centre**

#### **Initial work**

In late 2014, the NHS Wales Health Collaborative was asked by the Chief Executives in NHS Wales to develop a service model for a major trauma network for South Wales, West Wales and South Powys.

North Wales and North Powys were not included in the project. Betsi Cadwaladr University Health Board was already part of the North West Midlands and North Wales Major Trauma Network, with patients in North Wales having access to the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the North West Midlands and North Wales Major Trauma Network and access treatment and care via the trauma unit in Shrewsbury. Some patients in Powys are also served by the Birmingham, Black Country, Hereford and Worcester Trauma Network.

A Project Board was established, supported by a Clinical Reference Group (CRG). The service model for major trauma services for adults and paediatrics was developed by the CRG, in line with the NHS England standards for major trauma, and approved by the Project Board in May 2015, with further work on phasing undertaken more recently.

#### **Option Appraisal**

In June 2015, an option appraisal workshop, led by clinicians, was undertaken which identified the need for a major trauma network with a major trauma centre based in the region to support the population of South and West Wales and South Powys.

The workshop included health boards, the Welsh Ambulance Service NHS Trust (WAST) and invited patient representatives from voluntary and charity support groups, and the Community Health Councils were also invited to observe.

The workshop considered five options:

- Do nothing
- No major trauma centre in the region, but patients would access services in England (Bristol)
- One major trauma centre for the region based at Morriston Hospital, Swansea
- One major trauma centre for the region based at University Hospital of Wales (UHW), Cardiff
- Two sites, based at Morriston Hospital and University Hospital of Wales (UHW).

The benefit criteria applied at the workshop were:

Benefit Criteria	Definition/Coverage	Weighting %
<b>Quality &amp; Safety</b>	Meets agreed clinical, quality and safety standards; Compliance with legislation, regulations and accreditation standards / performance; Supports rapid adoption of best practice; Clinical effectiveness, including:- <ul style="list-style-type: none"> <li>• Delivers improved outcomes for patients;</li> <li>• Supports R&amp;D;</li> <li>• Improves consistency in clinical practice</li> </ul>	35
<b>Equity</b>	Service meets potential differential impact on protected groups. Timeliness of access to specialist care for all patient groups / improvements in standards for specific patient groups	10
<b>Strategic fit</b>	Services delivered within network of integrated care; In line with outcomes of the South Wales Plan and other emerging service models. Does not destabilise other clinical services / developments;	15
<b>Sustainability /Future proof</b>	Availability of appropriately trained and skilled workforce; Service provided by a workforce which is “fit for purpose”, re European Working Time Directive (EWTD) and clinical training standards; Attracts and retains an excellent workforce across all staff groups; Delivers the critical mass required to achieve full benefit from resources and investment; Does not destabilise other clinical services / developments; Provides business continuity and service contingency in the event of a major incident, etc.	25
<b>Access</b>	Access to services is optimised. Service capacity will meet demand in a timely way Service will be delivered in an appropriate environment Suitable and timely transport for transfers between the MTC and trauma units; Avoidable transfers minimised.	15
<b>Total</b>		<b>100</b>

The participants in the workshop determined that the preferred option was a MTC on a single site based within the region and supported by a number of TUs:

Option	Base option appraisal (out of 200)	Reverse weighting		Equal weightings (out of 200)	Non average scores for detailed sub benefits (out of 1,020)	Non average scores AND equal weightings (out of 920)	Individual group scores		Add 5% to option 2 (up to maximum) (out of 200)
		a. With Strategic Fit weighted higher (out of 200)	b. With Access weighted highest (out of 200)				Groups 1 / 3 / 5 (out of 200)	Groups 2 / 4 / 6 (out of 200)	
1. Do nothing	34.2	43.3	45.0	40.0	167.5	180.0	18.5	49.8	34.2
2. Single site - UHW	176.5	169.4	168.8	172.0	910.0	800.0	177.3	175.7	184.9
3. Single site - Morriston	179.7	176.8	177.1	177.3	922.5	820.0	180.3	179.0	179.7
4. Dual site - UHW & Morriston	107.7	118.1	123.8	118.0	527.5	530.0	94.5	120.8	107.7
5. Outsourced service	89.8	84.3	88.3	86.3	472.5	410.0	94.7	84.8	89.8

Full sensitivity analyses are included in Appendix 7.

The workshop did not result in a recommendation on a preferred location for the MTC. However, in identifying the preference for a single site, Morriston Hospital, Swansea and University Hospital of Wales (UHW), Cardiff, were assessed to be the only two hospitals in the region that could potentially meet the criteria for a major trauma centre, due to the specialist nature of the service and the need for it to be co-located with relevant specialist services. This aligns with the analysis presented the above table.

The workshop agreed that, to support a population of approximately two million (deemed the minimum critical mass for sustainability) the network would need to be supported by a MTC located within the region. This ruled out the option of relying on services from the Bristol MTC. The potential for a dual site solution was considered, but eliminated because the critical mass for sustainability could not be delivered through such an arrangement.

### The Independent Panel

Building on the earlier work, an Independent Panel of specialists from across trauma and rehabilitation services in the UK ('the Independent Panel') was commissioned by the Collaborative Board (Chief Executives), on behalf of health boards in the region, to review the information and evidence available and make a recommendation on the preferred location of a MTC in the region.

Health boards in the region considered a formal report in January 2017. This report asked boards to note the arrangements for the Independent Panel to consider the evidence regarding the establishment of the proposed major trauma centre and to bring forward a recommendation of a preferred option for public consultation. This was supported by all health boards in the region.

The Independent Panel convened in February 2017, chaired by the National Clinical Director for Trauma to NHS England. The Independent Panel comprised representatives from across major trauma services in the UK. Panel members were selected based on their national and international reputations as experts in trauma care and the development of trauma systems and having previously been involved in the development of regional major trauma systems.

Representatives were invited to attend from health boards, Public Health Wales, the Welsh Government, Community Health Councils (as observers), Emergency Medical Retrieval and Transfer Service (EMRTS), Welsh Ambulance Service Trust (WAST), Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC).

The Independent Panel was asked to undertake the following:

- Review the service model and specification for major trauma services for adults and paediatrics, across the region.
- Consider supporting evidence from Abertawe Bro Morgannwg UHB and Cardiff and Vale UHB for the provision of a MTC at Morriston Hospital, Swansea or the University Hospital of Wales (UHW), Cardiff as part of the major trauma network for the region
- Provide an independent view on the two options for the location of the MTC.
- Provide a view on the phasing of any implementation requirements and priorities for investment within a MTC.
- Advise on the impact on remaining services at Morriston Hospital and UHW Hospital in the event they are not identified as the MTC.
- Advise on the preferred location of a MTC for the region.

### **Recommendations from the Independent Panel for a Major Trauma Network**

After considering the evidence, the Independent Panel made the following five recommendations in their report:

- A major trauma network for South and West Wales and South Powys with a clinical governance infrastructure should be quickly developed.
- The adults and children's major trauma centres should be on the same site.
- The major trauma centre should be at University Hospital of Wales, Cardiff.
- Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network.
- A clear and realistic timetable for putting the trauma network in place should be set.

In making their recommendations, the panel identified three main factors that should shape the design of a major trauma network:

- Clinical interdependencies, i.e. the services that need to be available at the location of the MTC, as set out in the relevant standards
- Critical mass, i.e. the minimum number of people needed to make a service, in this case major trauma, sustainable.
- Travel times: The Panel considered the geography of Wales and concluded that, with the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the MTC.

The panel concluded that providing specific highly specialist services, such as neurosurgery and paediatric neurosurgery, on the same site as the major trauma centre was the main factor in deciding where to locate the centre. It is important to have these specialist services available immediately if you suffer a major trauma. Providing these services on the same site is a minimum requirement.

health boards formally received a copy of the report from the Independent Panel alongside their recommendations for consideration at their board meetings in September 2017. They were asked to agree, in principle, to the recommendations from the Independent Panel, and, in doing so, agree to a period of consultation on the recommendations of the Independent Panel. All health boards agreed,

in principle, to the above recommendations of the Independent Panel as the basis for a formal consultation.

### Consultation Process

As the proposals were deemed as substantial service change, a full consultation of twelve weeks was required. The process was designed in accordance with the 'Guidance on Engagement and Consultation on Changes to Health Services'. The Collaborative Leadership Forum considered the process, the six health boards in the region and the six Community Health Councils. As a collaborative process, Health Boards and Community Health Councils (CHCs) agreed that a consistent approach should be taken by all, ensuring equality of opportunity for all populations groups regardless of geographical location.

The consultation process took place between November 2017 and February 2018.

The outcome of the consultation was analysed and the recommendations developed as a result, i.e. to support the recommendations of the independent panel (detailed above), were reported and approved by the six health boards in the region in March 2018.

## 10.5.2 Designation of Trauma Units

With clarity on the location of the Major Trauma Centre (MTC) at University Hospital Wales, a decision was made by Network Board to commence the process for Trauma Unit (TU) designation, in order to inform programme-planning, preparation for delivery and ensure rapid implementation.

In May 2018, the network board requested that Health Boards complete a baseline assessment against NHS England quality indicators for those hospitals that were being proposed as 'candidate Trauma Units.' Information was provided as to which indicators needed to be met for day one and which could follow once operational.

Following due diligence and scrutiny, recommendations for TU designation were made in November 2018 to WHSSC Joint Committee and endorsed. In respect of Hywel Dda, a period of engagement was undertaken from June to August 2019 on TU designation, which resulted in recommendations being reported to and supported by the health board in September 2019.

TU designation has been based on which hospitals most closely comply with the NHS England quality indicators and service specification, and achieve alignment with health boards existing and future plans, as follows:

Cardiff & Vale University Health Board	
University Hospital Wales (UHW) - Adult and Paediatric TU	Rationale: it is important that in addition to being an MTC, UHW's TU capability is considered separate from its MTC capability. UHW has been chosen due to availability of onsite services and specialities that are not available at Llandough hospital.



<b>Swansea Bay University Health Board</b>	
Morrison Hospital – Adult and Paediatric TU (with specialised services to be considered in subsequent programme planning)	Rationale: the independent panel review indicated that Morrison Hospital would be a large TU. The designation is in line with the current local and regional role in providing trauma care and in line with the emerging clinical strategy for the Health Board.

<b>Aneurin Bevan University Health Board</b>	
Royal Gwent Hospital – Adult and Paediatric TU	Rationale: Royal Gwent Hospital and Nevill Hall Hospital will be designated TUs to cover the interim period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Health Board. As such, a pragmatic approach will be required on how additional TU requirements are met during the short interim period and this will form part of the implementation phase of the network development. The Health Board has indicated that they will consider, in principle, the impact on patients within the region without a nearby TU and how this could be managed through network protocols.
Nevill Hall Hospital – Adult and Paediatric TU	
Grange University Hospital – Adult and Paediatric TU	

<b>Cwm Taf Morgannwg University Health Board</b>	
Prince Charles Hospital – Adult and Paediatric TU	Rationale: Prince Charles Hospital is the only potential site between South Powys and the M4 corridor. The area covered by the Health Board is often sites of high-speed road traffic collisions and major trauma.
Princess of Wales (POW) Hospital – Adult and Paediatric TU	Rationale: in anticipation of the move the management of POW hospital from the former ABM UHB to Cwm Taf Morgannwg UHB from April 2019, both outgoing and incoming Health Boards supported the designation of POWH as a TU.

Royal Glamorgan Hospital will be a Local Emergency Hospital for the purposes of major trauma.

Hywel Dda University Health Board	
Glangwilli General Hospital – Adult and Paediatric TU	Rationale: this is the only hospital available with all the requisite specialities and support services on site. There is a longer-term plan for a single TU within the Health Board to be developed at a new hospital on a site between St Clears and Narberth. The designation of Glangwilli General Hospital as the interim TU was approved in September 2019 following a period of engagement conducted by Hywel Dda UHB

Bronglais General Hospital and Withybush General Hospital will be rural trauma facilities for the purposes of major trauma.

Powys Teaching Health Board	
No TU	Rationale: there are no acute hospitals in Powys Teaching Health Board. Trauma patients will utilise existing patient flows into neighbouring Health Boards and England (e.g. TU at Hereford General Hospital). The development of Prince Charles Hospital and Nevill Hall Hospital as TUs will support Powys patient flows pertaining to the management of major trauma patients. The expansion of the EMRTS will also support this population.

The designation of TUs will be reviewed after the first year of being operational and national annual trauma peer review.

## 11 Commercial Case

This section of the Programme Business Case (PBC) outlines the proposed procurement requirements in respect of the preferred way forward, as determined by the South Wales Major Trauma Network service configuration.

Establishment costs that are not capital are all under £50,000 and will be subject to NHS Standing Financial Instructions. All expected procurements in 2019/20 are likely to be based on closed tenders or three quotations. The procurement route for all equipment identified within the Cardiff and Vale UHB case will be through existing All-Wales framework agreements.

Capital infrastructure cases for the Major trauma Centre (MTC), Hywel Dda Trauma Unit and any requirements from Swansea Bay UHB for specialist supporting services will follow Welsh Government capital investment processes agreed directly between Welsh Government and the relevant health board.

The capital identified by the health boards is outlined in the table below:

Programme Capital Requirements	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
MTC Cardiff & Vale (MTC Construction and Equipment)	£5,426				
Hywel Dda Trauma Unit (West Wales General)			£1,252		
<b>Capital Total</b>	<b>£5,426</b>	<b>£0</b>	<b>£1,252</b>	<b>£0</b>	<b>£0</b>

The Cardiff and Value UHB capital requirement is outlined below:

### Cardiff and Vale UHB Capital Requirements 2019/20

	Construction	Equipment	Total
	£000s	£000s	£000s
Emergency unit - Resus bay equipment costs	£0	£134	£134
Extension, resus, streaming and triage bay refurbishment	£436	£0	£436
Room alterations to provide additional minors capacity	£150	£0	£150
Interim refurbishment of Polytrauma Unit (PTU) 14 beds	£1,109	£383	£1,492
Critical Care bed expansion – equipment only	£0	£194	£194
Theatres – Capital equipment including plastics	£0	£1,100	£1,100
Theatres - image intensifier	£0	£120	£120
Replacement scanner for emergency unit	£600	£1,200	£1,800
	<b>£2,295</b>	<b>£3,131</b>	<b>£5,426</b>

The enabling infrastructure development in Cardiff and Vale UHB will be procured via a separate contract arrangement through Cardiff and Vale UHB and Welsh Government. The total value of these works is approximately £5.4m, with the largest contract element being £1.2m. These contracts will be awarded following procurement processes that will be managed by the procurement and capital estates function of Cardiff and Vale UHB.

The estimated future capital requirement for the MTC theatres at the time of publication is in the region of £20-25m. Note that this is an integrated capital scheme which includes the vascular hybrid theatres.

Hywel Dda UHB has identified £1.25m for the development of a 10 bedded landing pad in Year 2 (2021/22) at Glangwili General Hospital, Carmarthen. However, it is envisaged that the Year 1 approach will be in-keeping with all other health boards, with consideration given to a dedicated landing pad, as appropriate, following a period of evaluation of actual activity.

## **11.1 Risk Transfer**

This section provides an assessment of how the associated risks might be apportioned between the service and contractors. Cardiff and Vale UHB will develop a full risk-transfer matrix through the capital infrastructure business cases that will be required for the final MTC business solution.

## **11.2 Procurement strategy**

The approach to procurement is set-out above, with the acquisition of capital assets to be discharged through existing NHS Supply Chain frameworks.

## **11.3 IFRIC 12 / FRS5 Accountancy Treatment**

This business case describes the totality of investment required for the establishment of the South Wales Major Trauma Network. The purchase and construction of assets within the network will be held on the balance sheet of each purchasing organisation.

## **11.4 HM Treasury Guidance.**

It is recommended that Cardiff and Vale UHB take guidance from the HM Treasury relating to IFRIC 12, which is guidance only applying to infrastructure.

Because the programme will not have any ownership of assets deployed across the network there will be no need to apply Treasury Guidance on treatment of the assets and whole life costs through this business case. The schedule of capital equipment/schemes identified as requirements by Cardiff and Vale UHB and Hywel Dda UHB will need to take account of the requirements of the HM Treasury rules.

## 12 Management Case

### 12.1 Introduction

The management case sets out the 'achievability' of the programme. Its purpose, therefore, is to build on the preceding chapters by setting out, in more detail, the actions required to ensure the successful delivery of the trauma network against the agreed investment objectives and timeline. To achieve this, it sets out the programme management arrangements and implementation plan. It gives details of the commissioning arrangements and considers how these will affect the organisational and clinical governance arrangements once the network is operational.

This chapter also sets out the current programme management arrangements, handover arrangements to the Operational Delivery Network (ODN) and post programme assurance and evaluation. Finally, it describes the arrangements for benefits realisations and risk management over the programme timeline in detail.

### 12.2 Current Programme Management Arrangements

#### 12.2.1 Programme Sponsorship

The NHS Wales Health Collaborative (the Collaborative) has hosted the programme for the implementation phase, which includes programme planning and preparation for delivery. It has been agreed that Swansea Bay University Health Board, will host the ODN, in keeping with the recommendations of the independent panel review. The WHSSC Joint Committee confirmed this decision at its meeting on 26 March 2019.

In order for the Collaborative to enable health boards to successfully deliver this service change, it has taken the following approach in the organisation and management of the programme:

- The programme has adopted the general principles of PRINCE-2 methodology in managing the programme's activities and outputs and will meet the requirements of the WHC (2006): 001, Capital Investment Manual, NHS and Treasury Guidance, and any subsequent guidance that may be issued during the programme's lifespan.
- The project has used NHS standard documentation and products, where these are available, and has sought to benefit from experience and best practice from other NHS programmes.
- Specialist professional and technical advisers were employed for those activities where the necessary skills and experience were not otherwise available within the programme. The transfer of skills and knowledge from specialist advisers to the programme team was achieved, wherever possible and appropriate.

The above approach will continue to be utilised as the programme progresses. In managing the programme, the Collaborative aims to:

- Deliver the programme on time.
- Ensure effective and proactive lines of accountability and responsibility for the programme deliverables.
- Establish stakeholder involvement at all stages.

## 12.2.2 Programme Structure and Reporting

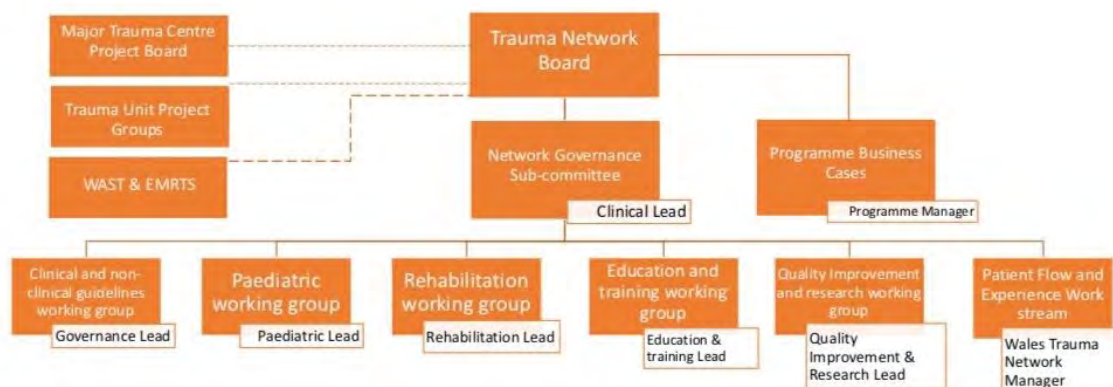
### Trauma Network Board and Overarching Structure

Following approval of the recommendations of the independent panel review by health boards, the trauma network board was established in May 2019 and meets monthly (see Appendix 19 for terms of reference and full membership). The Senior Responsible Officer (SRO) for the programme is Tracy Myhill, Chief Executive Officer, Swansea Bay University Health Board. The SRO and Dr Mark Ramsey, Medical Director, Morriston Hospital, jointly chair the network board. The network board is made up of senior clinical and managerial representation from all participating organisations including health boards, WAST and EMRTS. It also has representation from WHSSC, EASC, therapies and Welsh Government.

The network board is responsible for:

- Establishing and delivering a programme for the development of a high quality, safe and effective trauma network for the population of South Wales, West Wales and South Powys.
- Providing strategic direction and advice to the programme.
- Delivering the programme on time and to budget.
- Ensuring effective and proactive lines of accountability and
- Ensuring programme deliverables, including approval of pathways, policies and procedures.
- Ensuring that decisions are taken through correct channels and that wider communication with senior NHS management is functional.
- Ensuring continuing commitment to stakeholder support.
- Monitoring and risk management of the programme.
- Establishing user involvement at all stages of the programme.

The network board is accountable to, and reports to, the WHSSC Joint Committee for the activities outlined above. The figure below illustrates the governance arrangements of the programme:



### Internal Programme Governance Structure

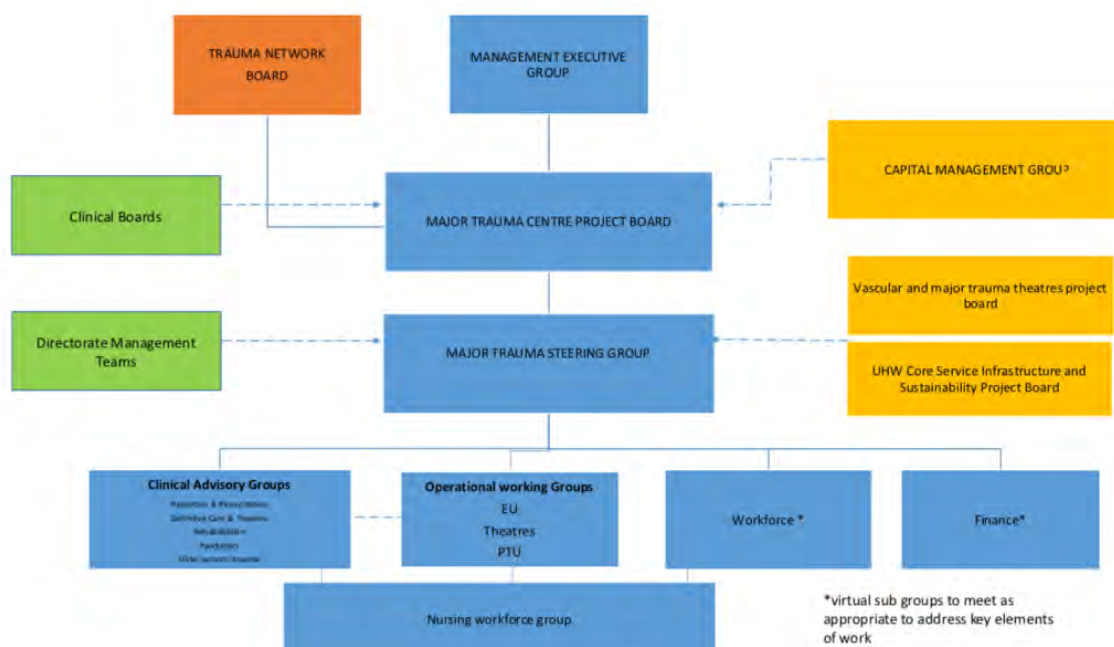
Within the internal governance structure, all members of the team are accountable to the Director of the Collaborative. A programme business case team has been created, consisting of the network clinical lead, head of planning for the Collaborative, programme manager and administrative support. In addition, a number of working groups have been created, led by respective network leads. The

groups draw upon the experience of clinicians and managers from across the region. Responsibilities of these groups include:

- Clinical and non-clinical guideline working group – development of trauma management guidelines.
- Paediatric working group – development of paediatric specific guidelines, addressing safeguarding issues and input into paediatric trauma education and training.
- Rehabilitation working group – operational planning, key workforce enablers, rehabilitation plans and advising on the ‘landing pad’ configuration.
- Education and training working group – developing a strategy in partnership with HEIW as well as development and quality assurance of products (see chapter 5).
- Quality improvement and research working group – supporting improvement in TARN data collection, as a platform for quality improvement and research initiatives. Developing metrics for quality assurance and commissioning.
- Patient flow and experience working group – specific focus on ‘care with treatment closer to home’.

The working groups report to the monthly network governance subcommittee, chaired by the network clinical lead (see Appendix 20). The governance subcommittee consists of the network leads, MTC/TU clinical leads, pre-hospital representatives, senior managers and external peer representation from North Wales and NHS England. The purpose of the committee during the implementation phase is to provide review and scrutiny of the work undertaken by working groups. The subcommittee is accountable and responsible to the network board. It reports to the network board through the network clinical lead.

### MTC Programme Governance Structure



The MTC programme structures indicated above are operational and report to the network board in respect of programme delivery and, within Cardiff and Vale University Health Board, to the Management Executive Group. The Executive Director for Planning is the SRO for the MTC programme. The network clinical lead sits on the MTC project board.

## Health board and Pre-Hospital Programme Governance Structures

Each health board has established a trauma project group to support implementation of trauma services within its catchment area, which reports to the network board. A member of the health board's executive team chairs the group in most cases. In order to ensure consistency of the scope of each group, the network board supplied each health board with generic terms of reference. Each health board has also established a rehabilitation group, feeding into the network rehabilitation working group. Finally, a joint rehabilitation group has been established between Swansea Bay University Health Board and Hywel Dda University Health Board to determine how a collaborative rehabilitation model could be developed.

In relation to pre-hospital services, the governance arrangements for the Welsh Ambulance Service NHS trust (WAST) sit within the planning directorate and for EMRTS with its clinical and operational board. These also report to the network board. WAST has also nominated individuals to all relevant working groups. Internally, WAST has established a major trauma project group, which is constituted of all personnel who represent the organisation at the above external boards and task and finish groups. This project group will meet monthly until the network goes live.

The network has asked all participating organisations to provide a structured written report to each network board meeting. Each report outlines progress towards developing the service specification and quality indicators, confirms adherence to the network implementation plan and highlights key areas of local risk. These reports enable the network board to understand the cumulative risk and support health boards to mitigate specific risks.

## Welsh Government Trauma Policies Group

In November 2018, a trauma policies group was established, bringing together policy leads relevant to major trauma services and including representation from NHS capital and revenue finance teams. The policies group meets monthly, chaired by Professor Chris Jones, Deputy Chief Medical Officer, Welsh Government. The meetings provide a forum in which the Collaborative programme team, WHSSC and the MTC programme team have an opportunity to present aspects of the development with policy leads, who provide support, challenge and scrutiny. All information presented at the policy group is discussed first at the trauma network board.

## Programme Resource

In order to progress the development of the trauma network, resources were secured from Welsh Government in order to appoint into a number of key enabling posts in December 2018. Welsh Government has funded these posts and appointments have been made to them on a non-recurrent basis until the end of March 2020. This is reflected in the financial case (Chapter 9). The requirements for ongoing resources are described within organisational requests (Chapters 5, 6, 7 & 8). The table below provides an outline of existing appointments and additional posts, with additional posts being funded from the resources secured through Welsh Government:

<b>Collaborative</b>	Network clinical lead – existing fixed term appointment Critical care and trauma network manager (CCTN) – existing appointment Project support officer – existing appointment Programme manager – additional post, appointed Network lead positions (governance, paediatric, rehabilitation, training and education, quality improvement and research) – additional posts, all appointed
----------------------	--



<b>MTC</b>	Programme director – additional post, appointed Clinical lead and deputy clinical lead HR support – additional post General manager Administrator
<b>All other Health Boards/WAST</b>	Programme manager and project support officer – SBUHB and HDUHB, additional posts Programme manager and project support officer – CTMHB, ABUHB and PTHB, additional posts health board clinical leads (2 for CTMUH), additional posts, partially appointed WAST planning officer, additional post, appointed
<b>WHSSC</b>	Planning lead – additional post, appointed Finance lead – additional post

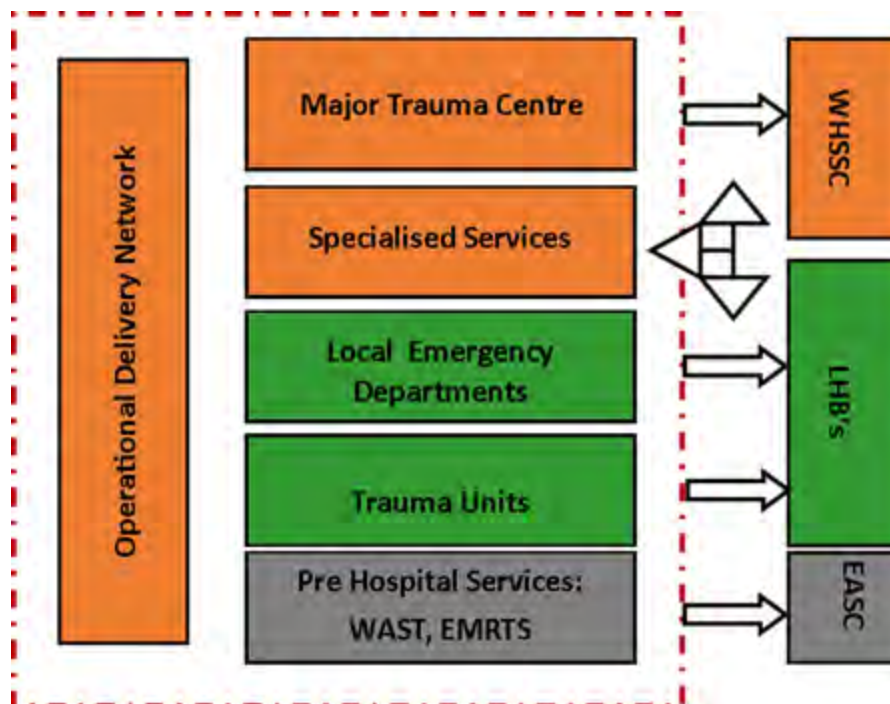
In addition to the above programme, resource was secured for early deliverables in relation to training and education, specifically in relation to surgical skills training. This is outlined in Chapter 5.

## 12.3 Commissioning Arrangements

At the September 2018 meeting of the WHSSC Joint Committee, members agreed the scope of the commissioning framework for Major Trauma (MT) which can be summarised as:

- An Operational Delivery Network (ODN) to be established to oversee the delivery of trauma services to the population of South Wales, West Wales and South Powys.
- The ODN and Major Trauma Centre at University Hospital of Wales will be commissioned by the Welsh Health Specialised Services Committee.
- Emergency Ambulance Services Committee (EASC) will commission WAST and the EMRTS.
- Health boards will be responsible for local commissioning.
- Existing trauma commissioning arrangements for Betsi Cadwaladr University Health Board will be retained.

The commissioning responsibilities for the major trauma functions held by NHS organisations within the network is illustrated in the diagram overleaf.



As illustrated above, the health boards retain the commissioning responsibility for the Trauma Units.

Under this model, the performance management arrangements would mirror those of services currently commissioned by the two Joint Committees of WHSSC and EASC respectively (see below).

### 12.3.1 Commissioning Responsibility for Pre-hospital Services

The Emergency Ambulance Services Committee (EASC) commissions WAST and the EMRTS. EASC includes the National Collaborative Commissioning Unit as one of its functions. EASC consists of a joint committee that acts on behalf of all health boards in undertaking its function.

Ambulance commissioning in Wales is a collaborative process, underpinned by a national collaborative commissioning quality and delivery framework. All seven health boards have signed up to the framework. Emergency ambulance services in Wales are provided by a single national organisation, WAST.

The framework puts in place a structure that is clear and directly aligned to the delivery of better care. The framework introduces clear accountability for the provision of emergency ambulance services and sees the Chief Ambulance Services Commissioner (CASC) and EASC acting on behalf of health boards and holding WAST to account as the provider of emergency ambulance services.

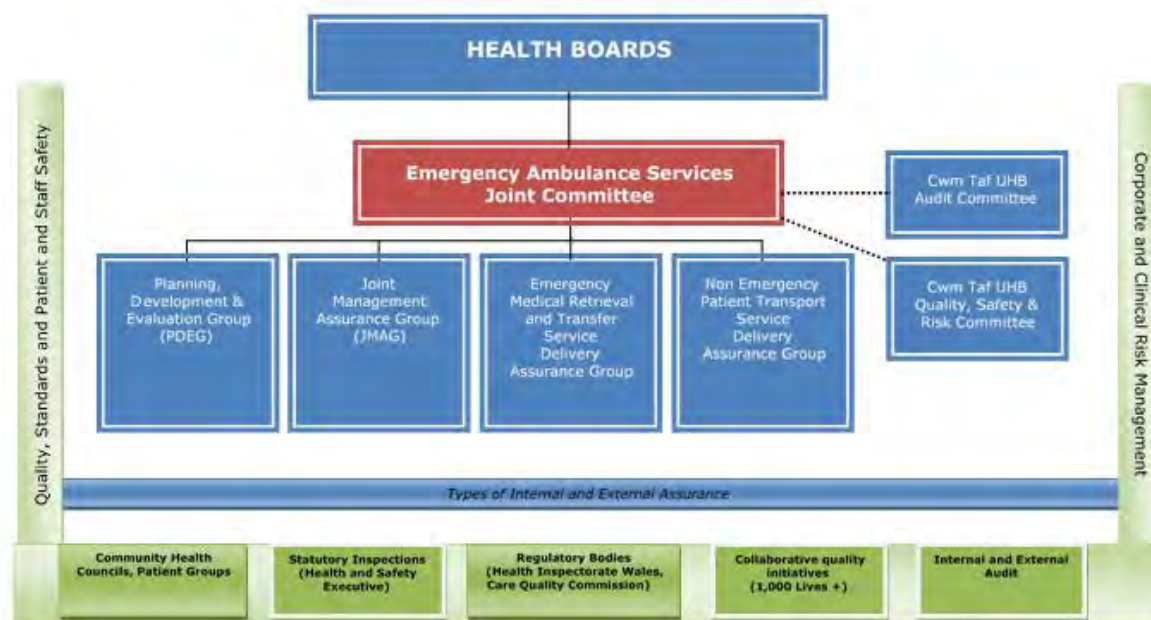
**The Emergency Ambulance Services Committee** ("Joint Committee") is made up of the chief executives of the seven health boards, **Chief Ambulance Service Commissioner** (CASC) and an independent chair, both appointed ministerially.

The seven health boards in Wales are required under legislation to work jointly to exercise functions relating to the planning and securing of emergency ambulance services. The CASC exercises these duties on behalf of the Joint Committee. EASC supports the commissioning intentions and the financial envelope required to improve and deliver ambulance services across Wales.

**The National Collaborative Commissioning Unit** (NCCU) is responsible to the CASC for the delivery of services to EASC. This entails ensuring that safe, effective and timely services are delivered. It also includes the creation, development, operation, refresh and evaluation of National Collaborative

Commissioning: Quality & Delivery Frameworks for ambulance services within NHS Wales covering Emergency Ambulance Services, Non-Emergency Ambulance Services and Emergency Medical Retrieval Transport Services.

### EASC Governance Framework



### 12.3.2 Local Health Board Commissioning Responsibility

Each health board will retain the commissioning responsibility for its local trauma services.

The following hospitals were approved as adult and paediatric TUs, following a recommendation by WHSSC Joint Committee and health boards:

- UHW, Cardiff – TU function for its own population.
- Morriston Hospital, Swansea – TU with specialist services
- Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Aneurin Bevan University Health Board)
- Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend.
- Glangwili General Hospital

Royal Glamorgan Hospital, Llantrisant, will be a local emergency hospital (LEH) within the network structure

Bronglais General Hospital, Aberystwyth and Withybush General Hospital, Haverfordwest will be rural trauma facilities for the purposes of major trauma.

The commissioning arrangements for the Major Trauma Centre at UHW and the Trauma Unit at Morriston Hospital are complex, as within both of these hospitals there are specialised services,

commissioned by WHSSC on behalf of health boards, and non-specialised services, directly commissioned by the health boards. This is illustrated in the tables below.

#### Commissioning Responsibilities for Acute Phase

	Acute phase (continuum into ongoing care and reconstruction)																
	Emergency radiology ED	MRI 24/7	Teleradiology MTC <>TUs	General Surgery	Ophthalmology	ICU	Theatres / Anaes	Orthopaedic surgery	Plastic surgery	24/7 Interventional radiology	Vascular/ endovasc surgery	Cardiothoracics	Max-facial surgery	Neurosurgery	Spinal surgery	Liver surgery	Burns
MTC	H	M	H	H	H	M	M	H	W	M	H	W	H	W	H	W	W
TU	H	M	H	H	H	M	M	H	W	M	H	W	H	W	H	W	W

#### Commissioning Responsibilities for Ongoing Phase and Reconstruction

	Ongoing care and reconstruction									
	Radiology – MRI, IR, angiography	Critical care	Rehabilitation	Specialist rehabilitation	Specialist acute pain service	Craniofacial trauma support	Haematology	Obs/gynae	Respiratory physiotherapy (for pneumothoraces, chest drain and tracheostomies)	Complex peripheral nerve support
MTC	M	M	H	W	M	W	H	H	H	H
TU	M	M	H	W	M	W	H	H	H	H

Key

W	WHSSC
H	Health Board
M	Mixed – elements of WHSSC and Health Board commissioning

### 12.3.3 Commissioning of the Operational Delivery Network

The ODN team hosted by Swansea Bay UHB will be commissioned by WHSSC through an agreed SLA, and underpinned by quality and performance indicators. Managerial/executive responsibility is provided by the chief executive of the host organisation.

Each organisation participating in the trauma network will discharge its clinical and managerial responsibilities within its own organisational structures.

In addition, the ODN will be performance managed and benchmarked through national peer review and TARN submissions (TARN submission is mandatory for all Health Boards under the annual national clinical audit and outcome review annual plan).

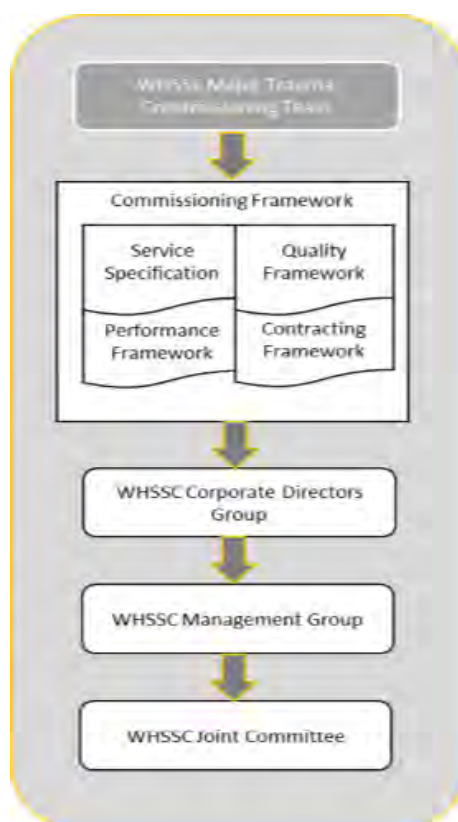
#### 12.3.4 WHSSC Organisational Structure

The **WHSSC Joint Committee**, whose membership is made up of an independent chair, independent members, the seven Health Board Chief Executives and other officers, has overall responsibility for the joint planning of specialised services and financial performance of WHSSC on behalf of health boards. Requests for approval of decisions at Joint Committee level are often informed by the **WHSSC Management Group**, which is made up of commissioners and finance representatives from each health board and provides a scrutiny and assurance function to items such as performance reports and business cases requesting funding.

Internally, the **WHSSC Corporate Directors Board** meets monthly to monitor performance and assess cases before progressing to Management Group and/or Joint Committee.

Beneath this, the WHSSC planning function is delivered through a speciality-based model of commissioning teams with representatives from planning, finance, quality and medical representatives. A **major trauma commissioning team** has been established and will work alongside the other commissioning teams, which include neurosciences, cardiac and the renal network, which is a commissioning network hosted by WHSSC.

The diagram below illustrates the WHSSC decision making process.



The Joint Committee is established as a Statutory Sub Committee of each of the health board in Wales. It is led by an Independent Chair, appointed by the Minister for Health and Social Services, and membership is made up of three Independent Members, one of whom is the Vice Chair, the chief executives of the Local Health Boards, Associate Members and a number of Officers.

Whilst the Joint Committee acts on behalf of the seven health boards in undertaking its functions, the responsibility of individual health boards for their residents remains and they are therefore accountable to citizens and other stakeholders for the provision of specialised and tertiary services.

### 12.3.5 Roles and Responsibilities of Commissioners

The table below sets out the roles for WHSSC, EASC, and the Major Trauma Network in developing and implementing the core elements of the commissioning framework.

	WHSSC	EASC	Trauma Network
<b>Commissioning</b>	<p>Scrutinising and approving the business cases for the Major Trauma Centre</p> <p>Scrutinising business cases for Trauma Units and rehabilitation services, to ensure alignment with MTC and Network – providing advice to the commissioning health boards</p> <p>Monitoring the quality and performance framework for the MTC, TU, Network and Rehabilitation Services</p> <p>Clarifying and developing the role of Morriston Hospital as a large trauma unit and provider of national and regional specialised services</p> <p>Developing financial framework</p> <p>Developing contracting framework across the network</p> <p>Developing commissioning policies and future service specifications for the MTC, TUs, and the Network</p>	<p>Scrutinising and approving the business cases for WAST and EMRTs</p> <p>Performance monitoring/management of WAST and EMRTs</p>	<p>Supporting the development of business cases for the Major Trauma Centre, WAST and EMRTs</p> <p>Supporting the implementation and monitoring of the quality and performance framework</p> <p>Ensuring compliance with the commissioning policies</p>

			and service specifications across the Network
<b>Operational and Governance</b>	Approving the operational and governance structure for the wider network including the TUs Boards  Approving the designation criteria for TUs		Developing the operational and governance structure for the network and Trauma Unit Boards  Designating of TUs
<b>Delivery</b>	Scrutinising and approving (through the WHSSC Joint Committee in partnership with EASC) the pathways for: <ul style="list-style-type: none"> <li>• Pre-hospital assessment</li> <li>• Acute trauma care</li> <li>• Acute rehabilitation</li> <li>• Rehabilitation and re-ablement</li> </ul>	Working in partnership with WHSSC to scrutinise and approve (as appropriate) the pathways for: <ul style="list-style-type: none"> <li>• Pre-hospital assessment</li> <li>• Acute trauma care</li> <li>• Acute rehabilitation</li> <li>• Rehabilitation and re-ablement</li> </ul>	Developing the pathways for: <ul style="list-style-type: none"> <li>• Pre-hospital assessment</li> <li>• Acute trauma care</li> <li>• Acute rehabilitation</li> <li>• Rehabilitation and re-ablement</li> </ul>

### 12.3.6 Contracting Framework

As part of the commissioning framework, WHSSC will develop a contracting framework for the MTC, with health boards retaining the responsibility for developing their own contracting arrangements for the Trauma Units.

WHSSC is responsible for implementing the contracting framework for both the MTC and the trauma ODN. This framework will ensure that health boards appropriately contribute to the cost of the MTC and the trauma ODN and that there is appropriate 'risk sharing' between health board commissioners and the providers for the operating costs of the MTC which will include adjustment for variation in performance and cost of delivery.

The WHSSC Finance sub group, made up of representatives from the seven health boards, considered options for contracting the MTC and agreed that a block contract with variations would be the preferred method in the formative years of the MTC.

This option sees an agreed block fee to cover the availability of the service, varied by agreed rebates for under-performance and/or any service unavailability or cases declined.

Once there is more certainty around staff appointment profiles, which are the most significant component of MTC costs, and clear outcomes from submission of data including through TARN, the preference of commissioners is to move to a cost and volume contract that would initially be tested in shadow form. The fixed component would be designed to recognise the importance of availability of key service inputs. The variable component would ensure a method that adapts the payments by commissioners to account for actual cost of delivery and performance level variation.

In both phases of implementation of the contracting framework, there will have to be clear information available to commissioners detailing actual staffing levels. Failure to recruit or retain staff at funded levels would trigger an appropriate financial adjustment.

### **12.3.7 WHSSC Quality and Performance Monitoring**

Commissioning teams are responsible for developing service specifications and policies that guide individual services and outline the key performance and quality indicators and standards that the service is expected to adhere to. WHSSC is responsible for the service specifications for both the MTC and the ODN.

Service specifications are important in clearly defining the core requirements that WHSSC expects to be in place for providers to offer evidence-based, safe and effective services and importantly ensure equitable access to services for Welsh patients. They describe the service to be provided, and the quality of service that WHSSC expects to be delivered. The specification also sets out the way in which the quality of the service will be measured, and how it will be monitored by WHSSC.

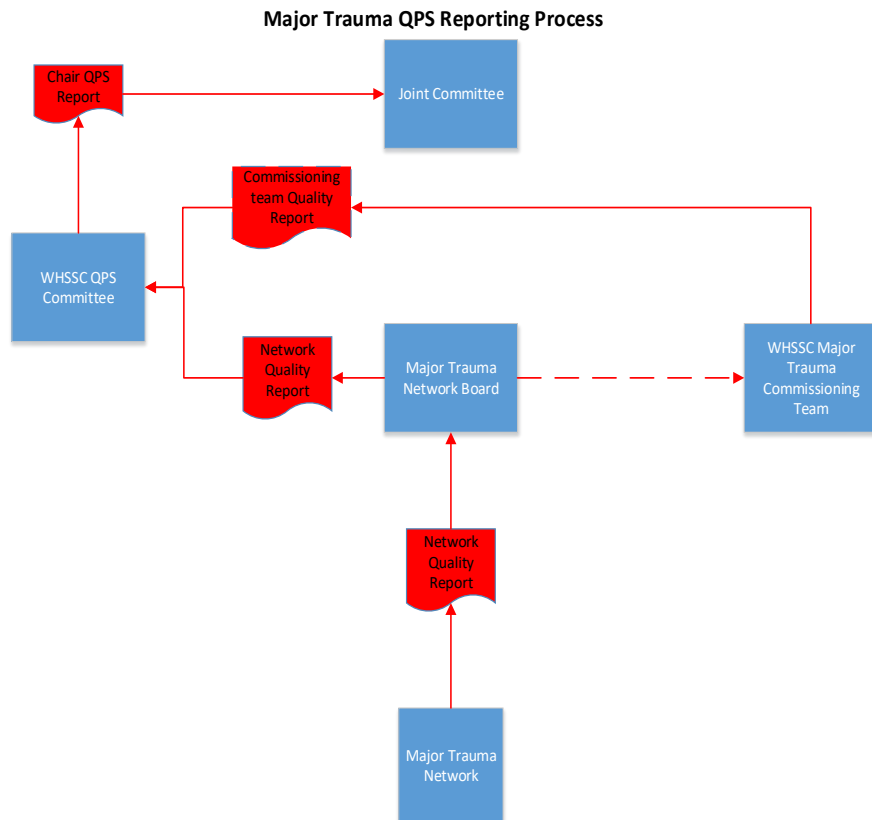
The consultation on the Major Trauma Network was informed by the NHS England Outcome Measures, with the assumption that these will be adopted upon implementation. These outcome measures are based upon the NHS England Service Specification which was developed by the NHS England Clinical Reference Group for Major Trauma.

Joint Committee, following the advice of the Major Trauma Network Board, has agreed to develop a service specification and outcome measures that are appropriate for NHS Wales but informed by the NHS England Outcome Measures.

The development of the service specification and outcome measures will be undertaken through the established WHSSC processes, using the policy and service specification consultation process, the WHSSC Management Group scrutiny process, and approval through the Joint Committee.

The WHSSC Major Trauma Commissioning team will work with the ODN to establish regular performance meetings and monitoring returns so that the network and MTC performance against these specifications can be monitored and shared as part of the monthly performance reports to Management Group and quarterly performance reports to Joint Committee.





WHSC will work closely with Swansea Bay University Health Board (SBUHB) as the host of the trauma ODN, to ensure that major trauma is a standing item on the regular executive-led meetings that it holds with SBUHB to discuss quality, finance and performance issues.

## 12.4 Implementation and Mobilisation

### 12.4.1 Implementation Planning Activity

The independent panel recommended that a trauma network with a clinical governance infrastructure should be quickly developed, and that a clear and realistic timetable should be put in place to ensure it was established. In the Autumn of 2018, the network board developed an implementation plan.

There are multiple component parts to the Trauma Network and as part of the implementation and preparation for go live, tranches of funding have been released in order that recruitment can take place for MTC capability to be in place before the triage tool is made live. It is the triage tool that will determine which patients should go to the MTC and so until the system is ready, the tool remains inactive.

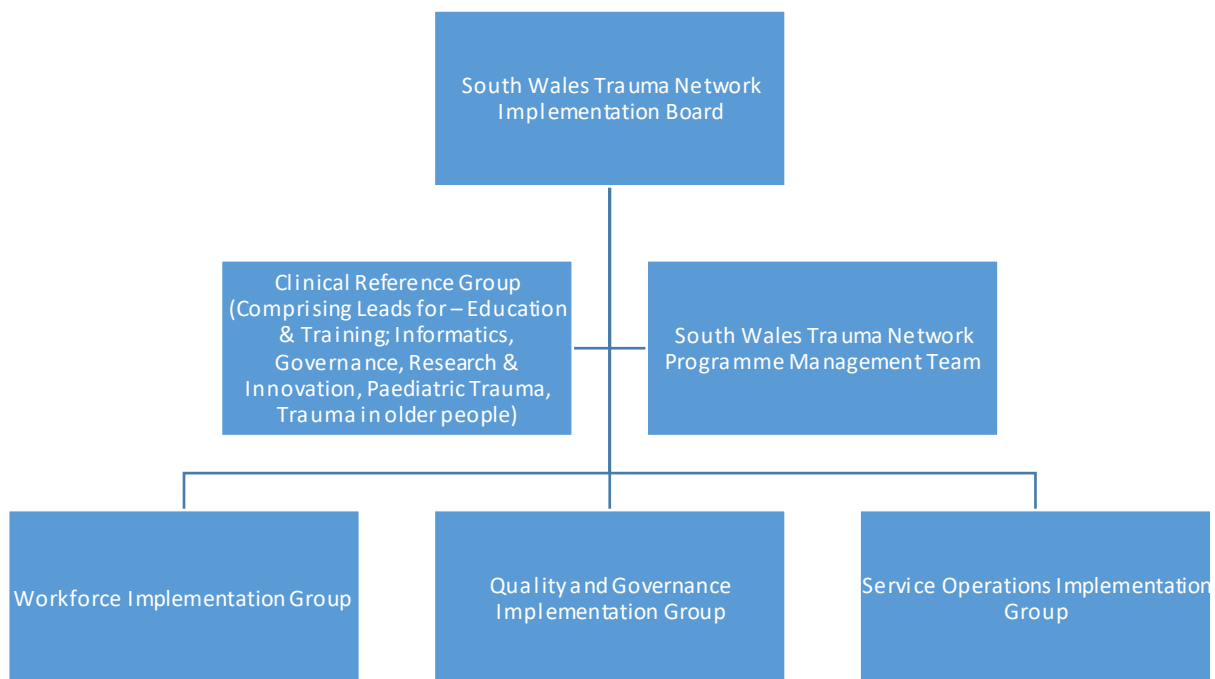
The ambition is for the network to go live on the 1st April 2020. However, final confirmation of this will be determined through the structure set out below and then agreed and signed off in conjunction with the lead commissioner by the implementation board.

### 12.4.2 Implementation Structure and Management Arrangements

As the network moves from its planning phase to implementation and operational delivery, hosting of the network will shift from the Collaborative to SBUHB. Draft implementation arrangements are illustrated below:

A robust and methodological programme arrangement will continue to be applied but the roles and representation across the programme will need to be amended as the focus moves from planning to execution.

The organisational structure for implementation is shown below:



### 12.4.3 Populating the Structure

The personnel involved in supporting and delivering implementation need to be balanced between seniority, service operational representation and ensuring all participating organisations are equitably represented.

#### Nominated Membership for Implementation

##### Implementation Board:

Meeting Frequency: 6 weekly

Chair: Tracy Myhill, Chief Executive SBUHB

Membership: One executive member representing each of the following:

- WHSSC
- EASC
- EMRTS
- Aneurin Bevan UHB

- Cardiff and Vale UHB
- Cwm Taf Morgannwg UHB
- Swansea Bay UHB
- Powys THB
- Hywel Dda UHB
- Welsh Ambulance Services NHS Trust
- Network Manager
- Programme Manager
- National Clinical Lead

**Programme Team:**

Frequency: Monthly

Chair: Network Manager

- Programme Manager
- 5 x sub group managerial leads
- 5 x clinical leads (incl. Network clinical lead)

**Each Subgroup:**

Frequency: Monthly

- 1 x clinical chair
- 1 x managerial lead (deputy chair)
- 1 x rep from each of the six health boards and WAST
- Programme Manager

Each participating organisation will be asked to identify up to five representatives, in order to ensure each sub group is appropriately representative of the system.

## **12.4.4 Critical Path**

Following agreement of the indicative timeline, the network board set out a critical path in relation to the development of the programme business case and associated health board business case information.

The current implementation plan has been further developed and is in keeping with detailed implementation plans for the different elements.

For trauma units, these will be developed as part of the next phase of implementation, based on the overarching principles.

The timeline for approval of the Programme Business Case is outlined below:

Workstream	Task Name	Responsibility	Finish Date	07/10/2019	14/10/2019	21/10/2019	28/10/2019	04/11/2019	11/11/2019	18/11/2019	25/11/2019	02/12/2019	09/12/2019	16/12/2019	23/12/2019	30/12/2019
Approval Timeline	Final review / scrutiny of draft PBC in readiness for reporting to Network Board; engage with HB/WAST reps as required	Executive Strategy Group	14/10/2019													
	Sign-off final PBC and draft IMTP content; prepare for combined HB/WAST Board Briefing	Trauma Network Board	21/10/2019													
	Progress update and briefing on arrangements for HB/WAST Board Briefing	Collaborative Executive Group	22/10/2019													
	Brief on the content of the PBC, service phasing, quality, cost, risks, mitigations, in preparation for formal receipt at Board Meetings in November.	Combined Health Board / WAST Board Briefing	23/10/2019													
	Final review of PBC / preparation for reporting to Boards / Welsh Government	Executive Strategy Group	w/c 28/10/2019													
	Welsh government Scrutiny	Welsh Government	W/C 21/10/2019 and W/C 28/10/2019													
	Gateway 3 Review	Programme Team	28/10/2019													
	Briefing for CHC	Programme Team	w/c 04/11/2019													
	Receive final PBC / preparation for Board meetings / internal briefings within Health Boards / WAST	Health Board/WAST - Executive / internal governance meetings	w/c 04/11/2019 and w/c 11/11/2019													
	Papers issued by Health Boards / WAST for Board meetings	Health Board/WAST Board meetings	w/c 18/11/2019													
	Health Boards / WAST to receive PBC for approval and draft IMTP sections for approval	Health Board/WAST Board meetings	w/c 25/11/2019													
	Special meeting to agree commissioning for pre hospital component of PBC	EASC (Note - consider joint meeting for EASC and WHSSC JC)	w/c 02/12/2019 or 09/12/2019													
	Special meeting to agree commissioning for MTC, specialised services and ODN	WHSSC Joint Committee	w/c 02/12/2019 or 09/12/2019													

The current implementation plan for the South Wales Major Trauma Network:

			Sep-19					Oct-19				Nov-19				Dec-19					Jan-20				Feb-20				Mar-20						
Workstream	Task Name	Responsibility	02/09/2019	09/09/2019	16/09/2019	23/09/2019	30/09/2019	07/10/2019	14/10/2019	21/10/2019	28/10/2019	04/11/2019	11/11/2019	18/11/2019	25/11/2019	02/12/2019	09/12/2019	16/12/2019	23/12/2019	30/12/2019	06/01/2020	13/01/2020	20/01/2020	27/01/2020	03/02/2020	10/02/2020	17/02/2020	24/02/2020	02/03/2020	09/03/2020	16/03/2020	23/03/2020	30/03/2020	06/04/2020	
ODN Implementation	Appointment of key in-year enabling posts for ODN	SBUHB																																	
	Confirmation of funding for year 1 and ingoing posts for ODN	WHSSC																																	
	Handover plan for ODN	Programme																																	
		Programme																																	
	ODN Governance arrangements finalised																																		
		Programme																																	
	ODN Management Team in place and infrastructure established	SBUHB																																	
	ODN operational policy developed	Programme																																	
	Patient Flow - 'care with treatment closer to home' policy approved	Programme / ODN																																	
		Programme / ODN																																	
	Clinical and non clinical policies produced and approved	Programme / ODN																																	
	Paediatric policies and pathways produced and approved	Programme / ODN																																	
		Programme / ODN																																	
	Training and Education for go live																																		
	Training resource for year 1 onwards	WHSSC																																	
	Rehabilitation including prescription approved and directory of services ready	Programme / ODN																																	
	Clinical informatics requirements ready	Programme / ODN																																	
	QI, audit and research - all HBs completed TARN dataset (backdated 1 year from go live) and all Health Boards completing respective dashboards.	Health Boards																																	
MTC readiness visit																																			
TU readiness visits																																			
Pre-hospital readiness visit																																			
Pre-hospital	Senior Paramedic - Trauma Desk Begin Employment	WAST																																	
	E Learning go live	WAST																																	
	All staff trained and E learning training completed	WAST																																	
Trauma Units with specialist services ie Morriston Hospital	Recruitment of key enabling posts in order to meet Day1 service specification and quality indicators																																		
	Identified 'landing pad' for repatriating patients within existing infrastructure																																		
	Agree internal organisational governance structure																																		
	Implement network policies and pathways																																		
	Training and education to reach to Day 1 requirements																																		
	Recruitment of additional plastic surgical staff to support MTC (Consultants and Middle Grades)																																		
	Phased implementation of South West Wales spinal service model in year 1 and 2																																		
All other Trauma Units	Recruitment of key enabling posts in order to meet Day1 service specification and quality indicators.																																		
	Identified 'landing pad' for repatriating patients within existing infrastructure																																		
	Agree internal organisational governance structure																												</						

### 12.4.5 Summary of Critical Enablers for ‘Go Live’

Chapter 5 provides details of the minimum requirements that need to be completed and/or in place before the ODN can become operational. These are summarised at a high level below and will inform the assurance process undertaken by the programme team and the collation of a detailed cross-organisational implementation plan. This will also assist with understanding the cumulative programme risk.

<b>ODN</b>	<p>Transition and handover of ODN to SBUHB</p> <p>Agree organisational governance structure and role of ODN</p> <p>ODN management team</p> <p>Day 1 requirements for the following undertaken and/or in place:</p> <ul style="list-style-type: none"> <li>• Service specification and quality indicators (see chapter 5)</li> <li>• Clinical informatics requirements (see chapter 5)</li> <li>• Training and education products (see chapter 5)</li> </ul>
<b>Commissioners</b>	<p>WHSSC contracting arrangements</p> <p>Quality assurance framework</p>
<b>Pre-hospital</b>	<p>24/7 EMRTS in South Wales (phase 1 development)</p> <p>Trauma desk capability (covering peak hours of activity)</p> <p>Pre-hospital triage tool and ‘silver trauma triage’ tool</p> <p>Online training on triage tool</p> <p>Resource availability for additional ambulance journeys</p>
<b>MTC (UHW)</b>	<p>Interim additional infrastructure requirements (emergency unit, poly-trauma ward, theatre capacity and critical care)</p> <p>Recruitment of key enabling posts in order to meet Day 1 service specification and quality indicators (see chapter 7)</p> <p>Agree internal organisational governance structure</p> <p>Implement network policies and pathways</p> <p>Clinical informatics requirements</p> <p>Training and education to reach to Day 1 requirements</p>
<b>TU with specialist services (Morriston Hospital)</b>	<p>Recruitment of key enabling posts in order to meet Day 1 service specification and quality indicators (see chapter 8)</p> <p>Identified ‘landing pad’ for repatriating patients within existing infrastructure</p> <p>Agree internal organisational governance structure</p> <p>Implement network policies and pathways</p> <p>Clinical informatics requirements</p> <p>Training and education to reach to Day 1 requirements</p>

	Recruitment of additional plastic surgical staff to support MTC (Phased implementation of spinal and orthoplastic model in year 1 and 2)
<b>All other TUs</b>	Recruitment of key enabling posts in order to meet Day1 service specification and quality indicators (see chapter 8) Identified 'landing pad' for repatriating patients within existing infrastructure Agree internal organisational governance structure Implement network policies and pathways Clinical informatics requirements Training and education to reach to Day 1 requirements Operational arrangements in HDUHB with rural trauma facilities

## 12.5 MTC/Health Board TUs/Pre-Hospital Readiness for Go Live

All quality assurance processes should include a mechanism to gather qualitative data from services to support identification of unforeseen issues as well as to ensure that all staff from front line through to senior management feel supported by the programme team in implementing the required changes. The process will also afford TU teams an opportunity to ask questions and seek clarification directly from clinical and managerial leads working in or on behalf of the programme team.

It is proposed that unit readiness visits are conducted as a collaborative exercise to enable individual health boards to receive constructive feedback on their state of readiness. This will enable the programme team to better understand each local service and specific issues, as well as being able to identify network wide issues that need resolution or escalation.

Consideration of the terms of reference for such visits will be needed. It is proposed that structuring visits around the patient pathway will provide a practical way of tangibly assessing local readiness. There should be enough time and space to enable free discussion of local issues and risks and how they might be resolved or mitigated.

## 12.6 Post Go Live: Operations and Governance

### 12.6.1 Challenges of Designing the Organisational Structure

There are a number of key challenges for the ODN in relation to the above organisational structure that the network board will need resolve before it transitions into an ODN board, and prior to the network becoming operational. The network governance subcommittee has explored these. A number of hypothetical scenarios that could arise help to illustrate the challenges and the role of the ODN board within the proposed organisational structure. These reflect challenges to the system raised through the process of peer and programme assurance reviews:

#### **MTC acceptance variation**

The ODN is alerted to an issue of significant variation of acceptance of patients from scene to the MTC, despite the presence of an automatic acceptance policy. The issue has been raised by the ambulance service. On discussion with MTC colleagues, it is suggested that the quality of the information conveyed to the MTC on passing a pre-alert is the cause of the problem. Despite some intervention by the ODN to improve the situation, the issues persist. The ODN escalates the issue to the respective commissioning bodies, but no single entity can confirm responsibility. The ODN is left with no influence over the problem and the issue remains unresolved.

### **Urgent transfer to the MTC**

A TU contacts the ODN stating that a 45 year old male with an isolated pelvic fracture has been waiting four days for an urgent transfer to the MTC. The standard states that the patient should have been transferred within two calendar days. Despite the patient being accepted for transfer, bed capacity in the MTC appears to be constrained due to significant winter pressures in the unscheduled care system. The ODN tries to contact the Chief Operating Officer in the MTC on behalf of the TU, but the issue remains unresolved.

### **Delay in transfers of care**

The MTC manager contacts the ODN stating that over the last two months they have had several delayed discharges of care to one particular TU. Currently, five patients at the MTC have been waiting in excess of two weeks for transfer from the time of completion of specialist care. This is causing considerable pressure on beds for new patients at the MTC. Despite the presence of an automatic repatriation policy agreed by all health boards, patient flow is becoming an increasing problem. The ODN discusses the issue with the Chief Operating Officer in the TU and learns that there are no appropriate beds available and, as such, the hospital is no longer able to accept patients back to their 'landing pad.' The ODN discusses the issue with WHSSC, but as commissioning of beds in the TU falls outside their remit they are unable to help, despite trying to intervene. The ODN is unable to resolve the issue and the problem continues, with a detrimental impact on patients and their families.

### **Pre-hospital trauma triage**

A lack of adherence to the triage tool in a region has led to a concern from the MTC to the ODN. Despite several educational interventions, the problem persists. The reasons seem to be multifactorial, due to the inappropriate triage by ambulance personnel and advice given by the nearby TU. This is affecting patients, who are subject to delayed transfer to the MTC. The ODN attempts to investigate the issue through facilitation, but both the ambulance service and TU deny that they are the cause. In the proposed structure, whilst the ODN gives a view on the issues and develops an action plan, this advice is not followed. Given the commissioning arrangements in place, no single entity can confirm responsibility. The ODN has no further influence on the matter. Subsequently there is a serious adverse incident, which could have been prevented had the ODN been able to ensure practice changed.



### **Community rehabilitation and ongoing care**

Despite the placement of rehabilitation coordinators and therapists in a TU as part of the network development, the MTC makes the ODN aware of several patients who have returned from the MTC to the community with ongoing rehabilitation needs that have received no community rehabilitation. On further assessment, it appears that the TU's resources put in place for major trauma are mostly used for other patients groups (e.g. isolated neck of femur fractures, strokes). The ODN discusses the issue with the directorate manager in the TU, but does not manage to convince the manager that the position should change. Furthermore, adherence to TARN PROMS/PREMS is limited. Despite making suggestions to improve the situation, the ODN has no influence over the outcome and the problems continue.

### **TARN case completeness and quality**

Despite resourcing a full time TARN coordinator, case ascertainment and accreditation in a TU remains poor. TARN informs the ODN that the TU is an outlier for mortality and would like to understand if this is an issue of data completeness. Despite several requests for further information from the TU, TARN has not managed to make progress. WHSSC are concerned that this may be affecting MTC performance, but are unable to help, as this falls outside their remit of specialist commissioning. The ODN approaches the TU to find that the TARN coordinator is used to undertake other audits in the clinical audit department and therefore is only available two days a week for TARN. On suggesting that the TARN coordinator is full time on TARN data collection, the TU state that this is not possible. The problem continues and the ODN has no way of determining the performance of the TU.

The above scenarios are hypothetical and not exhaustive but represent a sample of issues that are likely to arise, with an impact on the effectiveness of the network and on trauma patients. They provide a compelling case for optimising organisational structure from the outset. From these scenarios, the following themes have emerged:

- Complex commissioning arrangements with multiple commissioning bodies involved, risking a lack of accountability across the pathway. There is a disconnect between these and the ability to visualise the entire patient pathway.
- The ineffectiveness of the trauma ODN board acting solely in a facilitative/advisory capacity in relation to clinical and operational governance issues. An inability to be effective at maintaining 'operational delivery', given the complexity of commissioning arrangements and multiple providers.

The design must recognise the system of incentivisation and internal market forces does not exist in NHS Wales. It has also been confirmed that incentivisation and internal market forces will not be utilised as part of the commissioning framework of the trauma network.

## **12.6.2 Overview of Structure**

The organisational governance structure must ensure clear lines of accountability and responsibility across the pathway in order to achieve the best possible outcomes and experience for patients. This should align with the network's mission statement of 'saving lives, improving outcomes, making a difference.'

The arrangements must create an environment in which all components of governance are delivered openly and transparently. In addition, all providers must contribute equally and positively to the governance activities of the network.

Whilst some aspects of the organisational governance arrangements are clear, others present a level of complexity, which will challenge the effectiveness of the network to deliver as a whole and across the trauma pathway. The following outlines the current position with respect to organisational governance:

Three commissioning bodies:

- WHSSC – principal commissioning body, commissioning and performance management of the ODN, MTC and other specialist services supporting the MTC.
- EASC – commission and performance manage WAST and EMRTS.
- LHB Commissioner – commission and performance manage health boards.

Mechanisms will need to be in place to ensure accountability across the pathway. Following consideration of the scale of the challenge for operations in a live scenario, the need to embed the network within a robust structure that is owned at an executive level, the following arrangements have been derived. They reflect the views of the network board and service partners. They also reflect similar arrangements for managing trauma networks in the UK and beyond.

The network clinical governance structure will consist of the following boards/groups. This structure has been based on comparable networks in England and Scotland. Full details will be included in the network operational policy.

- Trauma Network Delivery Assurance Group (DAG) - top level system oversight and ownership, meets bimonthly in first year and quarterly thereafter. Chaired by WHSSC or independent member, accountable through WHSSC Joint Committee.
- Trauma Network Clinical & Operations Board (COB) - operational delivery, and responsible for ensuring timely escalation, management and resolution of operational issues. Meets monthly, chaired by a lead Chief Operating Officer. Will have a performance management function and maintain operational authority.

These two key groups will ensure delivery against the commissioning framework, the escalation of issues, learning and achievements into the senior leadership structure of the NHS. These groups are supported by the following core groups, through which the COB and DAG can discharge and commission their responsibilities.

- Network Governance Group
- Network Workforce Group
- Network Informatics Group

These Groups will oversee, support and receive outputs from a number of workstreams.

- Network work streams:
  - Clinical and non-clinical policies.
  - Paediatrics.
  - Education and training (in partnership with HEIW).
  - Rehabilitation.
  - Quality improvement, innovation and research.
  - Trauma in older people.
  - Injury prevention.

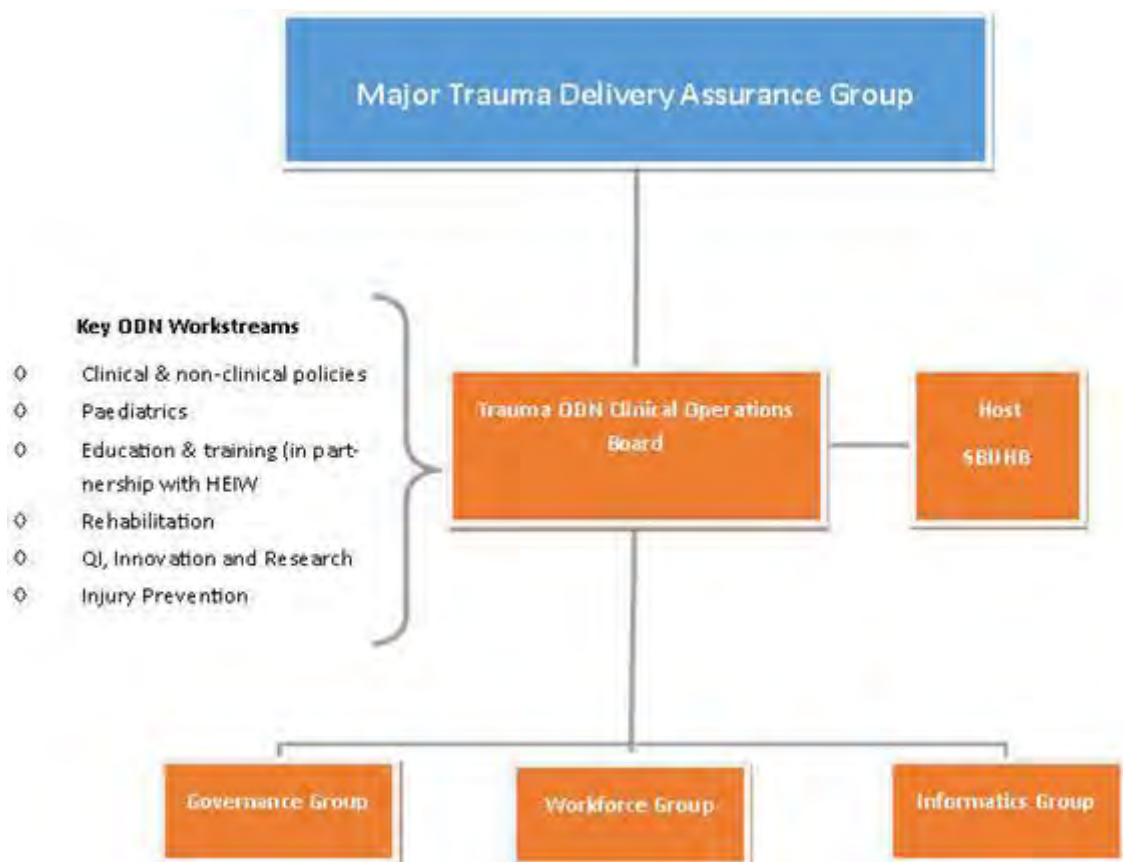
- Weekly teleconference between ODN and MTC clinical and operational management team.
- Monthly network teleconferences with ODN and network clinical and operational management teams.

Swansea Bay UHB will host the ODN. Swansea Bay will provide all organisational supporting arrangements and so the ODN will escalate, through Swansea Bay UHB, matters which pertain to enabling or support functions for the delivery of the network. These include (but are not restricted to):

- HR and workforce
- Financial and procurement
- Project and programme management
- Health and safety
- Statutory and mandatory training for ODN staff
- Risk and incident management
- Planning and managerial support

The ODN is, through the Delivery Assurance Group, accountable to WHSSC Joint Committee and the DAG will escalate directly to Joint Committee through the WHSSC structure, matters that pertain to commissioning and service delivery, planning and performance or any wider system related issues (e.g. patient flow, workforce risks and issues, approval for service change).

#### ODN Operating Structure:



### **12.6.3 Trauma Network Delivery Assurance Group (DAG)**

The trauma network DAG will meet bimonthly in the first year and then quarterly thereafter and be accountable for and oversee the delivery of whole patient pathway on behalf of the relevant commissioning bodies. The board will be responsible for ensuring effective clinical pathways of care between all providers in the network. In doing so, it will receive reports from the network Clinical Operations Board and Governance Group. The board will approve all work undertaken by providers and network working groups, pertaining to clinical governance.

Furthermore, in aligning with the NHS England service specification and quality indicators, the board takes its steer from the NHS England clinical reference group (CRG), a national forum of experts on trauma care. Presently, Wales is not represented on the national CRG and it is an important step for the programme to seek representation.

### **12.6.4 Trauma Network Clinical Operations Board**

The trauma network COB will meet monthly and oversee operational delivery of the whole pathway. It will actively manage performance and operational matters, being responsible for the development of the necessary plans and strategies to ensure ongoing sustainable service delivery. It will ensure that the schedule of business cases identified in this programme business case are delivered. It will oversee the closure and post programme evaluation and benefits realisation plan, as well as being responsible for developing the workforce and facilitating the development of network wide roles and ways of working.

### **12.6.5 Network Governance Group**

The network governance group will meet quarterly after the adult and paediatric clinical quality review meeting. The group will review themes emerging from all reporting into the network structure (including risk management). It will generate lessons and recommendations to share across the network and check that these are completed. It will also provide review and challenge to all work undertaken by providers and network working groups, prior to approval by the COB. Finally, the group will review governance issues pertaining to the Veterans Trauma Network.

The following list outlines minimum reporting criteria to the network governance group (this list is not exhaustive and providers will be encouraged to report any issues pertaining to clinical governance):

- All cases discussed in provider Morbidity and Mortality (M&M) meetings.
- All unexpected survivors and unexpected deaths.
- All cases where a complaint or concern is raised within a provider organisation.
- All cases discussed in adult and paediatric clinical quality reviews.
- All clinical incidents and serious adverse incidents raised by providers (minimum criteria set through network central incident reporting using the DATIX incident reporting system). These will still be reported through health board governance processes.
- TARN MTC and TU dashboards (incl. TARN PROMS/PREMS).
- Specific operational data impacting on clinical effectiveness and patient safety.
- The number and proportion of patients transferred directly to MTC, including cases of significant under- and over-triage in a pre-hospital setting.

- The number and proportion of patients that have an acute secondary transfer (within 12 hours) from a TU to MTC.
- The proportion of urgent transfers that occur within two calendar days.
- The number of patients with ISS  $\geq 15$  managed definitively within a TU and details of outliers.
- The number of patients where repatriation from MTC exceeds 48 hours from referral.
- Feedback of other networks relevant to major trauma (e.g. critical care)
- Peer review – the ODN has confirmed its intention to participate in the NHS England annual trauma peer review outlined below.

The frequency will be defined in the network operational policy, linked with the network informatics procedures.

The following outlines the outputs of the network governance sub-committee:

- Quarterly network report for network board and commissioning bodies. (Including performance and quality reviews)
- Annual internal and external facing network report.
- Quarterly lessons learnt bulletin from themed reviews, incident and serious adverse incident reporting shared with all providers.
- Urgent clinical and operational alerts (including changes in pathways and policies).
- Annual peer review report.
- Annual MTN conference.
- Annual performance and quality reviews with commissioners.

#### **12.6.6 Adult and Paediatric Clinical Quality Review Meetings**

These quarterly meetings aim to provide an open forum for sharing and discussion of clinical cases amongst multidisciplinary health care professionals who have been involved or wish to attend and learn. They will immediately precede the network governance group meeting. Specific themed criteria will be developed, but any provider in the patient's journey with concerns or questions (from the point of injury to rehabilitation and/or discharge) will be able to highlight cases for discussion.

These meetings will generate outcomes requiring input from the MTC and TU governance structures and network working groups, which will be agreed through the network governance group.

The ODN will also provide representation at the MTC clinical quality review meetings (or equivalent).

#### **12.6.7 MTC Clinical Governance Structure**

The MTC trauma board will oversee the activity of the MTC critical care huddle, TARN assessment meetings, morbidity and mortality meetings and the clinical governance, audit and quality committee. These will feed into the network governance group as indicated above.

#### **12.6.8 TU Clinical Governance Structure**

The TU trauma boards will oversee the activity of TARN assessment and morbidity and mortality meetings. The TU clinical governance structure will be responsible for overseeing the clinical governance of LEHs within the health board as appropriate. These will feed into the network governance group as indicated above.

### **12.6.9 Pre-Hospital Trauma Governance Group**

Given the number of providers involved in the delivery of pre-hospital trauma care across the region, a pre-hospital trauma governance group will be established to oversee clinical governance issues pertaining to major trauma. This group will review the effectiveness of the pre-hospital triage tool, trauma desk and manage any issues raised by providers pertaining to pre-hospital care. WAST is the main pre-hospital provider for the network and provides a named representative to report into the network governance group as well as responses to the adult and paediatric clinical quality review meetings held by the network.

### **12.6.10 Weekly/Monthly Teleconferences**

A weekly teleconference will be held between the ODN and MTC clinical leads and respective managers. Once a month these will occur between the ODN and network clinical and operational management teams. These will be used as an opportunity to identify immediate clinical governance issues which require immediate clinical and operational alerts or sign post further discussions within provider organisations or the network structure. A structure will also include monthly conference calls with the North West Midlands and North Wales Trauma Network and an opportunity to undertake joint governance meetings at least six-monthly. This will set the trajectory for collaborative working and future planning.

### **12.6.11 Trauma Peer Review Process**

Participation in the annual peer review process will be an important component of the quality assurance process and a key marker for whether additional investment in major trauma services across the region delivers improvements in clinical effectiveness and governance, and areas for improvement. The NHS England annual peer review process, undertaken by the quality surveillance team, has a record for delivering successful reviews in England and Northern Ireland. It is recommended that the NHS England review process be adopted for the South Wales Trauma Network for the following reasons:

- The review is carried out consistently in line with NHS England quality indicators and service specification for major trauma, which the network will be adopting with appropriate variation for the Welsh system. This provides an opportunity for benchmarking with networks elsewhere.
- It aligns with North Wales, who participate in peer review as part of their quality assurance process with the North West Midlands and North Wales Trauma Network.
- It is a driver for service development and quality improvement.
- It provides focus on coordination within and across organisations, following the patient pathway.
- It is clinically led with user and carer involvement from the outset.

The process has three phases – a pre-review visit, review day and post review. Pre-review requires completion of a self-declaration against quality indicators and an evidence upload. This is followed by a five-hour review day. Post peer review, a report is written with a categorisation of review findings. This is sent to the provider and relevant commissioners. If any serious concerns are raised, separate notification is sent directly to the chief executive of the provider and copied to relevant commissioners.

The first review of the ODN, MTC, TUs and pre-hospital providers is expected to be undertaken at the end of year 1, with further reviews guided by the results of the first.

### **12.6.12 Collaborative Working with North Wales**

There is significant learning from the experiences from North Wales, which is part of the North West Midlands and North Wales Trauma Network.

There are opportunities for improving governance including shared learning from both good and sub-optimal practice. This includes improving quality of care and learning from processes in this network even where processes may vary slightly but where pathways and solutions may be transferable. The same is true for network pathways and policies. This also includes good practice and methodologies in relation to TARN data and analysis. Furthermore, North Wales has had experience of participation in national peer review and the South Wales trauma network to participate in this process, but also learn from the experiences in North Wales, to explore challenging areas at the outset. The training and education working group for the network will also gain an understanding from North Wales in relation to key deliverables. North Wales currently runs a two day trauma team course, which has helped TUs comply with nursing standards for trauma training. North Wales has also looked at strategies for improving patient satisfaction and capturing feedback from trauma patients, especially those who go through the MTC.

Finally, in terms of the development of the rehabilitation model in South Wales, learning will be shared with North Wales in terms of the development of their local model.

## 12.7 Business Cases Supporting Implementation and Achievement of Standards

### 12.7.1 Schedule of Business Cases

The PBC provides a framework for all associated major trauma business cases. The following schedule shows the quantum of anticipated business cases expected:

Timetable of Business Cases - Major Trauma Network																									
		Indicative Capital and Revenue Cases																							
		2019/20			2020/21				2021/22				2022/23				2023/24				2024/25				
		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Cardiff and Vale Health Board	Cardiff Interim Capital Case																								
	MTC Capital Build																								
	MTC Business Case - Adults																								
	MTC Business Case - Paediatrics																								
	TTL																								
	Polytrauma Unit																								
	Orthogeriatrics																								
	Therapies																								
	Trauma Unit Costs																								
Swansea Bay Health Board	Initial Specialist Services - Swansea Bay																								
	Operational Delivery Network Clinical Informatics																								
	Orthoplastics Support to MTC																								
	Orthoplastics Support for Isolated Open Lower Limb Fracture Model																								
	Acute Spinal Services Model																								
Wales Ambulance Services Trust	WAST Business Case																								
Aneurin Bevan, Cwm Taf, Hywel Dda, Swansea Bay and Powys Health Boards	Key enabling TU Posts																								
	Therapy / Neuropsychology and Level 2 training nursing resource requirements																								
	Orthogeriatric Requirements																								
NHS Wales Health collaborative	Key enabling ODN posts																								
	Operational Delivery Network																								
Key																									
	Current planned business cases																								
	Business cases to be considered in the future																								

The above schedule reflects the position as at September 2019 and will be subject to change. The future plans for business cases from the health boards are difficult to forecast and articulate at this stage. The change in patient flows to health boards will impact on demand for cases such as rehabilitation and the impact can only be fully understood when the network has gone live and TARN data has been collected.

## 12.8 Evaluation – Post Implementation

### 12.8.1 Post Programme Assurance and Evaluation

The outline arrangements for post implementation review (PIR) and project evaluation review (PER) have been established in accordance with best practice and are as follows:

Post-project evaluation is a mandatory requirement for all NHS bodies who are undertaking a project of this scope and scale.



This section of the PBC sets out the plans, which, the programme team has put in place to undertake a thorough and robust post-project evaluation.

## **12.8.2 Framework for Post-Project Evaluation**

Following the handover of the network to SBUHB the Collaborative is committed to ensuring that a thorough and robust post-project evaluation (PPE) is undertaken at key stages in the process to ensure that positive lessons can be learnt from the programme that will be of value for wider system learning. The lessons learnt will be of benefit to:

- The Collaborative – in using this knowledge for future projects.
- Health boards, pre-hospital services and commissioners – to inform their approaches to future major projects.
- The NHS more widely – to test whether the approaches used in this programme have been effective.

PPE also sets in place a framework within which the agreed benefits realisation plan can be tested to identify which benefits have been achieved and which have not.

NHS guidance on PPE has been published and the key stages, which are applicable for this project, are:

- Evaluation of the various processes put in place during implementation.
- Evaluation of the project in use shortly after the development is operational.
- Evaluation of the project once the developments are well established.

Once the handover is completed the ODN will draw up detailed plans for evaluation at each of these stages in consultation with its key stakeholders. This section will also set out how these arrangements will be managed, how information will be disseminated and on what timescale.

## **12.8.3 Evaluation – Implementation**

The objective of this stage is to assess how well and effectively the project was managed from the time of PBC approval through to the commencement of operational commissioning.

It is considered that this should be undertaken six months following operational commissioning of the development.

The evaluation at this stage will examine:

- The effectiveness of programme management.
- Communications and involvement during implementation.
- The effectiveness of the working arrangements established by the network board.
- Support during this stage from other stakeholder organisations – Welsh Government, health boards, WHSSC and EASC.

## **12.8.4 Evaluation – Project in Use**

It is proposed that this stage of the evaluation be undertaken up to 12 months after the completion of operational commissioning of the scheme in order that as many of the lessons learnt are still fresh in the minds of the programme team and other key stakeholders.

The objective of this stage will be to assess how effectively the project was managed during the operational commissioning phase and into the actual operation of the new development.

The evaluation at this stage will examine:

- The effectiveness of programme management.
- Communications and involvement during commissioning and into operations.
- The effectiveness of the working arrangements established by the programme board.
- Support during this stage from other stakeholder organisations – Welsh Government, health boards, WHSSC and EASC.
- Overall success factors for the project in terms of cost and time.
- Extent to which it is felt the development meets users' needs – from the point of view of patients and staff.

It should be noted that in order to provide an appropriate comparator to the final point in this section, a similar survey should be undertaken and compared to staff and patient engagement exercises undertaken during the course of the programme. This will help the service to gauge the level of satisfaction with the existing service. In this way, increases in satisfaction can be directly measured, although it is recognised that a direct comparison will not be possible as the exact respondents will not be the same.

#### **12.8.5 Evaluation – Project is Well Established**

It is proposed that this evaluation is undertaken about two to three years following initiation of commissioning. The objective of this stage will be to assess the effectiveness of project management during the implementation of the new development. The evaluation at this stage will examine:

- The effectiveness of the working arrangements established by the lead commissioner (WHSSC) and the ODN.
- Extent to which it is felt the development meets users' needs, from the point of view of patients and staff.

It is envisaged that participation in national peer review of the whole system at the end of Year 2 will form part of this evaluation.

#### **12.8.6 Management of the Evaluation Process**

The ODN will manage the process in partnership with the lead commissioner (WHSSC).

All evaluation reports will be made available to all participants in each stage of the evaluation once the ODN and WHSSC management processes have endorsed the report.

The ODN management team will undertake the majority of the work.

The costs of the final post-project evaluation, once the new working practices are fully established, will be borne by the ODN and are not included in the costs set out in this PBC.

The ODN will seek to ensure that they keep abreast of projects that have been fully evaluated when in use and which have utilised the latest PPE guidance. The ODN will then take a view of the extent to which external support is required.

## **12.9 Programme Assurance**

The South Wales Trauma Network is planned to go live operationally in April 2020. Health board services are currently finalising the resource requirements that they will need to invest in service change to meet the phased quality indicators and service specification over the next five years as set out by the trauma network board. They are also working through the requirements of their own designated TUs. Go live carries a high degree of risk. National changes to patient flow will occur because of the implementation of this service change.

### **12.9.1 Aspects of Assurance**

There are three key elements to providing robust assurance so that the service can launch. These are:

- Programme Business Case – as a blueprint for implementation and a record of the decision making process and governance (planning diligence).
- MTC/TU/pre-hospital state of readiness for launch.
- Testing of the network's business continuity plan.

Based on the outputs of these elements, the network board will report to the WHSCC Joint Committee in February 2020, to seek the authority to go live in April 2020.

## 12.9.2 Gateway Review of Programme Business Case (PBC)

The OGC Gateway Review 0: Strategic Assessment took place in July 2019. There were 11 clearly outlined actions were identified by the Gateway Team that had to be taken-forward to address an overall delivery confidence assessment of Red / Amber. The recommendations are outlined below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status/Comment
1.	The Programme Board and Programme Team should assess whether the current phasing and go-live date is affordable and achievable.	C- Critical	Do now	Closed/Complete
2.	Close out the gap between the programme team specification of minimum day 1 requirements and current Health Board Business Cases and further develop planning assumptions for each phase to progressively meet Trauma Standards.	E- Essential	Do by end 10/19	Closed/Complete
3.	Undertake a critical scrutiny of all current Health Board and WAST Business Cases and design the process for the preparation and scrutiny of revised submissions.	E- Essential	Do by end 10/19	Closed/Complete
4.	Ensure the PBC sets out all capital requirements, including all proposed new MTC investment.	E- Essential	Do by end 10/19	Closed/Complete
5.	Confirm with Health Boards their commitment to funding of this programme via WHSSC (for the MTC and ODN) and their own direct investment (in TUs and rehabilitation).	C- Critical	Do by end 10/19	Closed/Complete
6.	Clearly set out the composite approval process for the PBC and associated revenue and capital funding including the roles of WG, WHSSC, EASC and Health Boards and document this as part of an integrated approval and assurance plan for the programme.	E- Essential	Do by end 09/19	Closed/Complete
7.	Secure additional leadership capacity in the Programme Team to drive even more whole system collaborative working and the delivery and integration of the Major Trauma Network.	C- Critical	Do now	Closed/Complete
8.	Develop on a collaborative basis a detailed plan for the full implementation of the programme and its constituent projects, including dependencies milestones and critical path up to the point when major trauma standards are being met.	E- Essential	Do by end 10/19	Closed/Complete (programme phasing)
9.	Review the Programme Board structure which will be needed to drive forward the implementation phase, following approval of the PBC	E- Essential	Do by end 10/19	Complete
10.	The Programme should develop a co-ordinated and collaborative approach to developing a skilled network workforce, including recruitment, training and development, rotations, shared appointments and short term requirements.	C- Critical	Do now	Complete – Principles agreed and published
11.	Develop the governance structure and operational authority for the Operational Delivery Network (ODN) and clear lines of accountability between the MTC and the ODN, and between them and the HBs.	E- Essential	Do by end 10/19	Governance and accountability arrangements described in ODN chapter

To support this, the Executive Strategy Group was formed, with executive planning, finance and workforce input, in support of the programme team and to provide assurance to the SRO. An action plan was drafted and, where appropriate, working groups were formed to directly address the 11 actions. A professional peer review was arranged to review the MTC, Specialist Services, Trauma Units, Pre-hospital care and Operational Delivery Network planned to consider appropriate phasing.

The Gateway Assurance of Action Plan (AAP) took place in September 2019. Whilst significant progress had been made and acknowledged against the actions outlined in the Strategic Assessment that took place in July a delivery confidence assessment of Red/ Amber was concluded by the Gateway Team. Since this review the outstanding critical recommendations below have been addressed in the context of this business case. The full recommendations are outlined below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status
1.	Establish whether all the relevant recommendations derived from the Professional Peer review have been accurately reflected in the latest Major Trauma Centre and SBUHB Specialist Services Business Cases.	C- Critical	Do now	Complete
2.	Seek an approach to close any gap in the initial service specification and affordability expectations between WHSSG and the Major Trauma Centre and SBUHB Specialist Services.	C- Critical	Do now	Complete
3.	Model the timing of recruitment to assess the service specification to which the network can operate from 1st April 2020 and include in the PBC.	E- Essential	Do by 15/10/19	Key enabling posts identified, funded and out to recruitment
4.	Determine the operating, accountability and governance structure for the ODN.	E- Essential	Do by 15/10/19	Proposals drafted and out for consultation/agreement between Chief Operating Officers, Chief Executives and Trauma Programme Board.

Following the AAP review, outstanding critical actions were completed and remaining actions were noted to be progressing well as outlined above. The Gateway 3 Review: Investment Decision took place between the 28 - 30 October 2019. This Gateway review has provided a delivery confidence assessment of amber green. This indicates that 'successful delivery appears probable. However constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.' The review recognised that two major activities were happening in parallel: the completion and approval process for the PBC and mobilisation for go live. It reported that, since the AAP review, substantial progress had been made with both the PBC and implementation plans.

The review team made the following recommendations:

Ref No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status
1.	Establish the timeline and plan for achieving the standards for TARN data recording on a timely basis across the network.	Recommended	Do by 01/20	Working plan developed and signed off by network board (see Chapter 5) and risk assessment. Significant progress being made
2.	Set out in the PBC the likely scale of future capital investment needed in the new MTC trauma theatre.	E- Essential	Do now	Complete. Estimated capital range included in updated PBC.
3.	Provide guidelines for each HB on the specific commitments being entered into by them in approving the PBC.	E- Essential	Do now	To be confirmed via core board report
4.	Confirm the processes for Swansea Bay SS, TU and ODN, and other HB TUs to self-assess their readiness to proceed with operational mobilisation and go-live of the MTN.	E- Essential	Do by 12/19	Detailed requirements of evidence for readiness have been drafted and visits to Health Boards are being planned.
5.	Identify, map out and regularly communicate those elements of the new MTN which will be in place at initial go-live and those which will be added in the period following go-live.	E- Essential	Do by 12/19	This is highlighted in the PBC and will be part of the implementation arrangements and communication plan
6.	Publish a timetable and arrangements for implementation, including the standing down of the existing programme structure and the standing up of new mobilisation and implementation structure.	E- Essential	Do by 12/19	Included in PBC and to be adopted in Health Board plans
7.	Establish the detailed clinical decision making process to confirm that the MTN is safe to take live, together with the final MTN Board decision making process.	E- Essential	Do now	Meeting held with MDs to give steer, and will be agreed via Joint Committee
8.	Expand the approach to the management and reporting of recruitment to include the Plastic Surgeons and other posts in the Trauma Network.	E- Essential	Do by 12/19	Confirmed at the Executive Strategy Group and led by the Workforce Group
9.	Develop more clarity about how the MTC and each TU, working with the ODN, will practically operationalise the policy to repatriate patients from the MTC.	C- Critical	Do now	Draft document developed, consultation underway with network board, COOs and MDs. Following which will be

Ref No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status
				discussed with Welsh Government, with a plan to test in Jan/Feb 2020

### 12.9.3 MTC/Health Board TUs/Pre-Hospital Readiness for Go Live

All quality assurance processes should include a mechanism to gather qualitative data from services to support identification of unforeseen issues as well as to ensure that all staff from front line through to senior management feel supported by the programme team in implementing the required changes. The process will also afford TU teams an opportunity to ask questions and seek clarification directly from clinical and managerial leads working in or on behalf of the programme team.

It is proposed that unit readiness visits are conducted as a collaborative exercise to enable individual health boards to receive constructive feedback on their state of readiness. This will enable the programme team to better understand each local service and specific issues, as well as being able to identify network wide issues that need resolution or escalation.

Consideration will be needed on the terms of reference for such visits. It is proposed that structuring visits around the patient pathway would provide a practical way of tangibly assessing local readiness. This would require support by both a structured set of service aspects to cover, in order that the approach of the visits is consistent. There should also be enough time and space to enable free discussion to afford sufficient time and focus on local issues and how they might be resolved, or risks appropriately mitigated.

### 12.9.4 Testing of Business Continuity Arrangements

One of the critical tasks for the programme team will be to coordinate the development of comprehensive contingency arrangements for the network board to deploy if necessary on day 1. This will be informed by the visits and documented contingencies as well as with wider national strategic considerations (e.g. fit with Civil Contingencies Act and Welsh Government national Emergency Planning functionality).

A timetable for the programme assurance process is provided below:

Aspect	Activity	Lead	Due date for completion
PBC gateway review	Planning of review scope and terms of reference with Welsh Government Investment and Infrastructure planning colleagues	Rhys Blake, NHS Health Collaborative  Ian Gunney, Welsh Government	End of May 2019
	MT Network Board agree Terms of Reference and Scope	Tracy Myhill, SRO, programme	June 2019

	Execution of review	Gateway team	July 2019
State of readiness visits (subject to ODN readiness)	Planning of visit scope, required documentation and process	Dindi Gill, Network Clinical Lead Jennifer Thomas, Network Rehabilitation Lead Jeremy Surcombe	End of October 2019
	Approval of scope of and process for visits	Network Board	November 2019
	Undertake visit - MTC	Programme Team and any specialist advisors recommended through the board	Mid December 2019
	Undertake visits – TUs/pre-hospital	Programme Team and any specialist advisors recommended through the board	January - February 2020
	Produce visit report also to inform business continuity test exercise	Programme Team	End of February 2020
Business continuity plan testing	Planning of test exercise	Programme Team & external facilitator	End of December 2019
	Approval of ToR	Network Board	December 2019
	Undertake exercise	Network	January 2020
Contingency Planning for Go Live	Define principles of contingency planning for the network and trigger points for activation	Programme Team & Network Board	November 2019
	Activation of contingency plan depending on feedback from organisations as appropriate	Network Board	January – March 2020

## 12.10 Benefits Realisation Plan

In the case for change chapter, a list of benefits was described against key investment objectives. These investment objectives included health gain, equity, clinical and skills sustainability and value for



money. In May 2019 a benefits realisation workshop was held, involving a broad group of stakeholders. These included representation from pre-hospital services, health boards, commissioners and Welsh Government. Using information gathered from the workshop, a comprehensive benefits realisation plan has been developed. The plan is divided into the four overarching strategic themes, based on the investment objectives. These are broken down to identify key supporting actions, timeframes for delivery and responsibility/accountability for delivery and review of benefits. Each measurable benefit has been assigned a unique number for recognition and monitoring purposes. The timeframe given indicates the earliest that data will be available to determine whether a benefit has been realised or not. The benefits realisation plan will be used in a number of ways:

- Formal evaluation of the network.
- Subsequent quality assurance and/or peer review processes.
- Commissioning framework.

### Strategic Benefit – Health Gain

Strategic Benefit	Benefits Number/Description	Actions Necessary to Realise Benefits	Measurement	Target date for demonstrating benefit	Responsible for delivering benefits	Accountable
Health Gain	001/Improving survival	<p>Introduction of inclusive trauma network</p> <p>Improve TARN data collection to ensure accurate survival scoring</p> <p>Ensure at least 1 year of baseline data collection before ODN operational</p>	<p>TARN probability of survival (quarterly/annual reports for network wide and all providers)</p> <p>Additional survival rate</p> <p>TARN case ascertainment and accreditation</p>	March 2023	ODN providers	WHSSC/EASC/health board commissioning
	002/Improving functional outcomes	<p>Develop an inclusive trauma network with a focus on all aspects of the rehabilitation pathway</p> <p>Improve TARN PROMS data collection to ensure baseline data available</p>	<p>TARN PROMS (quarterly/annual reports network wide and all providers)</p> <p>PROMS baseline data (1 years) before rehabilitation model operational</p>	March 2025	ODN providers (specifically rehabilitation providers)	WHSSC/health board commissioning

<b>Health Gain</b>			Example provided in Appendix 21 & Appendix 22			
	003/Improving timeliness and quality of clinical care.	Establish network policies and pathways (incl. automatic acceptance policy to MTC)	<p>TARN MTC and TU dashboards/ quarterly and annual reports.</p> <p>Quarterly and annual network TARN reports</p> <p>Focused TARN quarterly and annual reports (e.g. orthoplastics, paediatrics)</p> <p>Benchmarking against national average</p>	March 2021	ODN providers	WHSSC/EASC/health board commissioning
	004/Improving patients experience	Multiple levels of intervention through introducing the inclusive trauma network (based on learning from patient experience workshop)	<p>TARN PROMS/PREMS (patient experience component) Example provided in Appendix 23.</p> <p>Frequency on usage of patient centred communication tool (e.g. application)</p>	March 2023	ODN providers	WHSSC/EASC/health board commissioning

			Patient surveys (themed annually)			
	005/Enhancing injury prevention	Development of injury prevention strategy in conjunction with Public Health Wales	Number of injury prevention schemes undertaken  Quantify prevention of injury/death/disability	March 2023	ODN providers	Welsh Government
	006/More coordinated response at incidents or mass casualty events	Integration of mass casualty plans in to network operational structure	Record of debriefs and learning from table top/live exercises undertaken with network	March 2022	ODN providers	WHSSC/EASC/health board commissioning
	007/Improved data collection.	Implement TARN working plan	Network wide improvement of TARN case ascertainment to 80% and accreditation to 95% (incl. all providers)  Contribution of all providers to TARN PROMS/PREMS	March 2021	ODN providers	WHSSC/EASC/health board commissioning

### Strategic Benefits - Equity

Strategic Benefit	Description	Actions Necessary to Realise Benefits	Measurement	Target/ Date	Responsible for delivering benefits	Accountable
Equity	008/Equity of access to specialist care	Implementation of pre-hospital triage tool and automatic acceptance policy to MTC (incl. rapid secondary transfer)	<p>TARN data:</p> <p>The number and proportion of patients transferred directly to MTC/TU with specialist services.</p> <p>The number and proportion of patients that have an acute secondary transfer (within 12 hour) from a TU to MTC/TU with specialist services.</p> <p>The proportion of urgent transfers that occur within two calendar days.</p> <p>The number of patients with ISS <math>\geq 15</math> managed</p>	March 2021	ODN providers	WHSSC/EASC/health board commissioning

			definitively within a TU.			
	009/More appropriate patient flow	<p>‘Care with treatment closer to home’ policy</p> <p>Landing pad configuration in health boards</p>	<p>All wales repatriation database:</p> <p>Number of repatriations exceeding 48hrs from when ready by origin health board.</p>	March 2021	ODN providers	WHSSC/EASC/health board commissioning
	010/Equity of care for trauma in older people	Trauma in older people pathways developed and early geriatric assessment	Number of patients 65yr and over who have a clinical frailty score documented by a geriatrician within 72 hours of admission.	March 2023	ODN providers	WHSSC/health board commissioning
	011/Equity of care for veterans returning to Wales in line with England	Implement the veterans trauma network in Wales	Number of veterans referred and reviewed by the network	March 2021	ODN management	WHSSC/health board commissioners

**Strategic Benefit: Clinical Skills and Sustainability**

Strategic Benefit	Description	Actions Necessary to Realise Benefits	Measurement	Target/ Date	Responsible for delivering benefits	Accountable
<b>Clinical Skills &amp; Sustainability</b>	012/Improved multiprofessional training and education	Implementation of network training and education programme	Number of training and education events held split by type  Number of online modules completed by providers  Number of users of triage tool and trauma APP  Number of calls made to trauma desk (where decision making supported)	March 2021	ODN providers	WHSSC/EASC/health board commissioners
	013/Enhanced engagement of the MTC with the wider network	Strategy for supporting wider network	Number of engagement sessions led by MTC	March 2021	MTC	WHSSC
	014/Enhance new recruitment across the region	Implementation of an inclusive network  Workforce strategy	Identified staffing recruited  Number of joint appointments made	March 2020 onwards  March 2020 onwards	ODN providers  ODN management	WHSSC/EASC/health board commissioners

			Number of rotational appointments made  Publication of strategy			
	015/Improved staff retention	Workforce strategy	Turnover rates	March 2021	ODN providers	WHSSC/EASC/health board commissioners



**Strategic Benefit: Value for Money**

Strategic Benefit	Description	Actions Necessary to Realise Benefits	Measurement	Target/ Date	Responsible for delivering benefits	Accountable
Value for Money	016/Economic benefits of enhanced survival, functional outcome and return to work	Develop an inclusive trauma network with a focus on all aspects of the rehabilitation pathway	<p>TARN PROMS (quarterly/annual reports network wide and all providers)</p> <p>Economic output (e.g. quality adjusted life years – using the secure online data linkage bank)</p>	March 2025	ODN providers	WHSSC/EASC/health board commissioners
	017/Reduced secondary transfers (observed over time, but not initially)	Implementation of pre-hospital triage tool and automatic acceptance policy to MTC	<p>Secondary transfer ambulance conveyance rates</p> <p>Number of secondary trauma transfers undertaken by EMRTS/hospital transfer team</p> <p>Cost savings from above</p>	March 2023	WAST/EMRTS/health boards	EASC/health board commissioners

	018/Reduced length of stay in critical care	Implementation of MTC	Reduced length of stay (TARN/ICNARC datasets)	March 2023	ODN	WHSSC/EASC/health board commissioners
	019/Flexible working across health boards boundaries	Agree HR protocols to enable cross-health boards working	Number of new posts created working across organisations and joint policies	March 2021	ODN providers	WHSSC/EASC/health board commissioners
	020/Benefits to other part of the healthcare system	Development of an inclusive network overlapping with other areas of strategic development	Number of other services directly benefitting from investment in major trauma services	March 2021	ODN providers	WHSSC/EASC/health board commissioners

## 12.11 Risk Management Plan

Programme risks are managed through each network board where an updated risk register is presented at each meeting. As the programme transitions towards go live and services begin to mobilise, risk management will continue to be an important governance element of the new implementation structure.

### 12.11.1 Future Risk Profile and Plan

There are a number of sources of risk identification as a consequence of the activities of programme planning for implementation. A number of key activities will follow the submission of this case to WHSSC Joint Committee. These are:

- **Risk plan to manage non delivery or overachievement of benefits realisation plan**

NHS Wales is making a substantial investment in this service, so it is imperative that the benefits undergo a full risk assessment. That risk assessment will then be signed off by the network board and shared with commissioners and will be formally logged as a handover document to the ODN.

- **Risks emerging from Trauma Unit site visits**

TU readiness is essential to the maintenance of effective patient flow and achievement of benefits and improved outcomes. Each TU will receive a tailored report and an assessment on the escalation of additional risks identified through site visits will be made in advance of the final business continuity test (which may serve to mitigate or remove some of those risks).

- **Risks identified through business continuity exercise**

Staff working in EDs are managing services under an acute degree of strain. Winter will invariably bring significant pressures on the teams expected to deal with repatriation and management of their own cases not determined as MTC referrals by WAST. The business continuity exercise will test a number of scenarios already set out as case vignettes in this chapter. A full report of the business continuity exercise will include risk assessments from site visits, benefits plan analysis and business continuity testing.

## 12.12 Communication/Stakeholder Engagement Plan

A comprehensive communication/ stakeholder engagement plan was developed in 2018, indicating key stakeholder groups and how communication would be managed, both during the implementation and operational phases of the programme. The schedule of stakeholders was developed from the work undertaken to identify stakeholders as part of the public consultation process. Feedback in relation to this document has been received from health board engagement leads. Integral to the strategy is the responsibility for health boards to regularly update their respective local stakeholders in relation to this development. Currently an action plan is being developed to support the broader strategy. This includes a division of key stakeholder groups e.g. patients, families and carers, health boards, pre-hospital services, commissioning bodies, Welsh Government, academic institutes and colleges and third sector organisations. Within the context of each stakeholder, a description will be provided of key activities and messages, the modality through which these will be communicated, sequencing of the plan and identification of the lead organisation.

## 12.13 List of Specialist Advisors

Given the specialist nature of this strategic development, the programme has made extensive use of special advisors throughout its work programme. The special advisors listed below have been fundamental to assurance of the programme and in addition to network board membership.

- Pre network board establishment
- Clinical Reference Group Membership
- Independent Panel Membership
- Post network board establishment
- National
  - Professor Chris Moran – National Clinical Director, Major Trauma NHS England
  - Professor David Lockey – Clinical Director, Severn Trauma Network and Interim Clinical Lead, South Wales Trauma Network (2017-2018)
  - Dr Martin McKechnie – National Clinical Director, Scottish Trauma Network
  - Kate Burley – Associate Director, Scottish Trauma Network
  - Dr Sally Lewis – National Clinical Lead for Value-Based and Prudent Healthcare
- Orthopaedic Trauma
  - Professor Ian Pallister – T&O consultant, Morriston Hospital
  - Mr Dean Boyce, Consultant Plastic Surgeon, Morriston Hospital
  - Mr Hywel Dafydd - Consultant Plastic Surgeon, Morriston Hospital
  - Mr James Lewis – Trauma & Orthopaedic Consultant, UHW
- Spinal Trauma
  - Mr Navin Verghese, Spinal Consultant, Morriston Hospital
  - Mr Sashin Ahuja, Spinal Consultant, UHW
  - Mr James Cordell-Smith, Spinal Consultant, Royal Gwent Hospital`
- Spinal Rehabilitation
  - Mr Sreedhar Kolli – Spinal Rehabilitation Consultant, Rookwood Hospital
- Thoracic Trauma
  - Mr Douglas West, Thoracic surgery consultant, University Hospitals of Bristol
- TARN
  - Antoinette Edwards – Executive Director, TARN
  - Laura White – Operations Director, TARN
  - Professor Fiona Lecky – Research Director, TARN
- Evidence based review
  - Dr Rowenna Morris-Clarke – Anaesthetist, Swansea Bay UHB

The August 2019 Professional Peer Review had input from the following:

- **Major Trauma Centre Case**
  - Mr Rob Faulconer, Consultant Vascular Surgeon, Plymouth Hospitals NHS Foundation Trust
  - Dr Ben Walton, Consultant ICM and Anesthetics, North Bristol NHS Trust
  - Dr Richard Hall, Consultant in Emergency Medicine, University Hospital of North Midlands NHS Trust
  - Dr Steve Novak, Consultant in Rehabilitation Medicine, North Bristol NHS Trust
  - Dr Judith Allanson, Consultant in Neurorehabilitation, Cambridge University Hospitals NHS Trust
  - Dr Giles Haythornthwaite, Consultant in Paediatric Emergency Medicine, Clinical Lead for the Paediatric Major Trauma Centre, Named Doctor For Child Safe-Guarding
- **Specialist Services**
  - Mr Shehan Hettiaratchy - Plastic and Reconstructive Surgeon, Imperial College, Trust trauma lead and lead surgeon; consultant plastic, hand and reconstructive surgeon, Imperial College Healthcare NHS Trust
  - Miss Loz Harry, Consultant Plastic Surgeon, Queen Victoria Hospital
  - Mr Mark Wilson, Consultant in Neurosurgery and Pre-Hospital Care Specialist, Imperial College Hospital
- **Trauma Units**
  - Dr Ash Basu, Consultant Emergency Physician, Betsi Cadwaladr University Health Board
  - Dr Adam Wolverson, Consultant in Intensive Care Medicine and Anaesthesia, United Lincolnshire Hospitals NHS Trust
  - Dr Steve Novak, Consultant in Rehabilitation Medicine, North Bristol NHS Trust
- **Pre-Hospital**
  - Dr Phil Cowburn, Acute Care Medical Director, South West Ambulance Services NHS Foundation Trust
- **Operational Delivery Network**
  - Mr Steve Cooke, Network Manager, West Midlands Trauma Network
  - Dr Louisa Stacey, Major Trauma Centre Manager and Thames Valley Trauma, Vascular, and Spinal Networks Manager, Oxford University Hospitals
- **Therapies**
  - Donna Pike, Therapies Service Line Cluster Manager, University Hospitals Plymouth NHS Trust
  - Jenny Coe, Major Trauma Rehabilitation Coordinator, Brighton and Sussex University Hospitals NHS Trust
  - Justine Theaker, Consultant AHP, Manchester Hospitals NHS Foundation Trust
  - Dr Lisa Robinson, Consultant Allied Health Professional – Major Trauma Rehabilitation, The Newcastle upon Tyne Hospitals NHS Foundation Trust

## 13 Conclusions and Recommendations

This Programme Business Case (PBC) describes the totality of the requirements for NHS Wales to establish the South Wales Trauma Network, serving the population of South Wales, West Wales and South Powys. The PBC outlines the trajectory of the programme over a five year period of phased implementation. It represents the culmination of significant work over seven years.

The vision for the establishment of the network is to enhance patient outcomes and experience, across the entire patient pathway from the point of wounding to recovery, and also includes injury prevention. The trauma network will improve patient outcomes by saving lives and preventing avoidable disability, returning patients to their families, work and education. The aim is to develop an inclusive, collaborative, world leading trauma network, with quality improvement informed through evidence-based medicine and lessons learnt from others.

The programme was established, following full endorsement by all six health boards in the region, of the following recommendations made by an independent expert panel, following a period public consultation:

- A major trauma network for South Wales, West Wales and South Powys with a clinical governance infrastructure should be quickly developed
- The adults' and children's Major Trauma Centres (MTC) should be on the same site
- The MTC should be at University Hospital of Wales (UHW), Cardiff
- Morriston Hospital should become a large Trauma Unit (TU) and should have a lead role for the major trauma network
- A clear and realistic timetable for putting the trauma network in place should be set

The network board was established in May 2018 and set out a robust case, aligning with both national and international strategic drivers for change. The case for change is compelling, with the prospect of benefits realisation aligned closely with key investment objectives of health gain, equity, clinical and skills sustainability, and value for money, including economic benefits. Thus, where indicated, a value-based healthcare approach has been applied.

The network board has overseen the development of the structure of the network, comprised of the following elements:

- An Operational Delivery Network (ODN) hosted by Swansea Bay University Health Board
- An adult's and children's MTC at UHW, Cardiff
- An adult and paediatric TU with specialist services at Morriston Hospital, Swansea
- Six adult and paediatric TUs at the following locations:
  - UHW, Cardiff
  - Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Aneurin Bevan University Health Board)
  - Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend
  - Glangwili General Hospital, Carmarthen

- Rural trauma facilities at Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest
- A Local Emergency Hospital at Royal Glamorgan Hospital, Llantrisant

The network board has also developed a phased clinical and operational model, based on the NHS England quality indicators and service specification for major trauma services. All providers and relevant commissioning bodies have agreed this model and requisite resource requirements, following several tiers of internal and external reviews, as outlined below:

- An ODN and management team hosted by Swansea Bay University Health Board. This includes requirements set out for network clinical informatics and training and education.
- Pre-hospital requirements for the Welsh Ambulance Service NHS Trust (WAST), including additional ambulance conveyances, the development of a national trauma desk function and an educational programme. The agreed first phase of the Emergency Medical Retrieval and Transfer Service Cymru (EMRTS) expansion to 24/7, from April 2020, is described within this case for completeness.
- Requirements for the combined adult and paediatric MTC at UHW, including the 24/7 presence of a consultant trauma team leader, the establishment of a polytrauma ward, additional theatre/critical care capacity, a plastic surgical service and a model of hyper-acute rehabilitation.
- Key enabling resources for TUs and an approach to the 'landing pad' for patients returning from the MTC for care with treatment closer to home.

The case describes the delivery of absolute requirements for Day 1, but also the schedule of business cases that will follow as part of the phased introduction of the network. In doing so, the case also sets out a timeline for implementation of the network (and composite parts) on 1 April 2020, with the ODN management team being put into place in January 2020. Whilst this presents an ambitious timeline, the programme is committed to achieving this.

In order to manage implementation, the case describes a revised implementation structure, commissioning and organisational governance arrangements and workforce principles to maximise positive benefits of recruitment for the wider healthcare system. Finally, a focus is placed on giving the ODN operational authority, particularly in relation to the repatriation of patients from the MTC and maintaining patient flow across the network.

The network board recommends that health boards, commissioners and the Welsh Government endorse this Programme Business Case, the agreed structure and the requisite phased resource requirements for the establishment of the South Wales Trauma Network, serving the population of South Wales, West Wales and South Powys, so that it can proceed with implementation.

The programme team would like to thank all contributors for their time and advice in developing this complex and challenging Programme Business Case.

# References

## Academic Publications

- Ali *et al.* Experience of managing open fractures of lower limbs in MTC. *Ann R Coll Surg Engl.* 2015 May; 97(4): 287–290
- Baarr LV *et al.* The effect of becoming a major trauma centre on the outcomes for elderly hip fracture injury. *Injury* 2015; 46(2): 384-387.
- Batrich *et al.* Impact on an acute trust after opening a major trauma centre. *B J Hospital Medicine* 2013; 74(2): 64-65.
- Bryce NT *et al.* Rapid ground transport of trauma patients: a moderate distance from trauma centre improves survival. *Journal of Surgical Research* 2018; 232: 318-324.
- Celso *et al.* A systematic review and meta-analysis comparing outcome of severely injured patients treated in trauma centers following the establishment of trauma systems. *Trauma* 2006; 2: 371-378.
- Davenport RA *et al.* Major trauma centre is a specialty hospital not a hospital of specialties. *Br J Surg* 2010 Jan; 97(1): 109-17.
- Durham R, Pracht E, Orban B, Lottenburg L, Tepas J, Flint L. Evaluation of a mature trauma system. *Annals of Surgery* 2006; 243: 775–85.
- Engel *et al.* Pre-hospital and in-hospital parameters and outcomes in patients with traumatic brain injury: A comparison between German and Australian trauma registries. *Injury* 2010; 41(9): 901-906.
- Gabbe B *et al.* Improved functional outcomes for major trauma patients in a recognised trauma system 2015. *Ann Surg* 2012; 255:1009–1015.
- Gabbe B *et al.* The effect of an organized trauma system on mortality in major trauma involving serious head injury: a comparison of the United Kingdom and Victoria, Australia. *Annals of surgery* 2011; 253 (1); 138–143,
- Gabbe B *et al.* Reduced population burden of road transport-related major trauma after introduction of an inclusive trauma system. *Ann Surg* 2015; 261(3): 565-572.
- HAQ J *et al.* Implementation of an oral and maxillofacial surgery trauma team in a major trauma centre. *British Journal of Oral and Maxillofacial Surgery* , Volume 55 , Issue 4 , 396 - 399
- Hay *et al.* The impact of the Major Trauma Network: will trauma units continue to treat complex foot and ankle injuries? *Injury* 2014; 45(12): 2005-2008.
- Hendrickson S *et al.* Plastic surgical operative workload in major trauma patients following establishment of the major trauma network in England: A retrospective cohort study. *J Plast Reconstr Aesthet Surg.* 2016; Jul;69(7):881-7. doi: 10.1016/j.bjps.2016.02.003. Epub 2016 Feb 12
- Kehoe *et al.* The changing face of major trauma in the UK. *Emerg Med J* 2015; 32(12): 911-915.
- Khan F *et al.* Systematic review of multidisciplinary rehabilitation in patients with multiple trauma. *BJS Jan 2012* Volume99, IssueS1. Supplement: Trauma Supplement p88-96
- MacKenzie E, Weir S, Rivara F, *et al.* The value of trauma centre care. *Journal of Trauma: Injury, Infection, and Critical Care* 2010; 69: 1–10. 94.
- McDermott *et al.* Management deficiency and death preventability of road traffic accidents before and after a new trauma care system. *J Trauma* 2007; 63(2): 331-338.
- McKechnie PS *et al.* Time to CT and surgery for HPB trauma in Scotland prior to the introduction of major trauma centres. *World J Surg.*41(7):1796-180



- McKee *et al.* Right treatment at the right time in the right place. *Ann Surg* 2015; 261: 558-564.
- McQueen C *et al.* Impact of introducing a major trauma network on a regional helicopter emergency medicine service in the UK. *Emerg Med J* 2014; 31: 844-850.
- Metcalfe *et al.* Effect of regional trauma centralization on volume injury severity and outcomes of injured patients admitted to trauma centres. *Br J Surg* 2014; 101(8): 959-964.
- Moran C *et al.* Changing the System - Major Trauma Patients and Their Outcomes in the NHS (England) 2008-17. *EClinicalMedicine* 2-3 (2018): 13-21.
- Preston JF *et al.* Major trauma outside a trauma centre: prehospital, emergency department and retrieval considerations. *EMCoNA* 2018; 36(1): 203-218.
- Rotondo MF *et al.* What price commitment: what benefit? The cost of a saved life in a developing level I trauma centre. *Journal of Trauma and Acute Care Surgery*. 2009; 67(5): 915-923.
- Rotondo M, Smith R. American College of Surgeons Committee on Trauma. Resources for the Optimal Care of the Injured Patient. *American College of Surgeon* 2014. Chicago IL. 100.
- Séguin J *et al.* An economic evaluation of trauma care in a Canadian lead trauma hospital. *Journal of Trauma: Injury, Infection, and Critical Care* 1999; 47: 99-103.
- Simons RU *et al.* Impact on process of trauma care delivery 1 year after the introduction of a trauma program in a provincial trauma centre. *J Trauma* 1999; 46(5): 811-816.
- Sinclair *et al.* Clinician tasking in ambulance control improves the identification of major trauma and pre hospital critical care team tasking. *Injury* 2018; 49(5): 897-902.
- Slade A *et al.* A randomised controlled trial to determine the effect of intensity of therapy on length of stay in a neurological rehabilitation setting. *J Rehabilitation Med* 2002; 34(6): 260-66.
- Spreadborough *et al.* A study of outcomes of patient Rx at a UK MTC for mod-severe injuries *Journal of Plastic, Reconstructive & Aesthetic Surgery* 2018; 69: 881e887.
- Dr T.A. & Lecky Professors F.E, S. Mason and J. Nicholl (2015). NHS England Economic Evaluation of Regional Trauma Networks – Second Report. *Sheffield: University of Sheffield*. 97. NHS Clinical Advisory Group (2010).
- Taylor *et al.* The cost-effectiveness of physician staffed Helicopter Emergency Medical Service (HEMS) transport to a major trauma centre in NSW, Australia. *Injury* 2012; 43: 1843-1849.
- Wood RL *et al.* Clinical and cost effectiveness of post-acute neurobehavioural rehabilitation. *Brain Injury* 1999; 13(2): 69-88.
- Yip *et al.* Capacity planning for the implementation of major trauma centres. *RCS The Bulletin* 2016; 98(3): 122-126. Accessed at: <https://publishing.rcseng.ac.uk/doi/pdf/10.1308/rcsbull.2016.122>.
- Zarza B *et al.* Long-term survival and return on investment after non-neurologic injury: implications for the elderly trauma patient. *Journal of Trauma: Injury, Infection, and Critical Care* 2010; 69: 93-98.
- Hendrickson SA *et al.* Plastic surgical operative workload in major trauma patients following establishment of the major trauma network in England: A retrospective cohort study. *J Plast Reconstr Aesthet Surg* 2016. Accessed at: <https://doi.org/10.1016/j.bjps.2016.02.003>.

## Published Guidelines and Policies

A Healthier Wales plan, 2018. Accessed at: <https://gov.wales/sites/default/files/publications/2019-04/in-brief-a-healthier-wales-our-plan-for-health-and-social-care.pdf>.

Amber review: a review of calls to the ambulance service categorised as amber, 2018. Accessed at: <http://www.wales.nhs.uk/sitesplus/documents/1134/NHS-Amber-Report-ENG-LR.PDF>.

ARCH. A regional collaboration for health report, 2017-2018. Accessed at: <file:///C:/Users/di008773/AppData/Local/Microsoft/Windows/INetCache/IE/WFWZ3R3P/Regional%20Working%20and%20Collaboration%20Annual%20Report%202017%202018.pdf>.

British Orthopaedic Association. Open fractures, 2017. Accessed at: <https://www.boa.ac.uk/resources/boast-4-pdf.html>.

Hywel Dda University Health Boards. Transforming clinical services. Accessed at: <http://www.wales.nhs.uk/sitesplus/862/page/92263>.

National Audit Office, 2010. Major Trauma Care in England. London: The Stationery Office 99. Accessed at: <https://www.nao.org.uk/report/major-trauma-care-in-england/>.

National Implementation plan, Scottish Trauma Network, 2018. Accessed at: <https://www.scottishtraumanetwork.com/wp-content/uploads/2018/06/STN-National-Implementation-Plan.pdf>

NHS commissioning: service specification D15/S/a, major trauma, 2013. Accessed at: <https://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf>.

NHS commissioning: service specification D15a, trauma ODN 2012/13.

NHS Confederation: When tragedy strikes. Reflections on the NHS response to the Manchester Arena bombing and Grenfell Tower fire, 2018. Accessed at: <https://www.nhsconfed.org/-/media/Confederation/Files/Publications/When-tragedy-strikes-report-June-2018-WEB.PDF>.

NICE guideline [NG39]. Major trauma: assessment and initial management, 2016. Accessed at: <https://www.nice.org.uk/guidance/ng39>.

The National Clinical Audit of Specialist Rehabilitation following major Injury (NCASRI), 2019. Accessed at: <https://www.hqip.org.uk/wp-content/uploads/2018/02/SbAilk.pdf>.

Regional Trauma Networks for Major Trauma, 2010. Accessed at: <https://www.uhs.nhs.uk/Media/SUHTInternet/Services/Emergencymedicine/Regionalnetworksformajortrauma.pdf>.

Shaping our Future Wellbeing Strategy, Cardiff and Vale University Health Board, 2015-2025. Accessed at: <http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/10%20-%20UHB%20Shaping%20Our%20Future%20Wellbeing%20Strategy%20Final.pdf>

Specialist Rehabilitation in the Trauma pathway: British Society of Rehabilitation Medicine: core standards, 2013. Accessed at: <https://www.bsrn.org.uk/downloads/bsrm-core-standards-for-major-trauma-24-10-13-version1.4newlogo-forpublication-finalforweb-checked1-12-14.pdf>.

Task and Finish Group on Critical Care Final Report, July 2019. Accessed at: [https://gov.wales/sites/default/files/publications/2019-07/task-and-finish-group-on-critical-care-final-report\\_0.pdf](https://gov.wales/sites/default/files/publications/2019-07/task-and-finish-group-on-critical-care-final-report_0.pdf).

The Royal College of Surgeons of England, 2009. Regional trauma systems - interim guidance for commissioners. London: The Royal College of Surgeons of England. Accessed at: <https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/regional-trauma-systems-interim-guidance-for-commissioners/>.

Welsh Ambulance Service NHS Trusts, Integrated Medium Term Plan Summary 2018-21. Accessed at: <http://www.ambulance.wales.nhs.uk/assets/documents/e414e14c-4c7a-4c54-8316-554e5abcd5b2636723556913360426.pdf>

## Abbreviations

ABUHB	Aneurin Bevan University Health Board
AHP	Allied Healthcare Professional
AIS	Abbreviated Injury Scale
APLS	Advanced Paediatric Life Support
APP	Advanced Paramedic Practitioner
AEMT	Advanced Emergency Medical Technician
ASD	Air Support Desk
ATLS	Advanced Trauma Life Support
BCUHB	Betsi Cadwaladr University Health Board
BOAST	British Orthopaedic Association Standards for Trauma and Orthopaedics
CAG	Clinical Advisory Group
CCC	Clinical Contact Centre
CCP	Critical Care Practitioner
CHC	Community Health Council
CRG	Clinical Reference Group
CT	Computerised Tomography
CTMUHB	Cwm Taf Morgannwg University Health Board
C&VUHB	Cardiff and Vale University Health Board
CWTCH	Care with Treatment Closer to Home
DGH	District General Hospital
DSTS	Definitive Surgical Trauma Skills
EASC	Emergency Ambulance Service Committee
ED	Emergency Department
EMRTS	Emergency Medical Retrieval and Transfer Service Cymru
EMT	Emergency Medical Technician
EPALS	European Paediatric Advanced Life Support
ETC	European Trauma Course
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
ICD-10	International Classification of Diseases, Tenth Revision
IMTP	Integrated Medium Term Plan
ITS	Inclusive Trauma System
ISS	Injury Severity Score

LEH	Local Emergency Hospital
MRI	Magnetic Resonance Imaging
MTC	Major Trauma Centre
NEPTS	Non-Emergency Patient Transfer Service
NHSWHC	National Health Service Wales Health Collaborative
NMTNG	National Major Trauma Nursing Group
NWMNWTN	North West Midlands and North Wales Trauma Network
NWIS	National Health Service Wales Informatics Service
ODN	Operational Delivery Network
PACU	Post-Anaesthetic Care Unit
PBC	Programme Business Case
PEDW	Patient Episode Database for Wales
PER	Project Evaluation Review
PIR	Post-implementation Review
PPE	Post-project Evaluation
PTHB	Powys Teaching Health Board
PREMS	Patient Reported Experience Measures
PROMS	Patient Related Outcome Measures
QI	Quality Improvement
SBUHB	Swansea Bay University Health Board
SCIC	Spinal Cord Injury Centre
SRO	Senior Responsible Officer
SWP	South Wales Programme
SWTN	South Wales Trauma Network
TARN	Trauma Audit and Research Network
TNCC	Trauma Nursing Core Course
TTL	Trauma Team Leader
TTM	Trauma Team Member
TU	Trauma Unit
UHW	University Hospital of Wales
VTN	Veterans Trauma Network
WAACT	Wales Air Ambulance Charity Trust
WAST	Welsh Ambulance Service NHS Trust
WATcH	Wales and West Acute Transport for Children Service
WCP	Welsh Clinical Portal
WCRS	Welsh Care Records Service

WHSCC	Welsh Health Specialised Services Committee
WPAS	Welsh Patient Administration System
WPRS	Welsh Patient Referral Service
WRRS	Welsh Results Reporting System

# Glossary of Terms

## **Case Ascertainment**

Proportion of patients submitted to Trauma Audit and Research Network (TARN) compared to expected number based on Patient Episode Database for Wales (PEDW) dataset. Marker of data completeness.

## **Case Accreditation**

Proportion of key fields completed for each patient and submitted to TARN. Marker of quality of data submitted.

## **Computerised Tomography (CT)**

A scanning technique that uses x-rays to take highly detailed images of the body.

## **Critical Care**

Refers to two related processes. Firstly, 'critical' refers to discernment or recognition of a crucial and a decisive turning point, the deterioration of the patient's condition, followed, secondly, by 'care' (i.e. intervention including resuscitation and transport to a critical care service). Critical care resuscitation and treatment interventions include a complex range of general and specialty procedures, supports and diagnostic procedures. Thus, the critically ill patient benefits from appropriate and timely critical care in the health system with a greatly increased probability of survival.

## **Definitive Care**

The care that is rendered to conclusively manage a patient's condition, such as full range of preventive, curative acute, convalescent, restorative, and rehabilitative medical care.

## **Injury Severity Score**

An anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (head, face, chest, abdomen and extremities including pelvis, external). Only the highest AIS score in each body region is used. The three most severely injured body regions have their score squared and added together to produce the ISS score. An ISS of 9-15 implies moderate trauma and an ISS>15 implies major trauma. An ISS>9 implies 'candidate' major trauma.

The ISS is calculated retrospectively once the patient's injuries are fully known.

## **Inter-Hospital Transfer**

### *Primary Transfer*

A transfer where a patient is retrieved from a pre-hospital environment.

### *Secondary Transfer*

A planned transfer of a patient to a local facility as a result of capacity issues or for the ongoing repatriation of the patient.

### *Hyper-Acute Secondary Transfer*

A transfer where a patient is retrieved from a hospital environment. This is for a time critical, life threatening condition. This may occur when a patient has acutely deteriorated or following a patient self-presenting or being transported to the hospital due to the paramedic crew making the decision that further ongoing transport would have endangered the life of the patient. This is also known as a delayed primary transfer.

**Landing Pad**

The environment to which major trauma patients will return once their specialist care is complete (e.g. at the MTC). It includes the structures in place to support and enhance the confidence of medical and nursing staff in managing patients in the recovery, rehabilitation and re-enablement phases of their journey.

**Level 1 and 2 Trauma Nursing Competency**

The levels of competency required for nurses engaging in the care of adult and paediatric major trauma patients. These have been developed by the National Major Trauma Nursing Group.

**Local Emergency Hospital**

A hospital in a Trauma Network that does not routinely receive acute trauma patients. It has processes in place to ensure that, should this occur, patients are appropriately transferred to a Major Trauma Centre or Trauma Unit.

**Major Incident**

A significant event, which demands a response beyond the routine, resulting from uncontrolled developments in the course of the operation of any establishment or transient work activity. The event may cause, or have the potential to cause either:

- Multiple serious injuries, cases of ill health (either immediate or delayed), or loss of life.
- Serious disruption or extensive damage to property, inside or outside the establishment.

**Major Trauma**

Serious, and often multiple, injuries where there is a strong possibility of death or disability.

**Major Trauma Centre**

A multi-specialty hospital, on a single site, optimised for the provision of trauma care, integrated with the rest of the Trauma Network.

**Mass Casualty Incident (MCI)/**

Any incident in which emergency medical services resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties. Sometimes called a multiple-casualty incident or multiple-casualty situation.

**Pre-hospital Care**

Covers a wide range of medical conditions, medical interventions, clinical providers and physical locations. Medical conditions range from minor illness and injury to life threatening emergencies. Pre-hospital interventions, therefore, also range from simple first aid to advanced emergency care and pre-hospital emergency anaesthesia. Care providers may be lay first responders, ambulance professionals, nurses or physicians of varying backgrounds. All of this activity can take place in urban, rural or remote settings and is generally mixed with wider out-of-hospital and unscheduled care.

**Probability of Survival**

This is calculated for each injured patient and retained on the TARN database. This allows comparative outcome analyses for hospitals and for other groups of patients to be performed.

**Reablement**

A short and intensive service, usually delivered in the home, which is offered to people recovering from an injury to promote and maximise independence.



**Rehabilitation**

A process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living.

**Rehabilitation Plan**

A plan used to document the rehabilitation needs of severely injured patients (ISS score  $\geq 9$ ) and identify how they will be addressed.

**Retrieval**

The use of expert medical teams to assess, stabilise, package and subsequently transport a patient from one site to another. The aim is the delivery of critical care equivalent to that provided at a major hospital facility.

**Rural Trauma Facility**

Used to describe the role of Bronglais General Hospital and Withybush General Hospital as part of the Trauma Network. These hospitals do not meet the quality indicators and service specification of a Trauma Unit, however, given their relatively rural location, will receive disproportionately more major trauma compared to a Local Emergency Hospital. These hospitals will need to maintain the ability to assess and treat major trauma patients, before onward transfer to the Major Trauma Centre or nearest Trauma Unit, as appropriate.

**Specialist Rehabilitation**

The total active care of patients with complex disabilities by a multiprofessional team who have undergone recognised specialist training in rehabilitation, led/ supported by a consultant trained and accredited in rehabilitation medicine.

**Trauma**

Physical injuries of sudden onset and severity, which require immediate medical attention.

**Trauma Care Pathway**

The process through which care is provided for patients who have suffered Major Trauma. Specifically, it describes the location and capability of each facility within the inclusive trauma system and outlines the ambulance bypass protocols and thresholds for transferring patients to more specialist units. The pathway has several stages, including pre-hospital care, acute care and surgery, ongoing care and reconstruction and specialised and local rehabilitation. Within the pathway, hyper-acute rehabilitation starts early. Two additional components have been added: injury prevention and social care.

**Trauma Network**

The collaboration between the providers commissioned to deliver trauma care services in a geographical area. The term is interchangeable with the terms 'Trauma Operational Delivery Network' and 'Inclusive Trauma System'.

**Trauma Unit**

A hospital in a Trauma Network that provides care for most injured patients.



<b>Report Title:</b>	<b>Draft Integrated Medium Term Plan 2020-23</b>						
<b>Meeting:</b>	<b>Board</b>				<b>Meeting Date:</b>	25/07/19	
<b>Status:</b>	<b>For Discussion</b>	<b>X</b>	<b>For Assurance</b>		<b>For Approval</b>		<b>For Information</b>
<b>Lead Executive:</b>	<b>Executive Director of Planning</b>						
<b>Report Author (Title):</b>	<b>Corporate Strategic Planning Lead</b>						

## SITUATION

The NHS Wales Finance Act requires the submission of a three year Integrated Medium Term Plan (IMTP) to Welsh Government. As the Board will be aware the Welsh Government approved the organisations plan for 2019-22. The plan is required to be refreshed, bringing forward a greater level of detail into the first year of the plan and considering actions for the next three year cycle.

The current working draft IMTP for 2020-23 is attached with this paper alongside the draft workforce IMTP.

Board Members are asked to note and discuss the draft plan. The plan will then be further refined ready for submission to Welsh Government by the 31<sup>st</sup> January 2020.

This draft plan does not contain the financial plan as we have not yet had our budget allocation for 2020/21 therefore whilst we have set out our priorities this will need to be reviewed in light of the budget parameters. The draft financial plan will be provided to the Finance Committee in December.

## REPORT

### BACKGROUND

The process of developing an Integrated Medium term plan is not one that sits outside of our approach to change and delivery in the organisation, it is integral to the way we do things round here. The IMTP process has been maturing in the organisation and the way we presented and conveyed our 2019/22 plan to Welsh Government provides a strong foundation for delivery. The maturing of the transformation programme, alongside work on commissioning, operational delivery and clinical strategy all combine as part of our approach to medium term planning.

Planning is not about a document but about creating opportunities for new conversations, helping teams make connections and providing a coherent narrative for our organisation. It is about clarity of expectation on priorities for our staff and with our partners, providing a basis for accountability.

Shaping our Future Wellbeing remains the focus and our IMTP sets out the process by which

we will deliver our strategy. Our organisational objective are our wellbeing objectives and the Wellbeing of Future Generations Act provide an underling driver for our organisation.

We have an approved plan for the next three years. Therefore the emphasis of this draft plan is a refreshing of the approved plan as opposed to drafting a new plan from scratch.

The plan is set in the context of the Area plan and partnership working with other Health Boards. There are a range of national priorities driven through a range of programmes and whilst we must acknowledge the role we plan in delivering these programmes we must have a relentless focus on deriving better value for our patients and communities.

## ASSESSMENT

This first draft plan sets out our priorities and core areas of action for the next three years. It has been developed following robust engagement across the organisation and with partners.

The Planning process provides a space for our clinical teams to articulate what is important to them in delivery our strategy.

The Board is asked to note the draft IMTP and discuss the proposed plan.

**ASSURANCE** is provided by:

Assurance is provided through our clear process for the production of the IMTP. A detailed timeline is available and robust scrutiny through Clinical Boards, Management Executives, and HSMB ahead of Board submission is in place.

## RECOMMENDATION

The Board is asked to:

- Note the draft IMTP for 2020-21

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X
<b>Five Ways of Working (Sustainable Development Principles) considered</b> <i>Please tick as relevant, click <a href="#">here</a> for more information</i>			
Prevention		Long term	
		Integration	
		Collaboration	
		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>	Yes / No / Not Applicable <i>If "yes" please provide copy of the assessment. This will be linked to the report when published.</i>		





# CARING FOR PEOPLE, KEEPING PEOPLE WELL

















A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



Cardiff and Vale UHB IMTP 2020-2023



**PLAN ON A PAGE:** This diagram sets out our Delivery Priorities for 2020-23, mapped against our Strategic Priorities

 <b>Home First</b> <b>Action Areas</b> <ul style="list-style-type: none"> <li>Strengthening our focus on prevention- Healthy Weight and Smoking cessation</li> <li>Implementing the Primary Care Model for Wales- Focussing on Primary Care Sustainability</li> <li>Enhancing Cluster and Locality Working</li> <li>Out of Hours Service redesign</li> <li>Opening the first tranche of Health and Wellbeing Centres and Wellbeing Hubs</li> <li>Preventing Decline- frailty pathway, promoting wellbeing, preventing deconditioning</li> </ul>			 <b>Avoiding Waste Harm and Variation</b> <b>Action Areas</b> <ul style="list-style-type: none"> <li>Focussing on Time at Home- Admission avoidance, Outpatients transformation</li> <li>Maintaining Regulatory Compliance</li> <li>Diagnostic Sustainability- Endoscopy, MRI, CT, EUS</li> <li>Surgical Efficiency and Centralisation- Planned and Emergency theatre flow</li> <li>Anti-microbial stewardship</li> <li>Improved management of deteriorating patients</li> <li>Right Patient, Right Place, First Time</li> </ul>		
 Reduction in still birth rate and low birth weight babies	 Improved childhood emotional health and wellbeing	 Number of people over 75 living in own home	 Reduction in average length of stay	 Reduction in all cause premature mortality	 Reduction in cancellations and Did Not Attend
 <b>Outcomes that matter to people</b> <b>Action Areas</b> <ul style="list-style-type: none"> <li>Major Trauma Centre and Hub Implementation</li> <li>Continued delivery of the Single Cancer Pathway</li> <li>Redesign of the Stroke Pathway</li> <li>Established Prehabilitation to Rehabilitation Programme</li> <li>Advanced Therapies and Genetics</li> <li>Regional Service Delivery- Vascular Centralisation, Paediatric Service, Spinal Service, critical care, respite services for complex need</li> </ul>			 <b>Empower the person</b> <b>Action Areas</b> <ul style="list-style-type: none"> <li>Additional Learning Needs Services</li> <li>Transformation of CAMHs</li> <li>Greater service user engagement in mental health service development</li> <li>Transforming services for vulnerable groups- Prisoner Health and wellbeing, homeless services, asylum seekers</li> </ul>		
 <b>Outcomes</b> Achieve financial break even	 Achieve 26 week referral to treatment times target	 Increase in outpatient activity in the community	 <b>Outcomes</b> Improved staff engagement score	 Increase incomes from research and innovation activity	 Reduced vacancies

## Me, My Home, My Community

Caring for people, keeping people well is a mission without boundaries. Our residents and the wider population we serve don't see the organisations above the door. We need to work not simply to build integrated services but to support resilient communities. This is why this plan is set in the context of our Area Plan and is focused on supporting the wellbeing of communities.

We were pleased this plan was approved in 2019. This plan refresh will take us over the halfway mark of our long term strategy [Shaping Our Future Wellbeing](#) and we remain fundamentally committed to its delivery. The design principles of the strategy, home first, empowering individuals, delivering outcomes that matter to people and avoiding waste, harm and variation are principles which cross organisational boundaries and support the achievement of the Area Plan. In setting the national context A Healthier Wales correlates with Shaping Our Future Wellbeing but challenges us to go further in partnership across the public sector and to accelerate the deployment of our strategy.

Sustainability for Cardiff and Vale UHB cannot be achieved without sustainability in NHS Wales's system, social care and communities. Our strategy and this plan recognises the important role we play in delivering specialist services across South Wales, our responsibility for teaching the next generation of clinicians and delivering excellence in clinical research and innovation.

We have built a platform of sustained delivery, there has been continued improvement in the performance of our health system and we have demonstrated operational grip. We now need to move from this foundation of delivery to tangible transformation of services for our communities, focused on delivering better value.

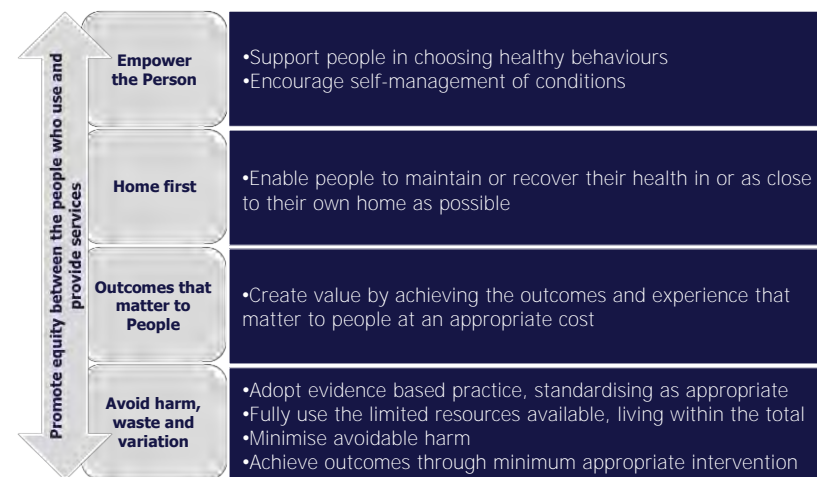
Our approach to delivering this step change is drawn from learning from our partnership with Canterbury District Health Board and other successful change

programmes. We will change the way we use data in the organisations to support decision making, understand the impact of change and monitor the benefits across our communities. This more effective use of data will allow us to support clinically driven change at a faster pace, reducing bureaucracy as we focus on outcomes and impact. Driving out variation and supporting primary care through the implementation of standardised health pathways will also be central to our approach to change. Planning, delivery, finance and workforce are not separate facets of an organisation, our approach is an integrated one further integrating these elements.

You will see throughout this plan a focus on prevention, bolstering services in the community and supporting the timely access to care regardless of the nature of this care and the organisation delivering it. Prevention is working in partnership to co-produce the best possible outcomes, you will see in the plan actions to develop resilient communities, optimise the benefits of interventions and develop wellbeing services in partnership with local authorities and the third sector.

Ultimately this plan, alongside the Area Plan, is about people. Our vision is that a person's chance of leading a healthy life will be the same wherever they live and whoever they are. In setting our plan for the next three years, this is the measure by which we will test success.

### Our Design Principles





## The Plan For 2020 To 2023

This document is designed to capture our core intentions, give clarity on our priorities, be clear on the anticipated improvement and, importantly, help our staff understand how their work contributes to the delivery of Shaping Our Future Wellbeing.

Our core priorities for 2020-23 are:

1. Primary Care: sustainability and the further development of community services.
2. Unscheduled Care: delivering a resilient and high performing system.
3. Planned Care: meeting standards.
4. Cancer Service: delivering the single cancer pathway and improved outcomes.
5. Achieving Financial Balance.
6. Mental Health: continue to transform and improve our services focusing on home first models.

You should be able to identify how all of the activity set out in this plan links back to these core organisational priorities. Embedded within each is a focus on all forms of prevention; building resilience in the community, targeting secondary prevention in our planned care programme and building early intervention and long term prevention into our health pathways.

The plan is split into three broad sections:

1. Our context and drivers across our region as a partner in health services and our clinical services strategy.
2. The core enablers for delivering improvement.
3. Our key actions for 2020 to 2023.

A single document can never capture the breadth of activity that takes place across the health board. Planning is not about a single document and this plan should be read alongside a range of plans and the annexes which set out in detail our intentions for the next three years.

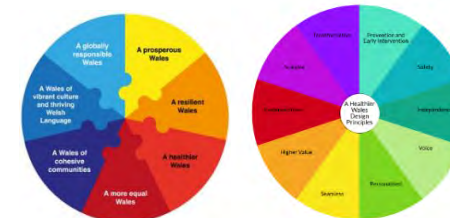
You will be able to recognise that this plan is set in the context of A Healthier Wales and the design principles encompassed within it. We have also drawn heavily on the Well-being of Future Generations (Wales) Act in shaping our plans.

As an organisation we strongly believe in our core values and expect our staff to exhibit these values and behaviours. In 2018-19 these behaviours were integrated in to all workforce processes, including recruitment, promotion, appraisals, induction and performance management. Furthermore these values underpin the approach to delivery set out in this plan.



### Our well-being objectives

You will not find in this document a separate section listing projects we are delivering to support the Act. The Act challenges us to fully embed the five ways of working within our work. The ten Strategic Priorities in Shaping Our Future Wellbeing are our well-being objectives (see next page).



Using our objectives and design principles to guide our work programmes will maximise our contribution to the well-being goals and the application of the sustainable development principle. Through the Public Services Boards in Cardiff and the Vale we also contribute to the joint well-being objectives in both partnerships.

We have included some flags to identify how our activity aligns with the Act but we hope our routine use of the principles of the Act shine through our plan.

Within the UHB we have an Executive-led Well-being of Future Generations (WFG) Steering Group which meets quarterly, and a Board-level WFG Champion. The Steering Group oversees the implementation of the Act in the UHB, as well as identifying and spreading good practice and learning, and reviewing and reporting on progress against the well-being objectives.

### Our well-being objectives

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1 Reduce health inequalities</li> <li>2 Deliver outcomes that matter to people</li> <li>3 All take responsibility for improving our health and wellbeing</li> <li>4 Offer services that deliver the population health our citizens are entitled to expect</li> <li>5 Have an unplanned (emergency) care system that provides the right care, in the right place, first time</li> </ol> | <ol style="list-style-type: none"> <li>6 Have a planned care system where demand and capacity are in balance</li> <li>7 Reduce harm, waste and variation sustainability making best use of the resources available to us</li> <li>8 Be a great place to work and learn</li> <li>9 Work better together with partners to deliver care and support across care sectors, making best use of our people and technology</li> <li>10 Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives</li> </ol> |
|---|---|

## CONTENTS

Our Context and Drivers		Key Enablers	
The Population we serve		Quality	
Prevention		Workforce	
Area Plan		Finance	
Primary and Community Care		Performance	
Mental Health		Capital and Estate	
Cancer		Digital	
Regional Planning		R&D and Innovation	
Working with the Wider Health System		Our approach to Change	
Delivery		Governance	
Clinical Strategy Overview		Key Actions for 2019-22	



## Value Based Healthcare

Our plan is based on delivering the best possible outcomes for our population within the resources available to us. We want to do more of the things that help Wyn and less of the things that don't. This is what we mean by Value Based Health Care and it is an underlying principle throughout our plan. Value is a strong connecting approach for sustainability of our services. We want to grow a clinically-led approach to framing & realising value across pathways, building on developments that clinicians have already put in place. This will require improvement, technological, financial and project management support at the front line service level. We will test innovative approaches to this, including through our Innovation partnership work. Value Based Health Care, as with our approach to the Wellbeing of Future Generations Act, is not about a series of projects or specific pieces of work but an underpinning approach to the way we design and deliver services in our system. The information on this page captures some of

what we are doing to support our teams to apply value based healthcare

### Clinical Care and Outcomes

We are designing our services on the principle of what matters to Wyn. Valuing Wyn's times is an important part of this work as well as ensuring we capture and act on the outcomes and experiences that Wyn wants to enable him to live well in his community.

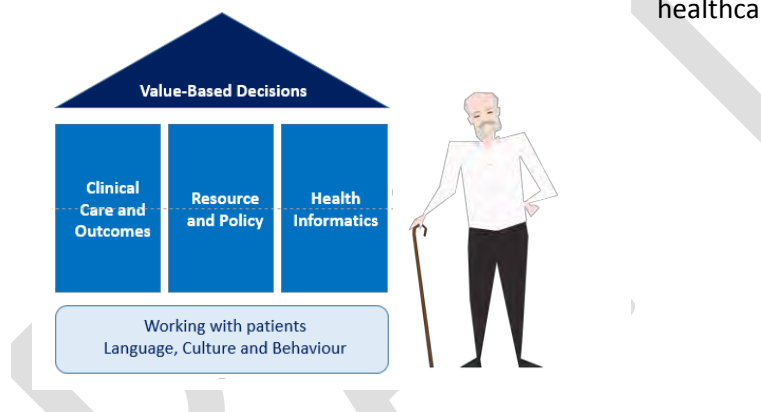
We have a number of exemplar projects supporting our learning:

**Hip and Knee Arthroplasty-** we are capturing Patient Reported Outcomes, undertaking patient level costings and have produced a virtual viewer to help us have better conversations about what matters to Wyn.

**Inflammatory Bowel Disease-** we are capturing patient reported outcomes and rolling our Patient Knows Best to support this process focussing on a reduction in follow up appointments through timelier management of symptoms

**Lung Cancer-** Patient level data visualisation has been developed with the national programme and shared decision making tools in place

This is not an exhaustive list of our exemplar programmes and further examples can be found here [\(LINK\)](#)



### Health Informatics

We are rapidly improving our ability to talk to Wyn, his carers and family about what matters to him through digital platforms.

We are already capturing Patient Reported Outcomes through the national system in and through our roll out of Patient Knows Best

**HealthPathways-** The HealthPathways tool provides a further opportunity to derive better value for Wyn. We are Co-producing pathways focusing on the outcomes our citizens want, these are then captured in the tool to provide standardisation of pathways. We now have over 70 pathways live in the system.

### Resource and Policy

We are putting in place the policies and resources needed for our teams to place value at the forefront of decision making

- We have developed an allocative efficiency framework to support in moving resources in our system to focus on what matters to Wyn
- As part of our data to knowledge programme we are enhancing our use of activity based costing and making outcome data more visible in our system
- We are putting in place a medicines and technology appraisal system through the remodelling on All Wales Therapeutics and Toxicology service to provide an improved evidence base to optimise our clinical decision making

## The Population We Serve

Understanding the needs of our population is essential for robust and effective planning. Our [Population Needs Assessment](#) developed with our regional partners provides a collective view of the population challenges on which we must build our plans. It is important we look beyond simply understanding the health needs of our citizens, but look at the wellbeing of our population which encompasses environmental, social, economic, and cultural wellbeing.



**Population growth:** The population of Cardiff is growing rapidly at nearly 1% per year, or around 36,000 people over the next 10 years. While overall numbers in the Vale are relatively static, the total population of Cardiff and Vale is expected to exceed 500,000 for the first time in 2020.



**Ageing population:** The average age of people in both Cardiff and the Vale is increasing steadily, with a projected increase in people aged 85 and over in the Vale of 15% over the next 5 years and nearly 40% over 10 years.



**Health inequalities:** There is considerable variation in healthy behaviours and health outcomes in our area – for example smoking rates vary between 12% and 31% in Cardiff, with similar patterns seen in physical activity, diet and rates of overweight and obesity. Uptake of childhood vaccinations is also lower in more disadvantaged areas. Life expectancy is around ten years lower in our most deprived areas compared with our least deprived, and for healthy life expectancy the gap is more than double this. Deprivation is higher in neighbourhoods in South Cardiff, and in Central Vale.



**Changing patterns of disease:** There are an increasing number of people in our area with diabetes, as well as more people with dementia in our area as the population ages. The number of people with more than one long-term illness is increasing.



**Tobacco:** One in six adults (15%) in our area smoke. While this number continues to fall, which is encouraging, tobacco use remains a significant risk factor for many diseases, including cardiovascular disease and lung cancer, and early death.



**Food:** Over two thirds of people in our area don't eat sufficient fruit and vegetables, and over half of adults are overweight or obese. In some disadvantaged areas access to healthy, affordable food is more difficult and food insecurity is becoming more prevalent due to increasing living costs and low wages.



**Physical activity:** Over 40% of adults in our area don't undertake regular physical activity, including a quarter (27%) who are considered inactive.



**Social isolation and loneliness:** Around a quarter of vulnerable people in our area report being lonely some or all of the time. Social isolation is associated with reduced mental well-being and life expectancy.



**Welsh language:** The proportion of Cardiff and Vale residents of all ages who have one or more language skills in Welsh is 16.2%, with around 1 in 10 people in Cardiff (11.1%) and the Vale (10.8%) identifying themselves as fluent. However, over one in four young people aged 15 and under speak Welsh in our area (26.7% in Cardiff and 29.6% in the Vale of Glamorgan).



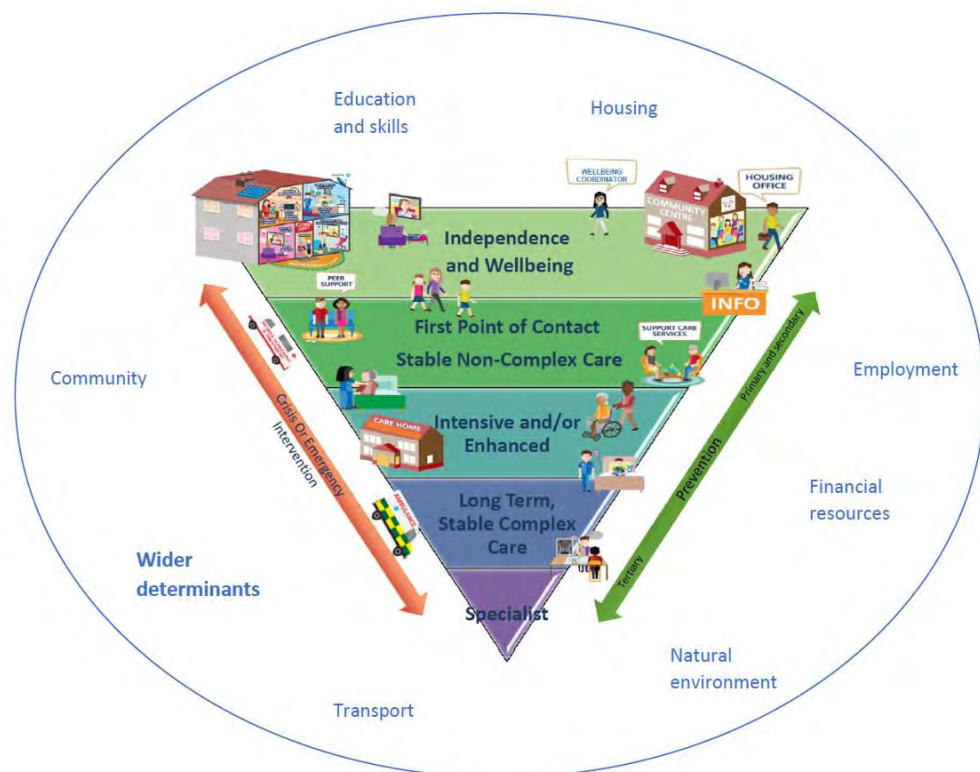
Cardiff has one of the most ethnically diverse populations in Wales, with one in five people from a black or minority ethnic (BME) background. 'White other' and Indian ethnicities are the second and third most common ethnic groups after White British.





## Prevention

Prevention is a core aspect of the health board's approach and seen as everyone's business in the organisation. Prevention takes place at all levels of our Seamless Care Model, surrounded by the impacts of, and our actions on, the wider determinants of health.



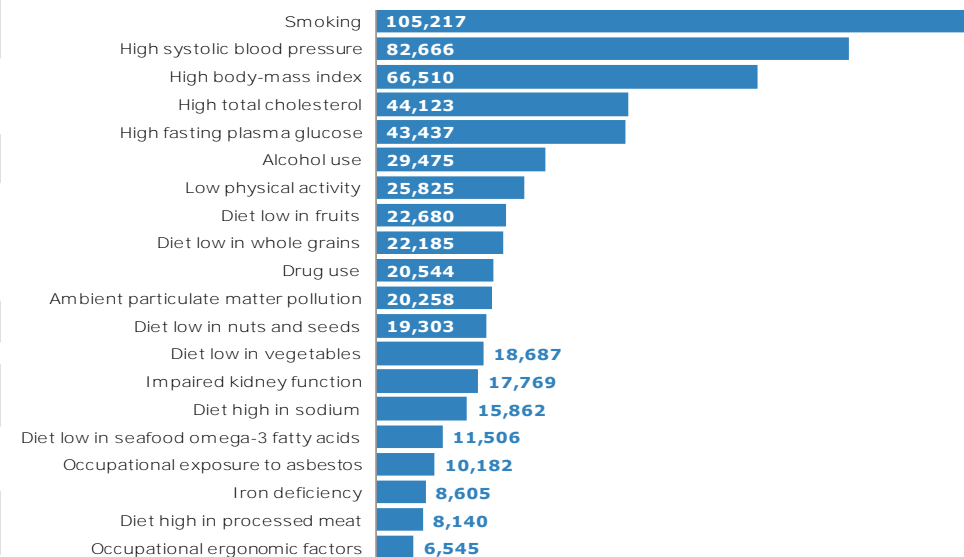
The key health needs of our population are set out in the Population We Serve section above. These include a growing and ageing population, stark health inequalities, changing patterns of disease, widespread unhealthy behaviours and social isolation and loneliness.

It is estimated that around a quarter (23%) of premature deaths are avoidable, with much of this burden relating to ischaemic heart disease and lung cancer (ONS, Avoidable Mortality in England and Wales, 2017). People who die

prematurely from avoidable causes lose on average 23 potential years of life. A review of the main contributors to Disability Adjusted Life Years (DALYs) in Wales is shown below, highlighting the importance and impact of tobacco use, cardiovascular disease, obesity, diet, diabetes, physical activity, substance misuse and air pollution, on health.

### Top 20 risk factors for disability-adjusted life years (DALYs), count of DALYs, all persons, all ages, Wales, 2015

Produced by Public Health Wales Observatory, using Global Health Data Exchange (IHME)



In response to these needs, preventative action is a key element of each of the plans of the clinical boards (principally secondary and tertiary prevention), complemented by strategic co-ordination and delivery of prevention programmes locally by the public health team (principally primary and secondary prevention).

Our full work programme and outcome measures are described in the [Cardiff and Vale Local Public Health Plan](#); priorities include:

- tobacco (implementing the key components of the smoking cessation system framework)

- immunisation (including contributing to the UK measles and rubella elimination strategy 2019)
- healthy weight (see below)
- healthy eating and physical activity
- healthy environment
- cross-cutting action on reducing inequalities in health, and wider determinants of health, with partner agencies and through the Public Service Boards in Cardiff and Vale

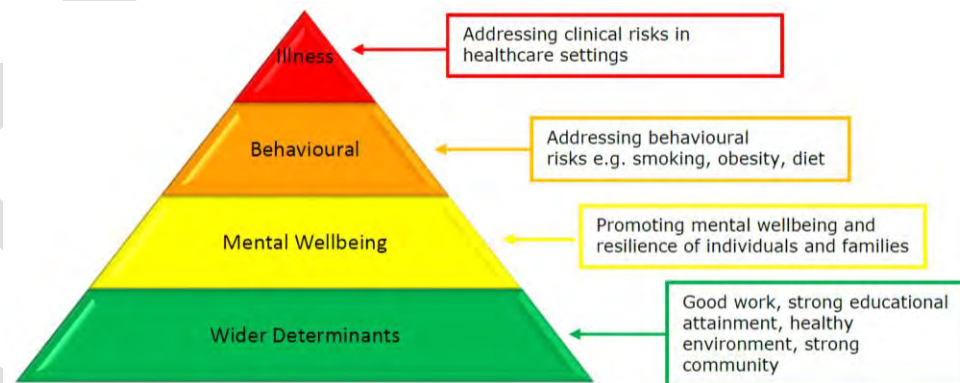
In response to the Public Health (Wales) Act, Welsh Government launched the Healthy Weight, Healthy Wales Strategy in October 2019. Across Cardiff and the Vale of Glamorgan, we started the process to create our local plan, Move More, Eat Well in January 2019. The process involved collaboration of both Cardiff and the Vale of Glamorgan Public Services Boards (PSBs), plus the Cardiff and Vale of Glamorgan Regional Partnership Board, using a multi-agency, multi-professional systems leadership approach. Locally, we held stakeholder engagement events on 12 and 13 March 2019, attended by circa 120 people. From this we created 10 priority areas, which were subsequently prioritised at a joint Cardiff and Vale of Glamorgan PSB event. We plan to engage stakeholders on the Move More, Eat Well Plan during 4 November to 15 December 2019, with a view to launching the Plan in March 2020.

Our focus is on individual behaviour change and developing environments which support and promote health, taking action on the built environment (for example to promote healthy travel behaviour) and other wider determinants of health such as education, housing and employment. We take a proportionate (progressive) universalism approach, aligned to prudent healthcare principles, to ensure our prevention advice, services and interventions are available to the whole population, with an additional focus on individuals and families in greater need.

Addressing clinical risk factors such as the management of hypertension is being taken forward through close liaison with primary care and sharing of pertinent data. Prevention and early intervention on children's emotional and mental well-

being and resilience is led by Children and Women's Clinical Board, working closely with key partners.

Population health interventions can be categorised into four types, with the population reach increasing as you go lower down the pyramid.



We work across a number of settings, including primary care clusters, pre-schools and schools (reflecting action on early years and positive childhood experiences as priorities), dementia-friendly communities, Food Cardiff and Food Vale, and workplaces. We work closely with partners in the public, private and third sectors directly and through the PSBs in Cardiff and Vale, and the Regional Partnership Board; and with specialist public health colleagues working in screening, health protection and environmental health. We are prioritising strengthening the bowel screening programme, working with PHW Screening Engagement Team and undertaking targeted projects in areas with low uptake. We are engaging through Cardiff PSB in implementing the homelessness strategy, taking a 'housing first' approach, which is leading to tangible results. We contribute to increasing employability through volunteering and apprenticeship schemes in the UHB, and via the PSB wellbeing plans.

In developing our plan we have worked closely with colleagues across the health board, and in Public Health Wales (prioritising tobacco, hypertension and wider

determinants for joint working), aligning our work with the strategic direction of both organisations.

Within the UHB, we are embedding prevention in all that we do, aligning to our Well-being Objectives and our mission of 'Keeping People Well'. We have identified that we have opportunities in our interactions with patients, as an employer and in developing our work environments to deliver this approach.



Excellent examples already exist of where this is happening, but these are not always coordinated for best impact, nor do they have systematic reach. Action and leadership will be required from across the organisation to deliver this systematically. We are therefore developing an approach that encourages each of us to consider what we can do to keep ourselves, our patients and our colleagues well. It is hoped that this will support a social movement within the organisation and ensure prevention becomes a core and visible part of what we do.

## The Area Plan, Delivering For Our Citizens

Delivering performance improvement and meeting the needs of our population cannot be achieved without partnership. In recent years our Regional Partnership arrangements have matured and strengthened. The [Cardiff and Vale of Glamorgan Area Plan and Action Plan](#) was published in March 2018 and sets out our regional priorities and the detailed actions we will undertake, over the next five years, to meet the following 12 key care and support needs identified in our [Population Needs Assessment](#).

The Area Plan sets the actions we are taking against our integration priorities:

- Older people (including people with Dementia)
- Children with complex needs
- Learning disability and Autism
- Integrated family support services
- Adult and young carers

We are already seeing the impact of this work. Programmes such as the introduction of First Point of Contact, Single Point of Access and Discharge to Assess have contributed to improvements in delayed transfers of care across Cardiff and the Vale.

Integrated Care Funding is also making a significant impact in improving the lives of our citizens. Some of the achievements are set out opposite and a full [annual report](#) on the work of the Regional Partnership Board has recently been published.

Delivery of the Area Plan and a continued focus on integration will be core to this next planning period. Reducing health inequalities, focusing on prevention, improvements in mental health and improving access to care, regardless of the provider, all require delivery through partnership.

However, regional delivery is not simply about delivering the core elements of the Area Plan. Core to the way we need to transform services in all areas of our work is greater integration. You will see, in the actions we set out for this planning period, a focus on working with partners to improve all areas of care.

Through Welsh Government transformation funding, the Regional Partnership Board is supporting the acceleration of change; joining up services with a greater emphasis on prevention and focusing on care in the community. The transformation funding will support the following initiatives:

- The development of the optimal 'Cluster' by understanding and facilitating connections between people, groups and communities.
- The creation of a single entry point to independence and well-being services and stable and non-complex care services.
- Developing an effective GP triage service by providing support and diverting people to the most appropriate services across health and social care.
- Development of a single access point within the hospital for all community based services, to tailor support that meets the well-being needs of the individual, providing preventative interventions and supporting independent living.
- Creation of a service that support patients who are more impaired and require a more intense package of re-ablement and homecare support, receive assessment in the most appropriate setting and link all partners involved in their care.
- Increasing awareness and implementing a new way of working across health, social care, education and the third sector to increase resilience and awareness in children and young people through peer support, timely intervention and signposting.
- Development of a 'blueprint' for place based integrated community teams.

The partnership has also submitted applications for additional funding to support more initiatives around children and young people



These proposals do not represent the totality of work we undertake with partners but allow us to test new models of care, built on the design principles outlined in A Healthier Wales. They will support us in demonstrating how we can shift more services to the top of our Seamless Care Model.



More information can be found on the Cardiff and Vale Integrated Health and Social Care Partnership [website](#)

## Keeping People Well: Regional Partnership Outcomes Framework

RPB has endorsed the vision and strategic aims of our outcomes framework. The outcome measures will be completed by January along with the indicators to track delivery of the measures.

**Home and communities first**  
Working with people and communities on the basis of strengths and assets. When needed services build on strengths on strengths

**Children have the best start**  
Children having the best start in life, through doing what works in their first 1000 days

**People live well**  
People living well throughout their lives making positive choices easily. All people having the best end of life – last 1000 days



**Empowering the workforce**  
Trusting and enabling the workforce to do the right things at the right time and pace for people

**Equitable**  
Risk to wellbeing is recognised and acted upon. Working alongside people to maximise inclusion and tackling barriers to equality. Respecting the needs and rights of everyone



## Primary and Community Care

Home first and empowering individuals are core pillars of our strategy. You will see throughout this plan a focus on community delivered services and supporting people to get back to their homes as soon as possible following a hospital stay. Full details of our plans for Primary Community and Integrated Care can be found in the clinical board plan [here](#).

We recognise the pressure on our primary care services and in particular those delivered by our contractor partners such as GPs, pharmacists and dentists. Primary care sustainability is therefore an integral objective for the next three years. Shoring up our services will enable us to have a solid foundation from which to take the next steps in transforming community services. There are a number of actions we have been taking and will continue to deliver over the next three years to deliver sustainability:

- Rolling out cluster based first contact musculoskeletal physiotherapy and mental health services with direct booking from GP receptions.
- Providing proactive estates solutions to enable practices to expand.
- Reviewing the skill mix within the Urgent Primary Care Out of Hours service to help balance demand and capacity.
- Improving uptake of learning disabilities annual health checks.
- Promote the benefits of registering veteran status with GP practices.

## Transformation and Improvement

It is through Clusters we will deliver an improved model of primary care and cluster IMTPs have helped to inform this plan refresh. The nine clusters across our region are maturing. We have put in place a specific Organisational Design programme for clusters and are reviewing their governance arrangements and resourcing. We are supporting cluster pharmacists in a number of medicine management projects and the roll out of the physiotherapy and mental health services on a cluster basis will further embed cluster based multidisciplinary teams.

The continuation of clusters working in partnership with local authorities and the third sector will further develop over this planning period. Our new models of

care supported through the transformation funding will be delivered through clusters, with cluster led programmes on social prescribing, reablement services and new models of triage. Within the Regional Partnership Board transformation programme we have specifically allocated funding to accelerate cluster development to support place based models of service delivery along with our regional partners.

The third year of this plan will also see the opening of our first Wellbeing Hubs in Maelfa and Penarth, these new centres will see a further strengthening of clusters and their role in the delivery of services in partnership.

The development of clusters and work to transform primary care will be informed by the progress made in the implementation of Pacesetter programmes for falls, pain clinics and social prescribing. For example the collative community falls clinics developed through the pacesetter programme are informing work across the organisation about how we join up our efforts to prevent and manage falls in the community.

The plans for each of our clusters can be found [here](#)

We have taken significant learning from partnership with Canterbury District Health Board, they have developed seamless services built on the principle of home first with primary care delivering to the top of its competence. The HealthPathways tool will help equip GPs and other clinical staff with tools to support individuals to stay in the community and the place based services delivered through clusters will be informed by the Canterbury model.

We recognise the crucial role primary and community services deliver as the foundation of our service models. Whilst we recognise the importance of sustainable general medical services our ambition is to deliver truly community based models of care built on a wellbeing model- empowering individuals and home first. We know this can only be delivered in partnership with a range of organisations across our region. Clusters provide a vehicle to design and deliver place based services meeting the needs of communities. Over the lifecycle of this plan we want to create a sustainable base, help clusters to mature and move from a primary care model to a community owned model of care.

## Mental Health

We have delivered significant transformation of our mental health services in recent years with more than 50% of resources now sitting in the community. We want to continue to build on this achievement further developing our services on a home first principle and designed through co-production. The development of our refreshed plan for mental health services was launched by services users and carers with an interactive session negotiating on priorities with delivery bodies.

Work to develop our Recovery College has begun and will continue through this next phase of plan implementation. The Recovery college is a Service User and lived experience led project, with the support of IMROC to provide educational opportunities for our Service Users, Carers and staff to balance the health and wellbeing improvements. When developed this will be a facility for all residents of Cardiff and Vale.

In 2019-20 we committed to rolling out across clusters Mental Health Practitioners working as extended specialist support to GPs, for people with mild to moderate mental health problems. This is supported by bespoke commissioned third sector psychologically based service. This is potentially a revolution in mental health support to meet ever increasing demands on GPs.

Following an extensive engagement exercise with the Community Health Council we saw the co-location of the three Vale Community Mental Health Teams, as a step towards the establishment of health and wellbeing centres described in Shaping Our Future Wellbeing Strategy. The teams are now functioning as one with efficiencies seen in managing demand, liaising more easily with related health and other agencies and seeing professionals working differently and more focused on service user outcomes and needs. New Community mental health services are emerging from traditional Community Mental Health Teams with the right professional seeing the right person in the right place and time. This has been helped by the new primary care liaison teams reducing demand therefore allowing services users to be placed at the centre of the care pathways instead of the pressures of demand management.

Recurrent investment from Welsh Government has been put to good use. All additional monies are focused on the principles of 'Home First, reducing hospital delays, improving access to psychological support and adding capacity to pressured specialist teams and supporting the integration. For example investment in areas such as; First Episode Psychosis, substance misuse dual diagnosis, psychological therapies and MATRICS Cymru. In addition we have invested in Peer Support Workers as part of a recovery college, the enhancing of EU cover, investing in specialist support to the CRTs to enhance the 'team around the individual' described in the dementia strategy and avoid unnecessary admissions.

Older people's mental health opportunities have been enhanced by the provision of new expert liaison posts into Community Resource Teams in localities and every care home in the Cardiff and Vale area, preventing admission and unnecessary contact with lead agencies.

Our Mental Health services now looks after approximately 95% of its specialist caseload in community settings. It is this home first model and increasing working across boundaries that we want to continue through this planning period. The current 'Together for Mental Health' delivery plan runs concurrently with this IMTP period with priorities up until 2022.

Our plan for Mental Health services can be found [here](#)

It sets out our priorities for 2020-23 which include:

- Establish a mental health single point of entry
- Establish a Recovery College
- Improving Mental Health Services for young people.
- Developing the Team Around the Individual for dementia patients.

## Cancer

We know that cancer outcomes are not good enough. Whilst we have made progress in recent years there is a need to accelerate the rate of improvement. We have challenged ourselves to make enhancements in cancer outcomes through focusing on transformation right across the cancer pathway.

The first tranche of this work focuses on Bowel and Lung Cancer, as they are both common cancers and mortality from these cancers is higher than we would want. This does not mean we will not be seeking improvements in other forms of cancer. We will concentrate our efforts and test our approach to change in the areas where we know we need to make significant improvement.

### Improving Cancer Outcomes- A whole System Approach

Me, My Home, My Community – Prevention and Identification	<p>Working with local authority and third sector partners we are putting in a range of community roles to support social prescribing, helping people to connect with local groups to become more active and combat social isolation.</p> <p>We will equip these community champions with knowledge about Bowel and Lung cancer to help identify symptoms and signpost people to the right services. Developing resilient communities who can be champions in supporting people be active and make positive choices such as quitting smoking.</p> <p>Aim- Improve stage at diagnosis- Lung Stage 4- 45.3% Colorectal Stage 4- 16.9%</p>
Improving Screening	Our bowel screening rate is the lowest in Wales at 51.5%, we want to set ourselves a stretch target of pushing the rate past 70% over the next three years. The introduction of FIT testing is an opportunity to improve screening rates, using community teams and partnership working to encourage uptake.
Responsive Clusters	Through the introduction of HealthPathways we will give GPs better access on how to ensure people are diagnosed and treated as quickly as possible, the standardised pathways for Bowel and Lung Cancer will reduce variation and ensure consistent access.

	We will also put in place FIT for Symptomatic Screening to help GPs differentiate between bowel disorder and cancer.
Endoscopy Improvement	Although significant progress has been made, we continue to support and implement an improvement programme in our endoscopy services and patient pathways; we know we need to continue this work and maximise capacity to speed up the diagnostic process.
Person Centred Care / Electronic Holistic Needs Assessment	Importantly, we will be capturing Patient Reported Outcomes Measures, and providing patients access to an electronic Holistic Needs Assessment. Working closely with our stakeholders and partners, this will allow us to better understand the impact of the interventions and signpost/provide additional support to ensure all patient needs are met.
Prehabilitation Programme	<p>Ensuring people are in the best possible shape for treatment can have a significant impact on clinical outcomes. We will draw together the significant work ongoing within the organisation including Making Every Contact Count, Patient Optimisation and Patient Centred Care (see above). We will take actions to maximise improved outcomes for patients and timely treatment to include:</p> <ul style="list-style-type: none"> <li>- Encouraging people to take appropriate exercise supported through social prescribing and community groups.</li> <li>- Intense prehabilitation to ensure issues such as Anaemia are addressed</li> <li>- Providing more information to patients about the surgery process and experience.</li> <li>- Pre-operative assessment clinics.</li> <li>- Enhanced recovery after surgery programme and post-operative bundle in place.</li> </ul>
Acute Oncology Services	We continue to support and develop services to meet patients' needs who require acute admission as a result of their Cancer treatment or who are found to have a previously undiagnosed cancer through an acute admission. Working closely with our stakeholders and partners we will develop a robust service and agreed pathway to ensure patients receive the right care, first time.

## Single Cancer Pathway (SCP)

In November 2018, the Welsh Government announced the move to public reporting of the Single Cancer Pathway, alongside the existing two cancer targets, from June 2019: <https://gov.wales/newsroom/health-and-social-services/2018/processcancer/?lang=en>

Through our established SCP Project structure, we continue to progress actions through a number of work streams to be able to more accurately report performance and to demonstrate continuous improvement against reported performance in 2019-20. Whilst Welsh Government has not yet set the percentage compliance for the SCP, the Health Board is committed to working towards and achieving 95% compliance against the 62 day target.

To ensure successful implementation and delivery, the three key areas of focus for us continue to align to three key work streams:

- **Information and Intelligence** - leading on ensuring processes are in place to accurately capture relevant patient data across all stages of the pathway and ensuring our IT systems are integrated and fit for purpose for tracking and reporting. Implementation of this programme is ongoing whilst we oversee the transition from Tentacle to our Patient Management System. The challenge remains delivery at scale and pace whilst ensuring this does not disrupt the implementation of the National IT & Informatics Agenda.
- **Demand and capacity** – working to identify the gap and implement solutions to balance demand and capacity in the short term and on a sustainable basis. We have, using a national tool, undertaken a second iteration of demand and capacity modelling for the SCP. Plans are in place to provide some additional capacity through the resources allocated from the Wales Cancer Network & Welsh Government, however further work

is needed to address the medium and long terms challenges of balancing demand and capacity.

- **Pathway improvement** – In parallel with improving timeliness of access to outpatients and diagnostics, we also need to pursue pathway improvement and new ways of working. Clinically led, we are working on a local and national basis to implement the initial nationally agreed standardised optimal pathways for specific cancer disease groups (released in August 2019). Furthermore, we also continue to develop further pathways, with the ultimate goal to reduce variation and improve outcomes for our patients.



## Regional Planning

We are committed to working collaboratively and at pace with Health Boards in South East Wales to secure the benefits of planning a number of priority services on a regional basis. The work programme comprises legacy programmes and elective work streams, with the following achieved in 2019-20:

Specialty Workstream	Progress in 2019-20
Paediatric, obstetrics and neonates	<ul style="list-style-type: none"> <li>Implemented flow changes in March 2019 in line with the south wales programme service model reflecting adjusted activity following Cwm Taf internal engagement</li> <li>Continued clinical collaboration to ensure quality service challenges have been collectively managed across the region</li> <li>Following a readiness review of paediatric service change CTM deferred the transfer of service from Royal Glamorgan to PCH, the review considered workforce, training, and performance associated with the emergency departments</li> <li>Completed capital scheme in UHW Obstetrics.</li> </ul>
Vascular services	<ul style="list-style-type: none"> <li>Delivered a regional out of hours interventional radiology rota</li> <li>Continued detailed planning to centralise South East Wales Vascular network with aim to implement from August 2020 subject to successful public engagement and consultation in Q4 2019/20 and approved regional business case in Q1 2020.</li> </ul>
ENT	<ul style="list-style-type: none"> <li>Sustainability issues have been addressed within Cwm Taf Morgannwg through integrating the medical workforce across the CTM hospitals.</li> <li>The regional clinical body continue to work collaboratively to provide joint head and neck cancer</li> </ul>

	MDT with surgery provided at both UHW and Royal Glamorgan
Diagnostics	<p><b>CT/MRI</b></p> <ul style="list-style-type: none"> <li>The Delivery Unit supported a standardised approach for repeating the regional demand and capacity work for MRI and CT for 2019/2020.</li> <li>Continued to utilise available capacity in MRI within CTMUHB. Aneurin Bevan UHB are to utilise 400 of the 800 spare MRI slots available for utilisation within CTMUHB.</li> <li>Continued to offer the opportunity for C&amp;V to house a mobile unit on the RGH site, so that they can increase capacity as and when required.</li> </ul> <p><b>Endoscopy</b></p> <ul style="list-style-type: none"> <li>The Regional diagnostic Planning group have developed a close working relationship with the National Endoscopy Programme Board. This will avoid duplication and enhance the work of both groups.</li> <li>To date the Regional Diagnostic Group has not come up with collaborative solutions for the delivery of endoscopic services in the short term. However, work has progressed during 2019/2020 within CTMUHB to develop a plan for Phase 2 of the Diagnostic Hub for which there has been agreement that the emphasis will be on the development of endoscopic services. As with Phase 1 of the Diagnostic Hub which focused on CT and MRI services, there is an expectation from Welsh Government that the Hubs development will offer support at a regional level. It must be noted that this is a 3 – 5 year plan.</li> </ul> <p><b>Endoscopic Ultrasound (EUS)</b></p> <ul style="list-style-type: none"> <li>During 2019/2020 a regional option appraisal process was undertaken. To ensure robust engagement with key stakeholders this was undertaken both “in-</li> </ul>

	<p>house” within health boards and at a regional workshop held on 13<sup>th</sup> May 2019.</p> <ul style="list-style-type: none"> <li>▪ The Preferred Option: All health boards agreed there would be enough activity in the future for a three site model, when demand reached the expected levels and that plans would be developed for a phased approach, as demand increased incrementally.</li> <li>▪ Phase 1: To develop a networked two site model based on the current two providers in SE Wales at Aneurin Bevan and Cardiff and Vale UHBs. This phase would focus on improving the sustainability of these current units by increasing capacity, trained operatives as well as utilising the capacity regionally.</li> <li>▪ Phase 2: As demand on the service increases, it was agreed there will be a need for extension of service provision. There service would then be expanded to a three site model i.e development within the Diagnostic Hub within CTMUHB. The training programme undertaken in Phase 1 to extend to CTMUHB staff.</li> </ul>
Ophthalmology	<ul style="list-style-type: none"> <li>▪ IAN</li> </ul>
Orthopaedics	<ul style="list-style-type: none"> <li>▪ The Orthopaedics planning group identified limited benefits to regional collaboration on enhancing capacity given the local opportunities for both service pathway improvements and capacity development planning. Each UHB was focusing on specific local pathway and capacity reconfiguration and redevelopment opportunities to optimise local service sustainability and access. This related specifically to: <ul style="list-style-type: none"> <li>- the implementation of the clinical futures strategy in AB UHB;</li> <li>- the configuration opportunities presenting in CTM UHB with the inclusion of Princess of Wales within the UHB’s service and estates</li> </ul> </li> </ul>

	<p>infrastructure; and</p> <ul style="list-style-type: none"> <li>- the development of CAVOC at UHL as part of Cardiff’s strategic clinical services plan.</li> <li>▪ The clinical and planning time and commitment that is required to support the above is significant and was considered to be of better value to the individual UHBs and the wider regional system.</li> </ul>
--	--

The 2020-2021 work programme seeks to build upon progress made to date and the maturing approach to regional planning, with the following summarising the specialty work programmes. Health Boards will ensure that the resources required to deliver the programme at pace are secured, for a combination of external and internal sources

Specialty Workstream	2020-21 Work Programme	Local Actions
Emergency Medicine	<ul style="list-style-type: none"> <li>▪ To establish a programme of work to implement the remaining requirements of the South Wales Programme (SWP) namely emergency medicine, acute medicine and consultant led inpatient paediatric services</li> <li>▪ To establish a regional project structure.</li> <li>▪ To review the SWP emergency medicine model within the current regional context, understanding any changes which have taken place since the SWP agreement.</li> </ul>	<ul style="list-style-type: none"> <li>▪</li> </ul>
Vascular services	<ul style="list-style-type: none"> <li>▪ Post implementation review of the Out of Hours Interventional Radiology Service.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Undertake Public Engagement and consultation in early</li> </ul>

Specialty Workstream	2020-21 Work Programme	Local Actions
	<ul style="list-style-type: none"> <li>to implement from August 2020 subject to successful public engagement and consultation</li> <li>Submission of a capital case for a hybrid theatre at the University Hospital of Wales to support centralisation.</li> </ul>	2020
Diagnostics	<p>For 2020/21, in relation to CT and MRI the regional group has:</p> <ul style="list-style-type: none"> <li>Agreed to continue using a standardised approach to demand and capacity planning with the support of the delivery Unit,</li> <li>As part of the collaborative approach, spare capacity within the CTMUHB Diagnostic hub will continue to be offered up to partners in the region. Commissioning arrangements are to be formalised.</li> <li>All Health Boards have identified that reporting capacity remains an issue and that all were outsourcing to managing this increasing problem. The South Central &amp; East Regional Planning &amp; Delivery Forum have requested an assessment across health</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

Specialty Workstream	2020-21 Work Programme	Local Actions
	<p>boards be undertake to determine the scale of the problem. Following this exercise a decision will be made as to whether imaging reporting becomes a work stream to be taken forward collaboratively during 2020/21.</p> <p>Endoscopy</p> <p>For 2020/21, the regional group will:</p> <ul style="list-style-type: none"> <li>Utilise the standardised approach to demand and capacity planning for endoscopy being developed, with the support of the delivery unit, within the National Endoscopy Programme Board.</li> <li>Assess demand and capacity and explore opportunities for joint working and shared working around solutions for meeting any shortfall in capacity.</li> </ul> <p>EUS</p> <ul style="list-style-type: none"> <li>Continue to progress work to implement Phase 1 of the network EUS model as described between Aneurin Bevan and Cardiff and Vale UHBs.</li> </ul>	



Specialty Workstream	2020-21 Work Programme	Local Actions
	<ul style="list-style-type: none"> <li>Continue to establish and implement a training programme across the three UHBs.</li> <li>Continue to develop a joint booking system for the EUS service.</li> </ul>	
Ophthalmology	<ul style="list-style-type: none"> <li>IAN.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

## **Working With The Wider Health System**

As we have set out a number of times in this document, working in partnership is core to the delivery of Shaping Our Future Wellbeing and achieving the ambition of A Healthier Wales. We have set out our role with our partners on the Regional Partnership Board and in achieving the ambition for health services across South Wales. In this section, we want to highlight just some of the work we will be undertaking with partners. This is not the full extent of our collaborative endeavours, but provides a snapshot of our approach.

### **Working with the Welsh Ambulance Service Trust and the Emergency Ambulance Service Commissioner (EASC)**

Working through the emergency ambulance service committee framework and the agreed [Commissioning Intentions](#), we have developed a strong relationship with the ambulance service. We are looking to continue the progress we have made with joint initiatives such as:

- Advanced Paramedic Practitioners
- Community Falls
- Single Integrated Clinical Assessment Services- clinicians in the control room supporting triage

The [Amber Review](#) demonstrates the progress made in providing a clinically driven response in emergency situations. The report sets out a number of opportunities for improvement, in particular supporting the ambulance service to get vehicles back on the road as soon as possible. A system wide response is needed to address this challenge. The actions we have set out in prevention, supporting more people to live well in their communities and our focus on reducing length of stay will also support improvement in ambulance provision. We are pleased to be working with the ambulance services not just on the emergency part of their service. Advanced paramedic practitioners can play a vital role in supporting primary care. Non-emergency patient transport similarly plays an unrecognised role in service transformation. For example the redesigned acute coronary syndrome pathway and introduction of a dedicated access vehicle has seen a reduction in referral to transfer times to two days, dramatically improving patient care and achieving NICE standards.

### **Working with Velindre NHS Trust**

Focusing on the appropriate use of blood products can make a significant difference for the Welsh Blood Service in managing the supply and demand of blood products across the system. Through the national [Blood Health Plan](#) we are focusing activity on using tools to make appropriate use of type O negative blood and reduce errors in the mis-identification of patients to improve transfusion practice.

The Welsh Blood Service is about much more than the supply of blood products and we are pleased to be working alongside it to support the programme of work led by the blood service to bring forward novel cell therapies as part of the Midlands and Wales Advanced Therapies Treatment Centre. This is a truly collaborative project with our neighbours in Cardiff University, industry and the NHS in Birmingham which has received funding from Innovate UK to bring forward new cellular therapies. The development of cell therapy services is built into our plans for the development of our estate.

We will be working closely with Velindre Cancer Centre to ensure seamless services for cancer patients; further aligning our pathways, developing acute oncology services, exploring how we jointly understand the clinical impact of new therapies and developing a prehabilitation programme. We are also committed to the Transforming Cancer Services Programme.

### **NHS Wales Shared Services Partnership**

Shared Services provide an invaluable role in supporting our work with 95% of NHS Wales expenditure processed through shared services systems and processes. Shared Services support is helping the organisation to maximise every pound spent though supporting work on value based procurement and ensuring effective contracting models are in place with our contracted services in primary care.

As we have set out in the plan, recruitment and retention of staff is a key enabler for our plans. Maximising Hire to Retire and the agility of our Electronic Staff Record is crucial to be able to respond as staffing pressures emerge.

Shared Services plays an important role in unsung areas which support service sustainability and transformation. We will continue to work with the service in areas such as:

- Scan and Store Service are creating capacity in GP surgeries to meet population growth.
- Developing contracting models that allow for greater collaboration and sharing of premises across multiple public, private and third sector partners.
- Delivering an effective laundry service, supporting the smooth and efficient running of hospital services.

### NHS Wales Informatics Service

Effective systems and the ability to turn data into meaningful information is essential to the delivery of our strategy. The goals of the Informed Health and Care Strategy are aligned with the objective of Shaping Our Future Wellbeing. We will continue to work with NWIS to ensure the roll out of national systems fully meet the needs of our population. We know we need to continue to support system development to have patients at its core.

### Welsh Health Specialised Services Committee

Our relationship with WHSSC is both as a commissioner and provider. As a provider we have improved our relationship and governance arrangements over the last year, ensuring a more robust approach to the development of service proposals. As a commissioner, we continue to participate in the effective collaborative process and support the increasing focus on clinical value in the proposals put before the joint committee.

Details of the WHSSC service developments for 2020-23 are included in relevant clinical board plans. As a high level summary, in line with the WHSSC Integrated Commissioning Plan, we will be taking forward service developments which include:

- Advanced Therapeutic Medicinal Products (Specialist Services Clinical Board)
- Major Trauma Centre

As a commissioner we recognise our responsibility in ensuring investment in new treatment options delivers value for patients across Wales. As a providers we know we need to deliver improvements in Cardiac Surgery and Neurosurgery services. We are making progress and have delivered improvement in those waiting for cardiac surgery in 2019-20 will continue to work with our partners to put forward plans for the sustainable delivery of neurosurgery patients.

### Health Education and Improvement Wales

We are delighted to begin working in partnership with Health Education and Improvement Wales (HEIW). Through recent IMTP planning discussions we have already provided the opportunity to share our agendas, priorities, plans and challenges.

We will be particularly pleased to work closely with the organisation as it develops and integrates workforce planning and leadership and succession planning into its core objectives. Early collaboration on our primary care workforce, in particular out of hours, is already underway.

HEIW Strategic Aims:



## Delivering On Our Commitments

We committed to strategic actions to deliver across the health board in 2019. This section outlines the actions we have taken:

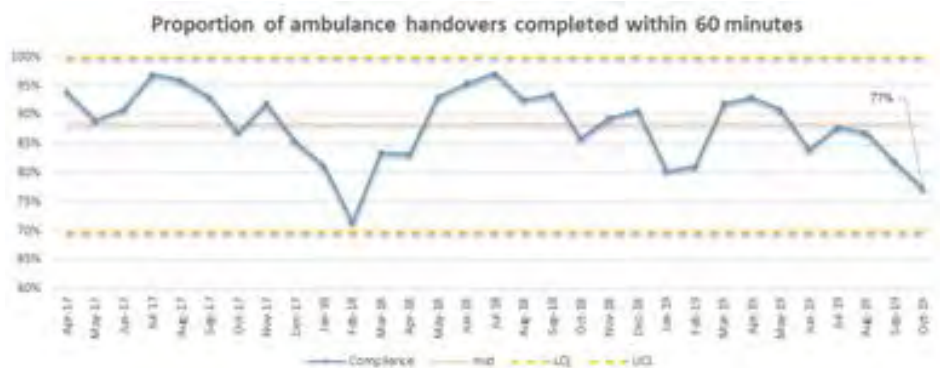
We said	We did	Result
Support the sustainability of general medical services through the roll out of MSK and mental health cluster based services	 <b>Delivered</b>	Over 3400 slots with a first contact physiotherapist were made available between 1 <sup>st</sup> April 2019 and 31 <sup>st</sup> August 2019, and over 2800 patients booked appointments with the service, the majority of whom would previously have required appointments with a GP
Development of response to population growth and establishment of a Primary Care Estates Strategy	 <b>Delivered</b>	We have undertaken a comprehensive review of our Primary Care estates and established a Primary Care Estates Strategy
Repatriation of CAMHS and development of Emotional Wellbeing Service	 <b>Delivered</b>	Specialist CAMHS provision was successfully repatriated and there was no disruption to the running of clinical services as a result of the transfer. An objective of the repatriation was the development and implementation of a single point of access (SPoA) to improve the referral process and access into children's mental health services this went live from 1 <sup>st</sup> April 2019
Improve access to Mental Health services for young people	 <b>Delivered</b>	We have established a Multi-Disciplinary Team with third sector support and enhanced the number of staff in the team. An evidence based specialist pathway has been introduced and demand is being met currently.
Development of team around the individual for dementia patients	 <b>Delivered</b>	Specialist Mental Health Practitioner posts have been developed to work in partnership with Community Resource Teams and Dementia Liaison Staff in GP practices
Community Mental Health Team Review	 <b>Delivered</b>	All Vale teams are now co-located. New service model based on direct access, minimal assessments and strengths based outcomes commenced
Open Young Onset Dementia unit	 <b>Delivered</b>	The unit has opened at Barry Hospital providing an age appropriate environment for patients
Introduce Health Pathways	 <b>Delivered</b>	We have successfully introduced Health Pathways into our system with over 60 pathways live on the system. We introduced the first Sepsis health pathway across the UK, Australia and New Zealand
Increase the number of patients who receive dialysis in the community	 <b>Delivered</b>	The nocturnal dialysis programme has commenced which converting existing patients from unit based to home therapies. The Renal Roadshow was held at the end of June helping to increase awareness of home therapies
Establish Non-Invasive Ventilation Unit at University Hospital Wales	 <b>Delivered</b>	An initial 4 bedded NIV unit was opened in 2019 which will be expanded to 6 beds through 2020
ENT Surgery Moved to UHL	 <b>Delivered</b>	The first ENT elective lists have taken place in UHL, resulting in patients who would previously have had their surgery cancelled on the day due to emergency pressures receiving timely care

## Performance Delivery 2019-20

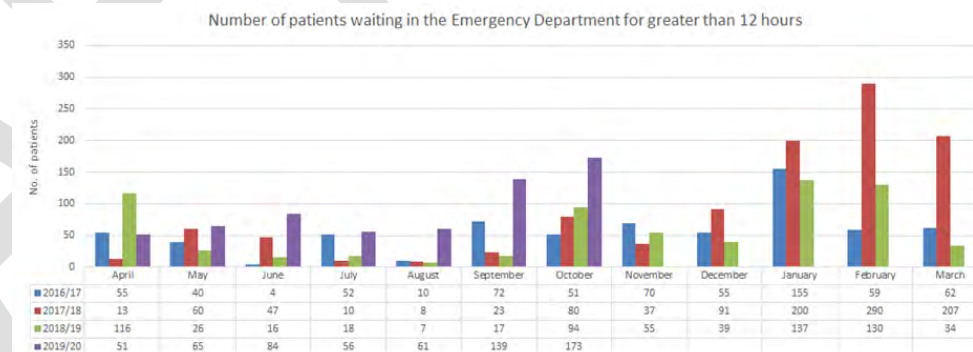
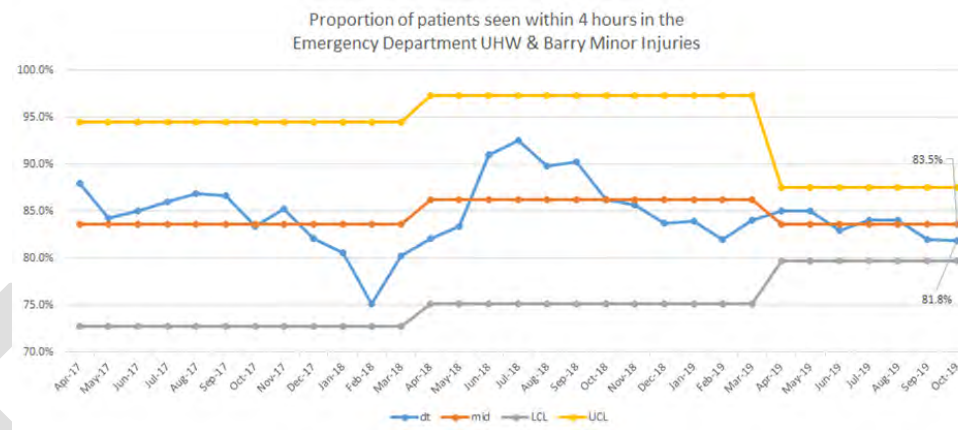
This section looks at our core performance against some key measures. This allows us to understand where we are making progress so we can support and accelerate improvement and where we need to focus actions to deliver change. Alongside our understanding of our population, understanding our performance to date sets the context for our plans.

### Unscheduled Care

The Health Board works with partners in Local Authorities, Welsh Ambulance Service Trust (WAST) and other Health Boards to provide responsive, high quality services to patients in Unscheduled Care.

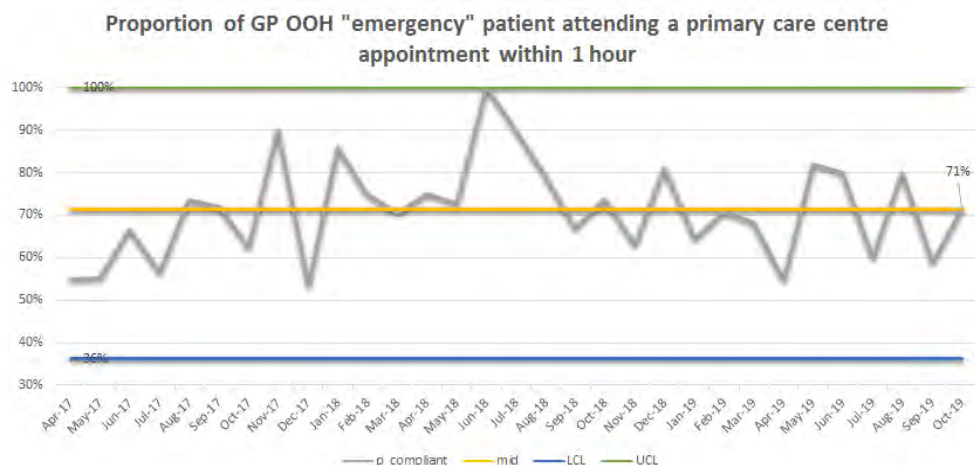


In respect of ambulance handovers, whilst we met our IMTP profile in April, since then we have been unable to meet the agreed IMTP trajectory. The Welsh Government (WG) minimum standard is 100% within 60 minutes. This indicator is reflective of system pressure and demonstrates the performance of our front door in responding to this.



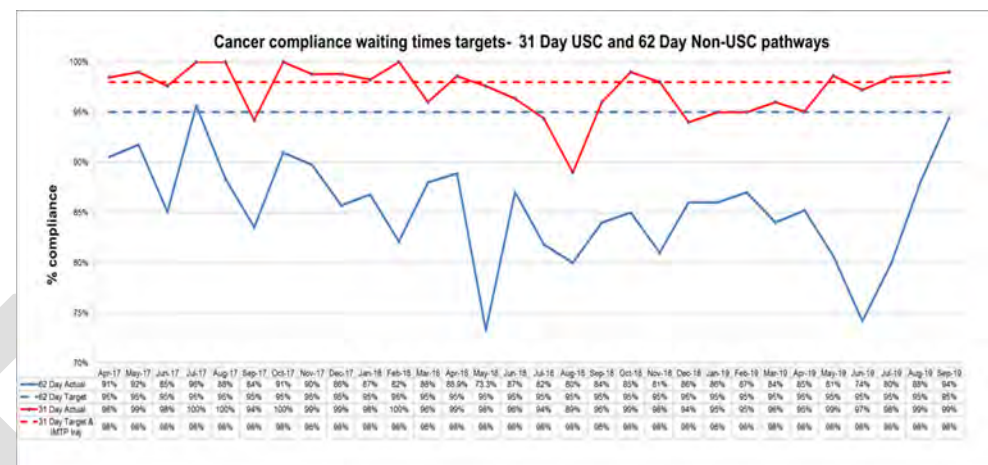
Performance against the 4 hour and 12 hour targets in our Emergency Unit have been lower than in 2018 and we remain unable to achieve our IMTP planned trajectories across all of our Unscheduled Care measures. This has been due to an average of 4% growth in EU attendances equating to on average 500 additional patients per month. Taken together, these measures demonstrate the need for collaborative solutions to reduce pressure and deliver improvement. You will see a range of actions set out in this plan which should support improvement in these indicators.





Following significant improvement in our GP out of hours performance in 2018, the 2019 year to date performance has been relatively static over the period. Actions to create sustainable primary care services and improve access to out of hours care in the community are core to this plan.

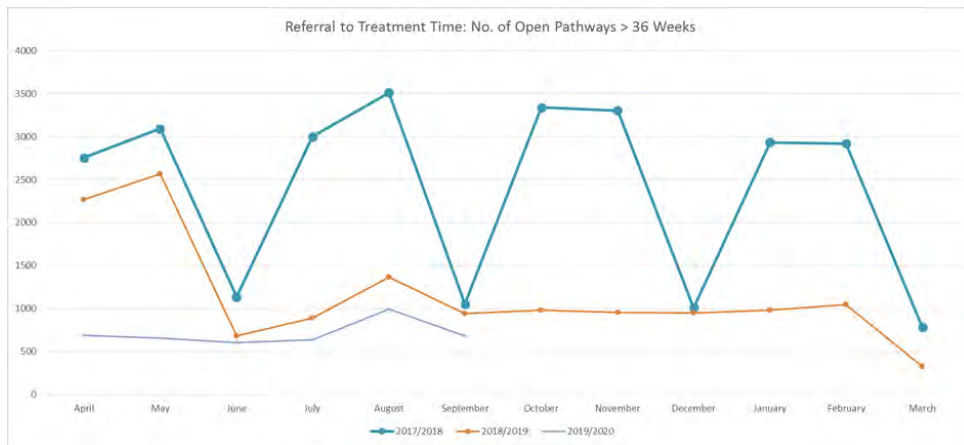
In **Cancer** services, although the UHB is currently meeting IMTP commitments in respect of the 31 day target, this is not consistent every month. The 62 day target is a greater challenge although there has been recent significant improvement. This is against a backdrop of rising demand. Our plans are focussed on balancing demand and capacity on a sustainable basis, particularly in tumour sites where demand increases have compounded pre-existing process and capacity constraints – Urology and Gastro Intestinal (GI) specifically.



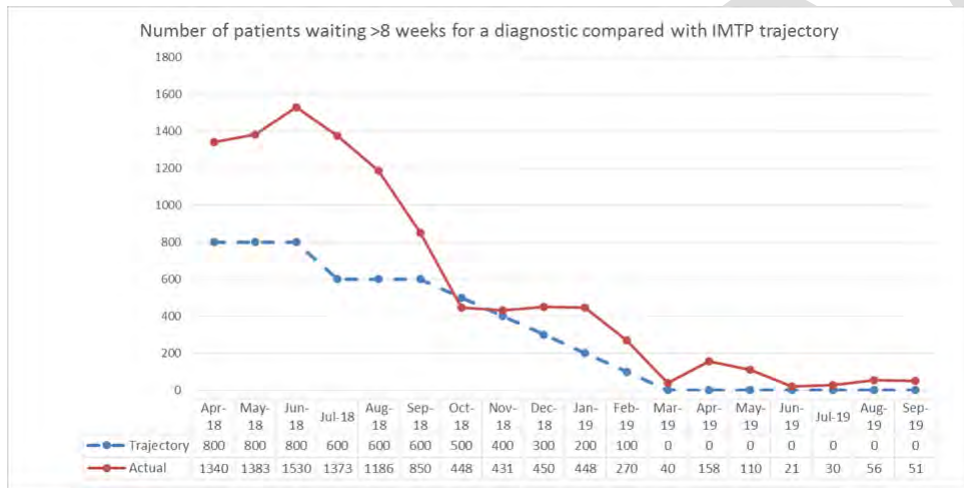
Single Cancer Pathway: The UHB continues with implementation of its SCP project plan. The Health Board has prioritised investment support from Welsh Government to help reduce the demand and capacity diagnostic gap (radiology and endoscopy) and in supporting development of an IT and Business Intelligence System that supports the SCP and national data requirements.

### Planned Care

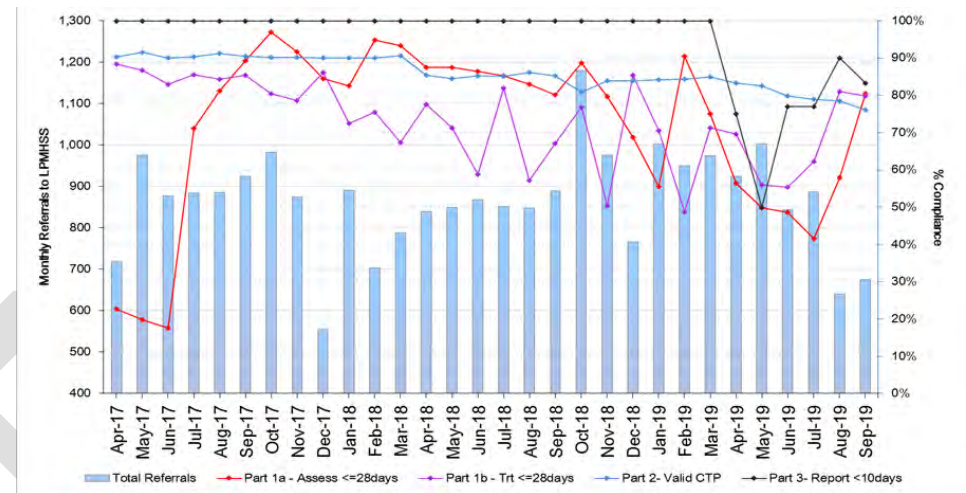
We continue to prioritise the reduction of waiting times for planned care. We are currently not able to meet our IMTP profile. We intend to continue our work towards no patient waiting longer than 36 weeks for treatment by 31st March 2020. We have been adversely affected in 2019 by national pension and tax issues affecting Consultant Medical Staff which has reduced our available capacity. Our main challenges are in Ophthalmology and Spinal Surgery.



Our diagnostic performance is similarly improving, with significantly lower volumes of patients waiting longer than 8 weeks than a year ago. We are not currently meeting our IMTP profile but our current plans are focussed on meeting the planned trajectories and eliminating these waits on a sustainable basis.



The performance of the UHB in **Mental Health** is measured primarily by 4 main target measures, 3 of which the UHB currently is meeting. Sustainable delivery of the targets on a monthly basis is adversely affected by high peaks of demand.



The service has invested in 2019 in primary care mental health liaison nurses to improve the responsiveness of the service and help direct referrals to the right place. This has shown positive benefits in the current year.

For children's services, there has been successful recruitment to all vacancies within the team, with new staff members now in post. This has supported an increase in capacity to better support meeting the demand.

We continue to work closely with our partners in local authorities and other agencies including HM Prison service, to continue to improve the Mental Health services we deliver for patients.

## Clinical Strategy Overview-

Our strategy, Shaping Our Future Wellbeing describes our ambition based on a set of design principles to develop and deliver joined-up care based on; home first, avoiding harm, waste and variation, empowering people and delivering outcomes that matter to people. These principles underpin our approach to the redesign of our health and social care system at both a macro and micro level. We have been working with clinicians and wider stakeholders, including the Regional Partnership Board to develop a strategic clinical services plan. This describes the major service changes and critical enablers required to reshape our clinical services in order to meet the future needs of our population.

The Clinical Services Plan has now been published and can be found [here \(link open in January\)](#)

The principal priority is to optimise the independence and health and wellbeing of our citizens by taking a truly whole-system approach. We will do this through improved collaborations with our partners in local authorities, the third sector, public health and the universities. The development and delivery of increasingly collaborative services across health and social care teams in the community is already embedded within our Area Plan. They will be continuously strengthened and developed to provide seamless, cluster-focused and locality-based services. These will be designed to meet the specific and variable health and social needs of the local populations within those areas. This work is aligned with the programme set out with partners under the banner of HEART – the health enterprise alliance for regional transformation.

This clinical services plan focuses on how we see hospital services developing over the next decade as part of a transformed system, providing the necessary support to primary care to enable people to remain living independently at home, and to provide timely access to specialist hospital treatment, whether this is as an acute emergency, or as planned treatment that can only be provided in hospital. We know that the way our hospital system is designed is not delivering the best experience or outcomes for Wyn.

We know that compared with the best healthcare systems in the world, we provide too much of our care in hospital settings. Wyn can sometimes wait too long to access the advice, diagnosis or treatment he needs, and often the system makes it difficult for Wyn to return home quickly if a spell in a hospital was needed. It is important to recognise that overall our outcomes benchmark well with other NHS providers across the United Kingdom, and our patient experience feedback is very positive overall. But we know that there is a lot more we need to do to deliver the services required into the future

We know that the facilities we will need to provide transformed services will need to be very different. In 2018 we developed an estates strategy which set out the condition, utilisation and functional suitability of our current infrastructure, and the outline plans for developing our estate over the next decade. The detailed plans will be informed by this clinical services plan, and the detailed service models that will follow. We know that we will need significant investment in our infrastructure, including replacing the University Hospital of Wales (UHW) which is no longer fit for purpose, and our business cases to secure the resources needed will need to clearly demonstrate the added value and benefit to patients and communities locally and across Wales.

UHW is not only a hospital for our local population but also a specialist facility serving the whole of Wales. A redeveloped facility will provide the opportunity to create a flagship of international standing. As the needs of the local, regional, supra-regional and national populations increase, our estate needs to react accordingly.

This clinical services plan does not attempt to describe how we see each individual service will develop over the next decade - it gives an overview of how we see the key service areas develop.



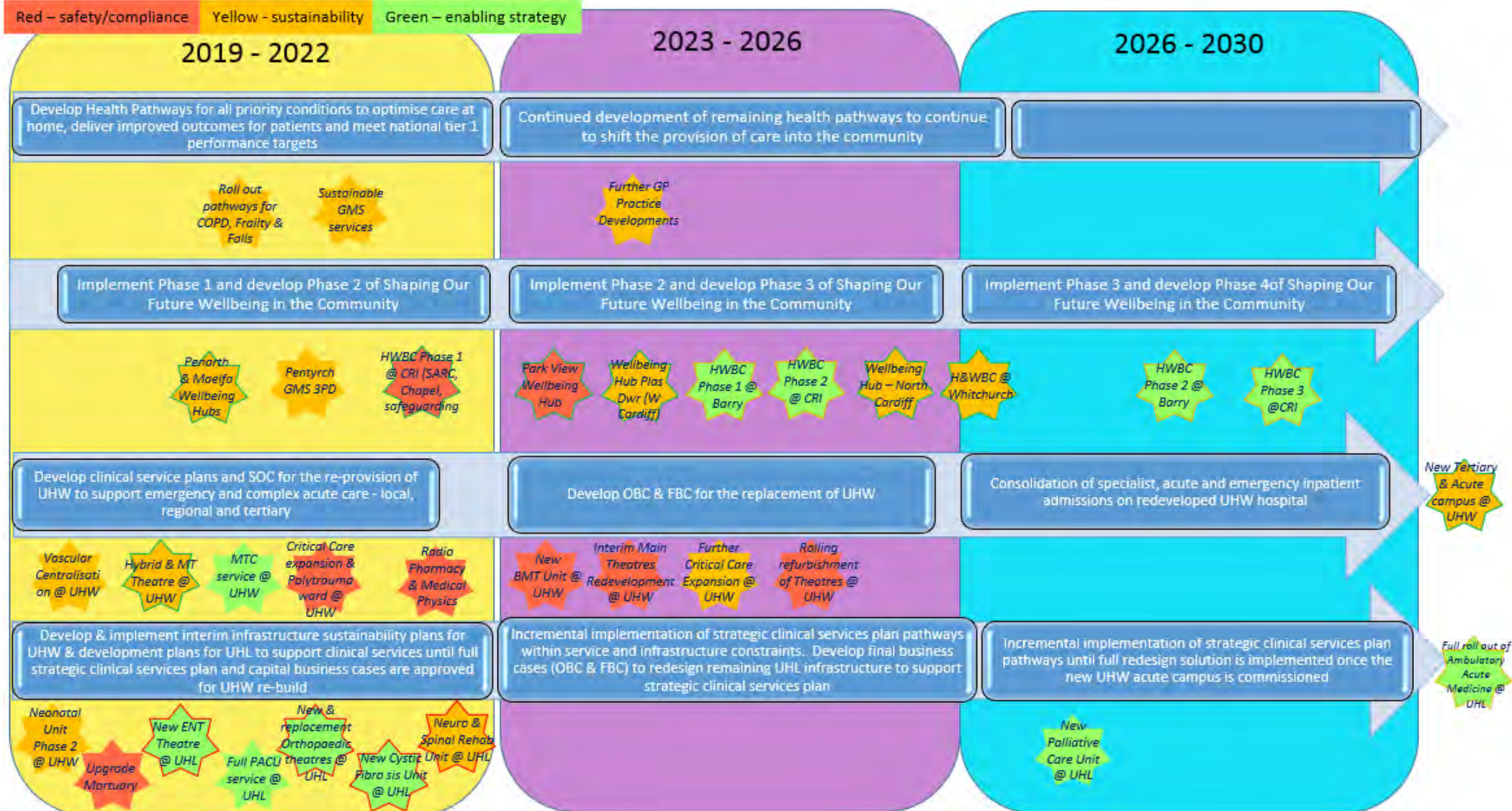
## Our Design Principles:

- We will work collaboratively with our neighbouring UHBs, Local Authority and other public and third sector partners to provide care through a connected health and social care system to improve health and wellbeing.
- Citizens should receive care at home or as close to home as possible – hospitals should only provide assessment or care that cannot be provided in the community.
- Patients requiring hospital admission should receive high quality, high value, evidence-driven, safe and compassionate care.
- Hospital care should provide the appropriate package of specialist care co-ordinated to meet the needs of the patient and focussed on improving outcomes.
- Innovative workforce models, new technologies and a flexible digital platform across clinical and wider care providers will support new models of care.
- Redesigned clinical pathways and services driven by the UHB's Transformation programme will deliver improved outcomes and value based healthcare.



## Key Enabler Milestones

Red – safety/compliance Yellow - sustainability Green – enabling strategy





## **KEY ENABLERS**

### **Quality, Safety and Improvement**

As an integrated healthcare provider, our focus on quality, safety and the patient experience must extend across all settings where healthcare is provided. We recognise that this cannot be a Framework that focuses on secondary care, but one that recognises that the majority of care received by patients is provided in a primary or community care setting and that the primary and community care element of the patients pathway, is as key to delivering safe, high quality care as that part of the pathway which is provided in more acute settings. What really matters for our patients carers and citizens must be central to our decision making, so that we can use our time, skills and other resources more wisely.

It is inevitable that there will be emerging risks to both patient safety and quality across the whole system of healthcare provision, and we will need to anticipate and respond to these. This will form an important focus for quality and safety initiatives over the next three years. During 2019 we have continued work to embed the QSI Framework across the UHB. There have been a number of positive achievements:

- Annual Quality Statement was published in May 2019. This year we focused on the experiences of our elderly, frail population in the community
- Continued to increase compliance with Patient Safety Solutions to 95%
- Approved a Health Board Falls framework
- We have continued to make good progress against the 2012-13 baseline numbers of HCAI and are performing well in comparison with peers across Wales
- Our Falls implementation Lead was highly commended at the Manchester Patients Safety Congress for his inter-generational Falls Awareness programme carried out in partnership with local schools, school children and elderly relatives as well as students from Cardiff University.
- We celebrated World Patient Safety day in September, by undertaking a staff engagement programme across the UHB to encourage staff to 'Speak up for Safety' and announced the launch of our Quality Clinics initiative and our Coaching for Safety programme.

- Undertaken significant improvements work in areas of concern during 2019 - 2020 including governance in relation to in-sourcing of surgical services, endoscopy decontamination, vascular surgery, and the care of patients with fractured neck of femur.
- Continued our work to put in place a more robust framework for implementation and monitoring of Health and Care Standards for Wales
- Secured a 75k investment from the Health Foundation to take forward a project to maximise how we analyse data to maximise how NHS learning from patient safety incident reports. We were one of only 10 organisations that succeeded.
- Continued to participate in a European research project to implement a TALK clinical debriefing tool to support staff after learning events in the clinical environment

During 2018-2019, the UHB has invested significantly in order to respond to the Infected Blood Inquiry. This is of particular significance to Cardiff because we are the Comprehensive Care Centre in Wales and Professor Arthur Bloom, a former employee and lead clinician in the Haemophilia centre during the 1970s until his death in 1992, was the Chair of the UK Haemophilia Centre Doctors' Organisation - an association of medical practitioners who work within Haemophilia centres in the UK and have an interest in the care of people with Haemophilia and other inherited bleeding disorders. In July 2019, Welsh patients and their families gave evidence at the Inquiry in Cardiff. We have continued to work with Haemophilia Wales, Welsh Blood Service, Public Health Wales, Velindre NHS Trust and other Health Boards across Wales.

During 2019 we have continued to make progress in terms of embedding Quality, Safety and Experience arrangements across the health board. All of our Clinical Boards report on a regular basis to our Quality, Safety and Experience Committee, providing assurance across the breadth of services delivered by the organisation. A standardised Quality, Safety and Experience agenda template aligned with the Health and Care Standards is now well embedded and provides a robust framework for assurance reporting to the Committee. A Quality, Safety and Experience dashboard is also well embedded and we have developed and launched a Nursing Dashboard, which will support quality improvement at ward level and also support implementation of the Nurse Staffing (Wales) Act 2016.

We have already embedded arrangements to respond to the actions aligned to the strategic direction of NHS Wales and progress against these actions is being monitored through the Quality, Safety and Experience Committee of the Board, which has a comprehensive work programme developed to meet the requirements of national strategic drivers, as well as key quality and safety issues in the Board Assurance Framework and the Healthcare Inspectorate Wales (HIW) Work Programme.

The Quality, Safety and Improvement (QSI) Framework 2017-2020 has set out our three year Framework. Work is now planned to develop a QSI framework for 2020-2023. This will involve a wide engagement exercise to seek the views of UHB staff, key stakeholders and patients and the public. Although the detail of the framework has not been determined as yet, it is likely to focus on the following themes:

- Actively seeking out safety problems
- Implementing good practice
- Re-designing systems and human factors
- Culture –making it safe for staff
- Patients as partners
- Better use of technology
- Sharing learning

#### Detailed 2020/21 Actions

Work will continue with Clinical Boards to implement the Quality, Safety and Improvement (QSI) Framework. The key areas of focus for 2019 – 2020 however, will be:

AIM 1 – GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
ACTION	OUTCOME	MEASURE
Leading Improvement in Patient Safety (LIPS) <ul style="list-style-type: none"> <li>• Deliver 2 cohorts (April and September 2020)</li> <li>• Align Clinical Board improvement projects</li> </ul>	Local quality improvement capacity and capability building is developed to support and enable teams to identify and address local QSE improvement priorities	Delivery of LIPS x 2 cohorts with .50% projects aligned to Transformation Increase in the number of people trained in IQT

with key Transformation priorities and with Amplify 2025	<b>Current position:</b> 900 staff trained in silver IQT methodologies <b>Target:</b> increase number of staff trained in silver IQT methodologies to 1000 +	
The UHB will continue to work with and respond to the Infected Blood Inquiry	Full engagement; timely responses to requests for information, not only from the Inquiry but also from patients, families and their representatives.	
Establish Human Factors training across the Health Board  Establish a Health Board Human factors Group	Human factors is considered routinely as an important element in solution generation so that the workplace and practices are designed and organised to minimise the likelihood of errors occurring and the impact of errors when they do occur.	Human factors group established with multidisciplinary representation and evidence of good engagement. Evidence that human factors are considered as part of investigations and action planning
AIM 2 – SAFE CARE		
ACTION	OUTCOME	MEASURE
Implementation of the Once for Wales Concerns management System	Year 1 2020-2021 - implementation of the complaints module	
Implement and embed 'Quality Clinics' and 'Coaching for Safety programme'	An increase in level of support currently available to staff to proactively manage patient safety issues in their areas	Safety culture results  Staff evaluation and feedback
<b>Serious incident reporting</b> Revision of Clinical Board SI Closure KPIs twice a year to	Reduction in same cause serious incidents that cause severe harm or death	Number of open SIs  Number of monthly SI

<p>maintain focus and improvement</p> <p><b>Reduction in the number of same cause Never events</b></p> <p>NatSIPPS – revise current implementation plan to focus on chest drain insertions, central line insertion,</p> <p>Work with clinical boards to establish a UHB wide Venous Access Service to standardise practice, improve patient outcomes and experience and improve more timely access for necessary interventions.</p>	<p><b>Current position:</b> (September 2019) - 95 Serious Incidents open 5 Never Events open &lt;50% closed within WG timeframes</p> <p><b>Target:</b> Further 10% reduction in number of open SIs 0 Never Events 75% of SIs closed within WG timescales</p>	<p>closures</p> <p>Number of same cause serious incidents</p> <p>Number of never events</p> <p>% of serious incidents closed within WG prescribed timeframes</p>	<p>Antimicrobial Safety Walkrounds</p> <ul style="list-style-type: none"><li>Implement improvement plan following receipt of ALL Wales HDSU audit</li><li>Continue work to reduce Caesarean Section Surgical Site Infection</li><li>Continue implementation of UTI guidance for District nurse and care home staff</li><li>Continue Peezy pilot (Improved urine sampling process, UTI pathways, dip sticking guidance) commenced in a Locality GP practice, GP OOH and Obstetrics</li><li>Antimicrobial stewardship</li></ul>	<p>written</p> <p><b>Target:</b> WG reduction expectation targets (need to confirm the 20-21 targets when they are issued) Cdiff - rate no more than 26 per 100,000 SA – rate no more 20 per 100,000 Ecoli – rate no more than 60 per 100,000 population</p> <p>Klebsiella – reduction of 10% in number of cases in 2019/20 when compared with 2018/2019</p> <p>Pseudomonas aeruginosa – reduction of 10% in number of cases in 2019/20 when compared with 2018/2019</p>							
<p><b>Infection Prevention and Control</b></p> <ul style="list-style-type: none"><li>Train senior medical staff in ANTT</li><li>Increase number of staff completing online ANTT training</li><li>Consider re-establishment of CEO reviews of MRSA</li><li>Continue to implement Antimicrobial Delivery Plan</li><li>Continue Medical Director led</li></ul>	<p>A reduction in the number of Healthcare Acquired Infections in line with or exceeding targets</p> <p><b>Current position</b> (up to end August 2019/target 2019-2020) Cdiff - 38/96 MRSA – 6/0 MSSA – 41/120 Ecoli – 164/22 Pseudomonas 13/30 Klebsiella 39/37 ** confirm these figures when last draft is being</p>	<p>Performance against WG targets for infection prevention and control</p>	<p>AIM 3 – EFFECTIVE CARE</p> <table><tr><th>ACTION</th><th>OUTCOME</th><th>MEASURE</th></tr><tr><td><p>Patient Safety Solutions – continue necessary actions required to achieve full compliance with:</p><ul style="list-style-type: none"><li>PSN30 – Medicine cupboards – in line with revised version when issued</li></ul></td><td><p>The UHB demonstrates compliance with all Patient Safety Solutions/notices/alerts</p><p><b>Current position:</b> 92% <b>Target:</b> 100%</p></td><td><p>% compliance with Patient Safety solutions/notices/alerts</p></td></tr></table>			ACTION	OUTCOME	MEASURE	<p>Patient Safety Solutions – continue necessary actions required to achieve full compliance with:</p> <ul style="list-style-type: none"><li>PSN30 – Medicine cupboards – in line with revised version when issued</li></ul>	<p>The UHB demonstrates compliance with all Patient Safety Solutions/notices/alerts</p> <p><b>Current position:</b> 92% <b>Target:</b> 100%</p>	<p>% compliance with Patient Safety solutions/notices/alerts</p>
ACTION	OUTCOME	MEASURE									
<p>Patient Safety Solutions – continue necessary actions required to achieve full compliance with:</p> <ul style="list-style-type: none"><li>PSN30 – Medicine cupboards – in line with revised version when issued</li></ul>	<p>The UHB demonstrates compliance with all Patient Safety Solutions/notices/alerts</p> <p><b>Current position:</b> 92% <b>Target:</b> 100%</p>	<p>% compliance with Patient Safety solutions/notices/alerts</p>									

<ul style="list-style-type: none"><li>PSA008 – Nasogastric tube misplacement</li><li>PSN 043 – tracheostomy guidelines</li></ul> <p>Continue implementation of NatSSIPS with focus on:</p> <ul style="list-style-type: none"><li>Central line insertion</li><li>Chest drain insertion</li><li>Nasogastric tube insertion (linked with PSA008)</li></ul>			<ul style="list-style-type: none"><li>Continue improvement work to increase compliance with Level 1 reviews</li><li>Implement required developments to EMAT to allow interface with Datix and direct input of Level 2 reviews</li><li>Establish local Medical Examiner implementation group and continue work to recruit Medical Examiners and to establish the infrastructure required to support the Medical Examiners office</li></ul>	reviews	
<b>National Clinical Audit</b> Identify the necessary resource to ensure that the UIHB is able to participate in all of the mandated National Audits.	The UHB participates fully in the National Clinical Audit and Outcome Review Plan (NCAORP)	Results of annual published reports			
<b>Mortality reviews</b> <ul style="list-style-type: none"><li>Strengthen current UHB arrangements for the routine monitoring, consideration and reporting of mortality data.</li><li>Development of the current EMAT system to allow analysis of death certification trends</li><li>Local implementation of the medical examiner system over the next 18 months</li></ul>	<p>The deaths of all patients are reviewed to ensure that they received appropriate safe, high quality care</p> <p><b>Current position:</b> the UHB has been addressing a decline in compliance with mortality Level 1 reviews – current performance is 80%; no compliance data for Level 2 reviews</p> <p><b>Target:</b> &gt; 90% compliance with Level 1 reviews; 100% compliance with Level 2</p>	% of Level 1 reviews carried out and recorded on EMAT			
AIM 4 – DIGNIFIED CARE					
ACTION		OUTCOME		MEASURE	
See Patient Experience section re Sensory Loss					
AIM 5 – TIMELY CARE					
ACTION		OUTCOME		MEASURE	
See Planned and Unplanned care					
AIM 6 – INDIVIDUAL CARE					
ACTION		OUTCOME		MEASURE	
See Patient Experience Section					

## Patient Experience Framework

The Wales Audit Office (2016) outlines how listening to the experiences of service users should be a fundamental part of learning in the NHS and in order to learn effectively, there is a need for structured, planned activity that is built in to normal working practices.

The NHS Wales Framework for Assuring Service User Experience was initially published in May 2013 and updated in 2015. The requirement to update the Framework was in light of Keith Evans report 'Using the Gift of Complaints'. Additions therefore to the balancing quadrant included concerns and compliments data and Third party surveys for example those undertaken by our Community Health Councils.



The following have influenced the development of this refreshed framework Health and Care Standards (2015)

- Listening and Learning to improve the experience of care (2015)
- All-Wales Framework for Assuring Service User Experience (2015)
- The NHS Outcomes Framework (2015-2016)
- Learning from Patient Experience: Key Questions for NHS Board Members
- Shaping our future well being

We refreshed the Patient Experience Framework to incorporate all elements of real time, retrospective, proactive/reactive and balancing patient experience across the organisation. Much of the detail in the framework has been informed by the All Wales Listening and Learning Group which has been established to embed the learning from the Evans Review a gift of complaints and to share good practice across Wales. The Health Board meets on a regular basis with our Community Health Council and their contact details are displayed on the 700 posters displayed across secondary and some primary care settings. Patients, families and carers can provide feedback in a wide variety of ways. Some may be specifically designed by organisations to encourage feedback,

### Detailed 2020/21 Actions

We will continue to deliver and embed the refreshed Patient Experience Framework and in 2019/20 we have had some key achievements

- Where possible the Health Board will use early resolution and respond to these concerns within 2 working days including the day of receipt The 30-day response rate to formal complaints is currently 85% and a trajectory is in place to as a minimum sustain the performance Implement real time feedback system across all areas of UHB Implement real time feedback system across all areas of UHB performance.
- A positive annual Ombudsman annual letter was received.
- The introduction of Happy or Not machines and ward feedback kiosks means we have received ON GOING real time feedback to date opportunities using these methods.
- We have rolled out the introduction of the John's Campaign to recognise and support the needs of carers in the hospital setting
- Schools are increasingly able to record Young Carer status, schools have achieved accreditation status



- We have worked with GP practices to develop carer champions
- In 2019 we became the first Health Board in Wales to sign the BSL charter and we will work over the next 3 years to embed the 5 pledges

ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2020-21		
AIM 1 – REAL TIME		
ACTION	OUTCOME	MEASURE
Implement real time feedback system across all areas of UHB	To provide real time information Analysis of the data and target more in depth analysis of the themes and trends	Demonstrable service improvement evidenced through experience/ quality measurements e.g. patient satisfaction score, increased compliments etc
Complete the review of feedback mechanisms  Agree the tools to be used	A suite of patient experience feedback tools in use  Patient satisfaction scores are consistently good.	Increased maturity demonstrated in Standards for Health self-assessment ratings  Patient Satisfaction scores
Increased consideration the varied roles that volunteers can support  To measure the impact of Volunteer roles and the enhanced value to both patient and staff experience  To develop the IT database for managing volunteer appointment, induction and management	To ensure that volunteer roles are considered in every business case To have a system in place in 2020 To secure investment for the young volunteers manager substantive post	Evidence of inclusion in business cases System in use Substantive post in place

To support the substantive appointment of a young volunteers manger following cessation of the PEARS funding in October 2020		
AIM 2 - RETROSPECTIVE		
ACTION	OUTCOME	MEASURE
Explore use of social media for gaining proactive feedback  Development of short on line surveys Develop APPS	Social media channels are regularly used as a vital engagement tool by the public	Monitor HITS Monitor completion rates
AIM 3 – PROACTIVE/REACTIVE		
ACTION	OUTCOME	MEASURE
Focus upon the 4 priorities for carers Early identification  Promote life alongside caring Access to information  Involvement in hospital discharge	Continue with young carers in schools Support identification of carers in primary care Identify staff carers  Work with local authorities to promote awareness of carers rights and individual plans which include carers needs Pilot a carer focussed role in UHL to promote roll out of the John's campaign, carer information and focus upon	Identification of carers recorded as a numeric Evidence of support in education and primary care  Carers accreditation Carers stories



	discharge	
<b>AIM 4 – BALANCING</b>		
<b>ACTION</b>	<b>OUTCOME</b>	<b>MEASURE</b>
Ensure timeliness of responses to 30 day concerns investigations to achieve significant and sustained improvement. Monitor performance via performance reviews and integrated Board report Continue to monitor: referrals to Public service Ombudsman the cases for investigation and those not investigated number of follow up letters related to the same concern	85% of all formal concerns are responded to within 30 days and all complainants are fully satisfied with the response from the UHB	compliance with 30 day responses  Referrals to Public service Ombudsman and the number taken into investigation

<b>High level 2021/22 and 2022/23 Actions</b>		
<b>AIM 1 – REAL TIME</b>		
<b>ACTION</b>	<b>OUTCOME</b>	<b>MEASURE</b>
2017-2020 develop and implement the customer care training programme	To be launched end of 2020 and linked with values into action work	Customer care programme in place
<b>AIM 2 - RETROSPECTIVE</b>		
<b>ACTION</b>	<b>OUTCOME</b>	<b>MEASURE</b>
2017-2020 develop and strengthen the use of patient stories	Thematic analysis of patient stories Develop a library of patient/ carer and staff messages in 2020	Development of a tool for identifying subject themes from patient stories

<b>AIM 3 – PROACTIVE/REACTIVE</b>		
<b>ACTION</b>	<b>OUTCOME</b>	<b>MEASURE</b>
Introduction of e datix systems	Triangulation of feedback information	Using the data to

Develop the methods for presenting and sharing the information with clinical areas	across patient experience and liaising with patient safety	inform of potential concerns more proactive rather than reactive E datix modules for patient experience implemented Develop the quantitative and quantitative triggers and the mechanisms for sharing the data
	Development of the analysis of information through customization of the modules and cross modular reporting  To work with colleagues in corporate nursing and patient safety to share information and focus upon areas for improvement	
Develop the reporting structures Continue to promote the thematic analysis and evidence of actions taken Develop systems that demonstrate the monitoring of the impact of any intervention	Patient Experience feedback is routinely used by Clinical Boards as part of their Quality, Safety and Experience assurance mechanisms and service planning arrangements	Quality and safety minutes of Clinical Directorate and Board meetings
<b>Aim 4 -Balancing</b>		
<b>ACTION</b>	<b>OUTCOME</b>	<b>MEASURE</b>
Progress implementation of Putting Things Right Training Programme	Consistent implementation of the PTR regulations Ongoing training subject to evaluation	Training programme in place – numbers attending Evaluations of

		training Improvement in general PTR metrics (as above)
<p>Sensory Loss</p> <p>In 2019 the UHB signed the BSL Charter</p> <p>5 pledges</p> <p>1 Ensure access for Deaf people to information and services</p> <p>2. Promote learning and high quality teaching of British Sign Language (BSL)</p> <p>3. Support Deaf children and families</p> <p>4. Ensure staff working with Deaf people can communicate effectively in BSL</p> <p>5. Consult with the local Deaf community on a regular basis</p> <p>To further develop the redress and Claims team roles to focus upon increased use of redress across the SI's to reduce litigation cost</p> <p>To ensure we capture all opportunities to use the Redress process</p> <p>Focus upon a training programme to share lessons and minimise reoccurring claims</p>	<p>To ensure compliance with the five pledges</p> <p>To review all SI investigations in line with the PTR guidance and where appropriate utilise the redress arrangements</p> <p>To implement and evaluate a training programme</p>	<p>Staff trained in basic BSL and deaf aware</p> <p>Use technology to support choices for BSL communication</p> <p>Regular consultation with the deaf community</p> <p>Monitor complaints and compliments</p> <p>To demonstrate a reduction in litigation costs</p>
Inquest Management-to develop the management and learning from inquests	<p>To support thorough investigation</p> <p>To minimise litigation costs</p> <p>To support staff in</p>	<p>To identify an awareness of all inquests and be aware of any</p>

	<p>preparation and training for inquests</p> <p>To ensure concerns are processed via PTR</p>	<p>concerns</p> <p>Instigate improvement actions at the earliest opportunity</p> <p>Robust training programme in place</p>
--	--	--

## Workforce and Organisational Design

Workforce planning is embedded throughout this plan and is integral to achieving all aspects of delivery. A detailed workforce plan has been published alongside this document and is available [here](#). We also recognize the role we play in supporting a strong workforce for the wider NHS and public sector. We want to have a pipeline of talent for all parts of the system.

There are five core components of our approach to our workforce



### Transforming Workforce

Workforce Transformation is necessary to underpin the achievement of the ten-year vision for the UHB Shaping Our Future Wellbeing. Amplify 2025 is aimed at creating a working environment where people can challenge and change and have permission to do so. Holistically, Amplify 2025 brings together:

- ❖ Social movement to unleash capability within the organisation – via the **Wyn Showcase**
- ❖ Leadership & Succession Planning
- ❖ Effective Appraisal for the individual and talent management (PADR)

### Engaged Workforce

We know the link between an engaged workforce and delivery. Improving the wellbeing of our staff and focusing on embedding our vision in values will be core to our success. Taking the learning from our recent staff survey, we will take prioritised action to improve staff experience in key areas.

### Capable Workforce

Here we are investing in our capability, focusing on talent management and training. Including improving our leadership capability.

### Efficient & Sustainable Workforce

These streams focus on delivering our core workforce metrics; delivering pay bill in budget, reducing sickness absence and promoting staff wellbeing.

Key Performance Indicator	2018-19 Outturn	YTD	Monthly Actual - Jun-19	2020-21 Target	2021-22 Target	2022-23 Target
Sickness Absence (12-month Cumulative)	5.11%	5.18%	4.93%	4.60%	4.40%	4.40%
YTD Sickness Absence (Financial Year)	5.11%	4.84%	4.93%	4.60%		
Job Plan Compliance (12 month review)	31.44%	27.41%	27.41%	85.00%		
Voluntary Resignation Turnover	6.57%	6.53%	6.53%	Reduction		
Pay Bill Over/Underspend	-0.31%	-0.32%	-0.31%	Underspend		
Variable Pay	8.55%	8.64%	8.74%	Improvement		
Actual (Contracted) WTE	12962.53	12924.25	12924.25	As per IMTP Predictions		
Fire Safety Mandatory Training	67.97%	68.69%	68.69%	85.00%		
PADR	56.37%	55.75%	55.75%	85.00%		

recruitment and retention of our workforce remains one of the core risks to delivering this plan. Our workforce plan sets out some of the ways we will address this challenge, however all elements of this plan contribute. Through becoming more efficient and developing new models of care we can support our workforce challenges.

Risk  
s  
We  
reco  
gnis  
e

DRAFT

## PERFORMANCE; ACHIEVING SUSTAINABILITY

### Planned and Unscheduled Care

As we set out in the introduction to this plan, we have made consistent and sustained improvement in the performance of our services over the past four years. In the course of this planning period our ambition is to continue this trajectory and achieve compliance across all of the main national targets. It is also a period when we need to accelerate the process of service transformation in order to achieve sustainable delivery, within the context of growing demand and our commitment to achieve financial balance.

Long-term demand trends suggest that maintaining our current performance against the existing measures (planned and unscheduled care) will require a further increase in activity in line with our growing population and demographic changes. Through our transformation work we believe there are opportunities to mitigate some of this demand through reducing variation and providing services closer to home.

In addition the introduction of new developments - e.g. FIT testing, single cancer pathway and new ophthalmology measures – will bring improvements in the care and experience for patients but are expected to require further step changes in activity. The UHB is fully engaged with the National Planned Care and Unscheduled Care programmes and has a range of initiatives to improve efficiency of services and transform models of care in line with our strategic direction.

In RTT and diagnostics the progress we have made this year and the past four years means we expect to deliver compliance against the 36-week RTT target and the 8 week diagnostic target. We are also improving our compliance against the 26-week target and have made significant progress in reducing our endoscopy surveillance backlog.

As part of the development of the 3-year IMTP the Health Board has developed two broad planning scenarios for RTT - **Maintain** and **Improve** performance. The extent to which we can deliver further reductions in waiting times is in part

dependent upon infrastructure and workforce constraints. Nonetheless our ambition is to deliver the higher activity levels required to continue the improvement trajectory towards compliance against both planned and unscheduled care targets. Further work is being done on detailed delivery plans which articulate the requirements necessary to deliver the improvements we aspire to achieve in order to secure compliance with national standards. The performance trajectories set out in Annex C describe our ambitions for the next three years and include the following:

IMTP profiles	2020-21	2021-22	2022-23
RTT>36 Weeks			
Diagnostics> 8 Weeks			
Therapies>14 weeks			
RTT- 26 Weeks			
Cancer 62 Day			
Cancer 31 Day			
Cancer 62 days from point of suspicion			
Under 4 hour waits in the emergency department			
People waiting over 12 hours in the emergency department			
Ambulance handovers over 1 hour			
Direct admission to a stroke unit < 4hrs			
Assessment by a stroke consultant within 24hrs			
Stroke patients who receive a 6 month follow up			

## CAPITAL AND ESTATE

The development of our estate is linked to our clinical services strategy. You can see the connections of our major capital schemes to the development of our service models. We have developed a comprehensive estates strategy which is available [here](#). The estates strategy recognises the level of risk we carry as an organisation in our ageing estate in meeting statutory health and safety standards, we also recognise the need for development of our buildings to deliver the ambition set out in our strategy and this plan. The estates strategy sets the need to redevelop our key sites, and rationalise some of our facilities in line with our new services models and digitally enabled agile ways of working and service delivery.

There are a number of highlights to draw out which will be delivered in this plan period:

### UHW Masterplan

As highlighted in the Clinical Services Strategy section we are working through the clinical role of our estate. We will be developing a masterplan for UHW working closely with Cardiff University and in the context of the City Region Deal to ensure we are maximising opportunities for digital, diagnostic, genetic and economic innovation.

### Critical Medium Term Infrastructure Requirements

Replacement and Refurbishment	NHS Wales Specialist and Tertiary Service Developments
Main Theatres 1-10, UHW	Hybrid Theatre (Vascular), UHW
Orthopaedic Theatres 5 & 6, UHL	MTC Theatre, UHW
B4 Haematology, BMT Day Unit and Outpatients, UHW	Paediatric Single Point of Entry (MTC), UHW
	Polytrauma ward
	Critical Care Expansion, UHW
	Long-term Ventilation Unit, UHL

Multiple options have been considered over the past two years for the most appropriate and cost-effective solutions to addressing these fundamental service requirements. This has led to the development of three essential enabling schemes:

- **UHW – New Block:** A three storey extension of the UHW building, providing a best-fit and cost-effective solution for: main theatres, BMT, critical care and polytrauma ward.
- **UHL – Two Storey Modular Build:** Providing replacement of the two Orthopaedic theatres and some flexibility for further theatre capacity plus a replacement decant/winter ward following the commencement of the Rookwood scheme.
- **UHW – Major Trauma and Hybrid Theatre:** A specific development adjacent to the Short Stay Surgical Unit and in close proximity to the Emergency Unit and Radiology Department to meet the minimum requirements of establishing a South Wales Major Trauma Centre and a South East Wales Hub for Vascular Surgery.

### UHW Neonatal Unit

The project will be completed in 2019-20 with the construction of the MRI facility. The scheme will provide space for two MRIs, which will be subject to a separate fit-out contract with the MRI supplier. The project will also provide undeveloped space for two more MRIs, which will be subject to a further business case. In addition, two floors will be provided as part of the completed scheme. This will provide for the relocation of cardiac measurement and office accommodation.

- **UHW Neonatal Unit Sustainability**
  - Provided strategic energy metering of electrical and mechanical services with remote monitoring
  - Building wide BMS environmental monitoring and temperature control
  - Installed energy efficient LED luminaires with longer service lifetime throughout the project



Reduced lighting energy usage with absence/presence detection control  
Mechanical plant has inverter motor control  
MRI installed 20.72 kWp PV array with estimated generation of 16,659 kWh and saving 10 tonnes CO2 annually  
Substantial future recycling potential from installed steel containment and steel/copper pipework systems

### **Re-provision of Specialist Neuro and Spinal Rehabilitation Services and Clinical Gerontology Services**

Construction will progress to refurbish and extend three templates at University Hospital Llandough to create ward, therapy and outpatient accommodation in order to facilitate the relocation of services from Rookwood Hospital.

The refurbishment of Cardiff Royal Infirmary Block 14 and 14A will be completed to provide a centralised facility for physiotherapy services to be co-located.

### **UHL Cystic Fibrosis**

Subject to approval of the business case by Welsh Government, extension and refurbishment work will commence in summer 2019 to provide additional ward accommodation to meet service requirements.

### **CRI Chapel**

Subject to the approval of a grant funding application and the business case by Welsh Government, refurbishment will be undertaken in the chapel to provide conference / meeting facilities, patient information and access to health awareness information as part of the development of the Health and Wellbeing Centre for the locality. The area will also include a cafe facility for the site and neighbourhood. As a result of the project being undertaken as a collaborative exercise, Cardiff City are relocating Roath Library to the refurbished area.

### **Shaping Our Future Wellbeing in the Community**

During the course of this plan we will open the first of our joint health and local authority Wellbeing Hubs at Maelfa and Penarth. We are also continuing to

develop our Health and Wellbeing Centre for Cardiff South and East with the phased redevelopment of Cardiff Royal Infirmary.

## **DISCRETIONARY CAPITAL**

### **Statutory Compliance**

An independent report of all areas of estate compliance was commissioned which identified 44 individual elements requiring annual inspection necessary to achieve compliance with the relevant statutory and mandatory obligations. The team has undertaken asset verification on the high risk areas and is continuing to undertake further verifications to identify all assets.

### **Ward Modernisation Programme**

A refurbishment programme has been developed to upgrade the wards to a high standard, dramatically improving the patient experience. Wards have been upgraded to include wet rooms with modern appliances throughout. The upgrades comply with the equality act where possible within the confines of the available footprint.

### **Lift Modernisation Programme**

We have an ageing stock of passenger lifts that while still serviceable are reaching a stage where major refurbishment or replacement will be required to maintain a service. Some lift components are now obsolete or on extended delivery. A refurbishment plan has been developed to upgrade the current passenger lifts.

## **ESTATES AND FACILITIES**

We are working through an Estate Strategy and Modernisation Programme. This has involved implementing a new maintenance IT software and systems to modernise planned maintenance and statutory compliance, using new technology to ensure a more proactive and planned service. In 2020-21 we'll be undertaking a full review of facilities function and developing a longer term strategic plan.

There are a number of important enabling functions within the organisation which are key to delivering our future service models. These are often forgotten but we recognise the need for our supporting teams to be part of the process of delivering our long term strategy. Some highlights in these areas include:

#### **Portering Review, UHW**

Roll out digital IT portering model in UHW following the successful trial at UHL. The software has dramatically improved response times at UHL, improving the patient experience. Improve accommodation to enhance service delivery and staff morale, this will also enable improved communication links to the helimed service.

#### **COMMERCIAL SERVICES (GIVE MORE SPACE TO ESTATES HERE)**

##### **Central Food Production Unit (CFPU)**

The CFPU currently supplies all patient catering outlets across the health board with cook freeze main courses, desserts, special therapeutic diets and a range of meals to meet cultural needs. Significant success has been achieved this year in delivering the new CFPU production model which is due to be implemented in 2019-20 migrating from the historic 7-day production to a 4/5 day production model delivering significant operational and financial efficiencies. This is being made possible directly due to

1. All-Wales IT Catering Ordering System being implementation in UHL & UHW.
2. CFPU is a “cook to freeze” model; production levels can be managed in line with business needs and remove the need for weekend production at enhanced rates.

##### **Concourse Redevelopment**

The PFI contract for UHW Concourse with Gentian Management Services Ltd. ceased during 2018 and the concourse became our asset. Gentian were

contracted to manage the facility for two year period while we undertook a review of its redevelopment and management. We now have an opportunity to use this commercial asset for the benefit of the population.

#### **SUSTAINABILITY**

We are progressing with the Refit program which will result in large scale Energy conservation measures being implemented at UHW, UHL, Barry hospital, Woodlands House and other areas as appropriate. The contractor has been appointed who will design, install and commission a range of projects which will result in energy and cost savings and a reduction in our carbon emissions. Such projects include:

- LED Lighting projects.
- High efficiency Ventilation systems.
- Pipe work insulation program.
- Solar photovoltaic systems.
- New centralised Boiler House and Combined Heat and Power plant for UHL including steam/heating system efficiency improvements.
- Control system upgrades.

Where appropriate innovative solutions will be adopted and all savings are guaranteed by the contractor under the program.

The project is being completed in 2 key phases with the initial program commencing in 2019/20 focussing on schemes that can be readily implemented with attractive paybacks. The subsequent 2020/21 phase will concentrate on more complex projects requiring greater detailed design and longer timescales for implementation.

We are also investing in energy saving schemes which will complement the Refit program including greater control of heating, ventilation and cooling systems,



shutting down of systems and equipment when not in use and water saving schemes including water less urinals where appropriate.

We are completing a Sustainable Travel plan encouraging where possible patients, staff and visitors to travel to UHB sites using alternatives means of transport. Electric charging points for electric vehicles will be considered and progressed.

We are undertaking a Bio diversity study/analysis for specific areas of the Health Board.

We will continue with our Environmental Management System including external ISO14001 Accreditation which blends together the key Environmental and Sustainability disciplines of the Health Board.

We are pleased to be a key member and play an active role in the Welsh Health Environmental Forum for the NHS in Wales.

This year a sustainability report will be completed highlighting our energy, environmental and sustainability performance throughout the year.

**Business Case Development of Capital Schemes (REFRESH)**  
**INSERT LATEST GANT CHART**

DRAFT

## DIGITAL AND DATA – CAV Digital Strategy

Building on our previous work, as outlined in the informatics strategic outline plan, we are in the process of developing our Digital Strategy for the next 5 years, designed to enable “Shaping our Future Wellbeing strategy 2015-2025. The digital vision will support the patients/citizens, professional and system leads in achieving the broad objectives as outlined below:

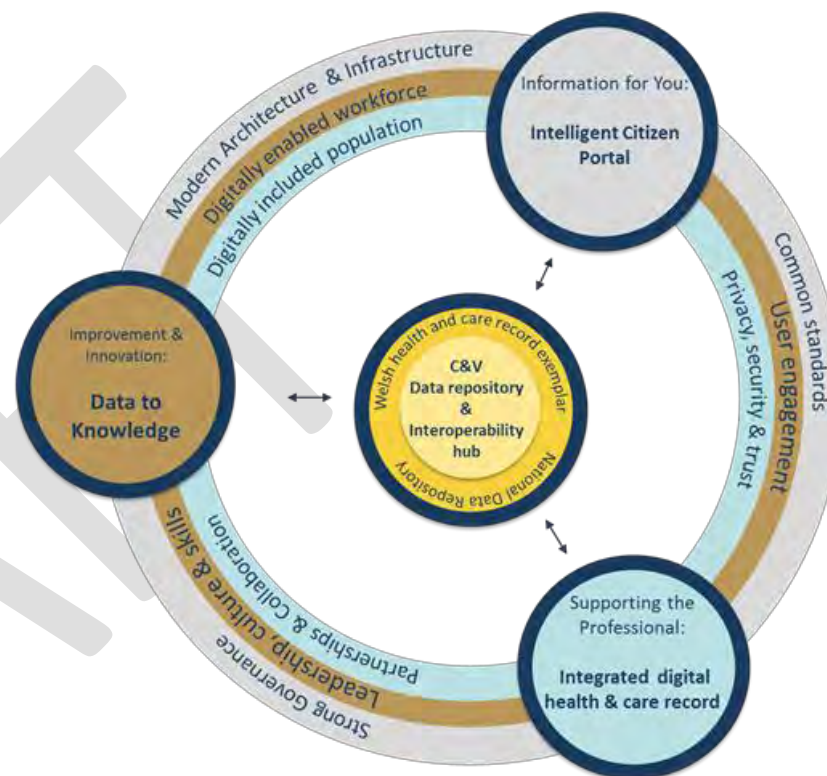


### Our digital strategy focusses on:

**The patient / citizen** – providing easy login to reliable secure information and the individual’s health record, supporting them to take greater responsibility for their own health and, where appropriate, to receive more services at or closer to home – through remote monitoring, videos, video calls and access to a range of health and social care via secure portal.

Patients/citizens will have greater control on who accesses their data; they will only need to enter information once, which will be re-used repeatedly. There will be more services in line with other businesses e.g. booking and changing appointments over the internet, receiving alerts, access to generic health and well-being advice.

**The clinician** – through a better digital patient record, with single sign-on to systems with single identity, there will be no need to enter information more than once, with the data re-used repeatedly. Clinicians will record structured



data “on the go” and generate automatic summaries of clinical interactions. Access to real-time lab and imaging results will provide greater efficiencies and better use of time, including patients’ time. We are also investing in infrastructure and functionality to deliver secure sharing of data across all care settings via single-sign on (rather than having to sign into multiple systems). A new information platform will support access to real-time data for clinicians and patients.

### **System Improvement and Integration**

We plan to put in place the digital technologies and to share data required to enable and accelerate the ability for health and social care professionals to make joint decisions on the complete data and co-ordinated care. In doing so the strategy will focus on the delivery of functions and applications as well as the enabling agreements to support the data sharing that is necessary to make this happen.

We have established three enabling programmes: Digitally included population; Digitally enabled workforce; Modern Architecture & Infrastructure to support implementation and realisation of the benefits of this plan, and have designed our approach around the establishment of a federated national data repository and interoperability hub which we see as being the digital keystone for ensuring citizens. Carers, clinicians and system leaders have immediate access to the information they require, and ultimately in delivering local and national objectives.

Our digital strategy will contain a work programme that describes the key enablers which are being implemented to deliver our strategic objectives, through the SoFW strategy. These are summarised as follows:

- Availability of the citizen portal to share information with patients.

- Development of a Clinical Data Repository (CDR) and core interoperability Hub.
- Enabling virtual care and outpatient Transformation.
- Real Time Clinical Data Availability to support service delivery and provide insights into demand and capacity
- Clinical Mobility and Cluster Working, utilising MS O365
- Digitally enabled organisation – achieving full digitisation of records
- Upgrading our infrastructure to enable and support the digital services environment.
- Working in tandem with all other NHS organisations in Wales to deliver the digital architecture, adopting design principles, enhancing integration engines to provide open platform and move to a national managed network and storage infrastructure.

Through our programmes we want to put real-time data in a consistent format directly into the hands of frontline clinicians to support operational planning, decision making and data led clinical discussion. We want the transformation of our services to be driven by our data.

## Research & Development

CVUHB had its best R&D performance for over 5 years -trial participation 6,579 in 2019/20, record commercial income generation -£1.7m despite an overall fall of HCRW funding of £2.2m over the same period, highest recruiting centre in several national and international studies, highest Welsh recruiter into Paediatric and cancer studies and innumerable prestigious publication in high impact journals. Despite this CVUHB knows it can and must do better and has undergone a radical revision in the way it envisages R&D and how to embrace the opportunities it brings along with Innovation and Improvement (I&I), to enhance the well-being and outcomes for ours and Welsh patients. Through the strategic alignment of common goals it is putting R, I&I at the forefront of impacting the patient care pathway and is actively disseminating this cultural change to all staff within the UHB. To achieve this vision CVUHB has fully adopted the WG R&D Finance Policy and initiated monthly meetings between the Directors of R, I&I to ensure consistency of vision, shared learning and actively performance manage progress against core objectives which include amongst many increasing patient access to clinical trials, new therapies and both medical and social innovations to improve daily living and outcomes. CVUHB has set up a Research Delivery Management Board (RDMB) with representation from all Clinical Boards (CBs), the R&D Office, Performance and Delivery teams, the Clinical Research Facility (CRF) and Finance and appointed a band 8 training manager. Chaired by the R&D Director in its first 6 months it has already written a new UHB strategic and accompanying implementation plan and approved appointment of 15 new additional R&D delivery staff. The R&D monies are now ring fenced within a specific Clinical Directorate (CD) R&D cost code under the control of each CD R&D Lead and the R&D Director. Each Clinical Board R&D Lead is having monthly meetings with their CD R&D Leads to ensure compliance with the strategic aims, to monitor performance in terms of study set up and recruitment and to disseminate the overall vision CVUHB is determined to establish that R&D and Leadership is at the core of who we are and what we do. All this underpinned by an expectation of the highest possible performance - which is personally led by the Medical Director at 6 monthly face to face meetings with all CBs- and value based principles.

CVUHB fully understands its leadership roles within Welsh Healthcare including R&D and has played a pivotal role in the successful bid for the Innovate UK Advanced Therapy Treatment Centre (ATTC). It is one of only 6 CAR T accredited centres in the UK. It has worked closely with all partners and was the first to open an ATTC study (Rexgenero). It has set up a Genetic Modification Safety Committee (GMSA) in conjunction with PHW colleagues at CVUHB. It has also opened the first non ATTC Gene Therapy Medicinal Product (GTMP) study in Wales and recruited two patients. CVUHB has already been chosen as sites for 4 further GTMP studies which are in set up.

There are still some issues with support services (Pharmacy and Radiology) being able to support commercial and non-commercial research studies in a timely manner but a plan has been agreed and is presently being executed.

Key programmes and actions to support delivery of Research and Development include		
ACTION	OUTCOME	MEASURE
<b>R&amp;D OFFICE</b>		
Joint Research Office with Cardiff University. Approval given by both CVUHB and CU Executive Boards to set up such a service in October 2018.	Joint Implementation Board in place but progress slower than anticipated due to Cardiff University needing to complete another piece of work ("Transforming Cardiff").	Meet WG metric on study set up times and increase research activity across CVUHB and CU (both numbers of studies and recruitment to them)
Work with HCRW in the "One Wales" project	Several members of CVUHB R&D Office staff assisting WG with this initiative.	Improve outward facing image of Welsh R&D to the commercial sector and increase commercial trial numbers and participants.

Key programmes and actions to support delivery of <b>Research and Development</b> include		
ACTION	OUTCOME	MEASURE
Appoint Deputy R&D Manager	Streamline R&D Office staff functions. Release resources to speed up approvals.	Improved study set up time.
Review amendment approval system	Work with HCRW in centralising amendment approval process and streamline activities and improved efficiencies	Improved study set up metrics leading to an increase in the number of studies being undertaken and recruitment.
<b>Research Delivery Management Board</b>		
Progress present new set up of directorate R&D accounts to include not only HCRW provided monies but also commercial and grant income.	Greater ability to flexibly manage income and expenditure, leading to improved directorate level management of research funding	Increase R&D output due to ability greater monetary/resource awareness
Review nursing and non nursing research job descriptions to provide band 5-7 posts	Through clear career progression attract and retain more research orientated staff	Undertake project to review skill mix in research delivery to maximise ability to support studies most cost effectively whilst ensuring patient safety
Identify funding and Set Up Research Nursing Bank	Increase ability to cover research nurse maternity, sickness and study leave. Improve ability to support specialist nurses to be able to undertake research by working on the bank	Improved set up and participant recruitment by "smoothing out" staff shortages

Key programmes and actions to support delivery of <b>Research and Development</b> include		
ACTION	OUTCOME	MEASURE
Encourage/support non – medical PI's	Identify funding/support structures to assist AHP's in being PI's. Appoint a professional development lead within R and D for the UHB.	Increased number of studies with non-medical PIs.
Working constructively with all Clinical Boards/Directorates, I&I, Human Resources and CVUHB's Organisational Development Unit to spread the culture of R, I&I being a core function of everyone's daily practice.	Provision of resources (education, monies, advice, delivery staff etc) to assist culture change	Enhance patient outcomes in all aspects of care.
Support Investigator led CTIMP studies by funding CTU activities	Continue to work with HCRW to find a way for a CTU to support investigator led non commercial pilot/feasibility studies. Consider funding/setting up CVUHB's own CTU via CEDAR.	Increased number of investigator led CTIMP studies and application to higher national funding bodies.



Key programmes and actions to support delivery of <b>Research and Development</b> include		
ACTION	OUTCOME	MEASURE
Establish performance management teams within each Clinical Boards.	Further engagement between RDMB and Clinical Boards to regularly explore R&D performance in terms of study delivery, recruitment etc. Comply with WG metrics for study recruitment to time and participant target. Better education of PI's as to importance of complying with WG metrics through face to face meetings and three monthly performance	Improved performance management of studies at Clinical Board level with improvement in study recruitment to time and target, and a reduction in non-recruiting studies. Produce 6 monthly performance reports.
Continue to streamline processes for setting up and delivering recruitment to commercial studies eg provide additional resources to support services such as Pharmacy, Radiology	Gain a reputation, UK and worldwide, as a centre of excellence for the placement of commercial studies, enhancing the opportunities for Clinical Boards to maximise opportunities for patients to participate in high quality studies as well as generating UK wide R&D Capacity and Capability process	Increase commercial income and re-invest in new research capacity/capability
Continue to expand our commercial activities via direct meeting with global pharmaceutical companies	Gain a reputation, UK and worldwide, as a centre of excellence for the placement of commercial studies, enhancing the opportunities for Clinical Boards to maximise opportunities for patients to participate in high quality studies as well as generating additional revenue	Meeting WG performance target of increasing number of and recruitment to commercial studies by 5% per annum

Key programmes and actions to support delivery of <b>Research and Development</b> include		
ACTION	OUTCOME	MEASURE
Focus support across research groups which are potential growth areas; cardiology, critical care, paediatrics, obs and gynae, surgery, mental health, diabetes	Capacity and Capability building to strengthen research teams for the future. Fund targeted consultant sessions.	Increase in number of studies/quality of studies being undertaken in these growth areas
Clinically lead the new Innovate UK Advanced Therapy Treatment Centre in Wales and increase other GTMP studies	Increased collaboration between PI's at CVUHB and commercial and non-commercial GTMP and Cellular therapy studies/initiatives	Increase research and patient access to very novel therapies across Wales
Assist other Welsh Units to develop their GTMP studies	Invite other UHBs to join CVUHB GMSC and provide CVUHB paperwork/skills to assist other UHBs with their GMSC set up.	Increased number of units (and hence patient participation) in Wales undertaking GMTP studies.
CLINICAL RESEARCH FACILITY		
Continue to undertake complex non commercial studies in the CRF including GTMP studies	Maintain status as a national research hospital for studies which cannot be undertaken elsewhere in Wales	Increase in number of complex non commercial portfolio studies in the CRF which are able to be supported. This is dependent on the number offered by external study sponsors and

Key programmes and actions to support delivery of <b>Research and Development</b> include		
ACTION	OUTCOME	MEASURE
		availability of Principal Investigators Improving set up time for commercial studies, as well as recruitment to time and target
Further develop the physical build capacity of the CRF	Safe and appropriate environment for a larger number of studies to take place in the CRF.	Clinical Research Facility is normal volunteer, cancer and non-cancer patient appropriate
Further increase use of Endoscopy suite on CRF	Encourage new researchers to use this facility	Increase number of endoscopy studies
Continue to support the development of a Paediatric CRF with expertise and advice and resources	Appropriate research setting for the placement of paediatric clinical trials requiring a CRF type set up.	Increase in number of paediatric research staff and studies

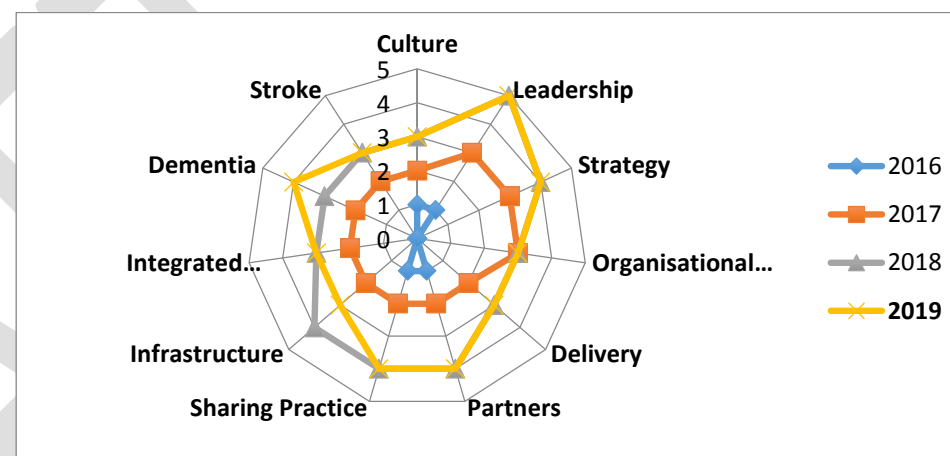
## Innovation

This year has seen a consolidation of the capability and performance of the health board's clinical innovation team, which continues to align with the Cardiff Clinical Innovation Partnership Strategy, the UHB's ten year strategy, A Healthier Wales and the Innovation Wales Strategy.

The Clinical Innovation Partnership Strategy focuses on:

- The Big Health & Service Challenges: Dementia, Integrated Diagnostics (Precision Medicine), Stroke, Operating Theatres
- Innovation Enablers: Partnership, Process – Acceleration, Infrastructure, Resources, Culture

The spider graph below shows the year-on-year progress against the partnership strategy:



## Innovation Delivery against Strategy

**Partnership:** The continued support and commitment from the College of Biomedical and Life Science, Cardiff University and the Clinical Innovation Hub has been critical to the success of the joint strategy.

We also continue to partner with multi-national organisations including MSD, GE, Renishaw, Medtronic, Siemens, Creo Medical and Invacare. There are also local SME partners working closely with the team. The health board has also retained a close relationship with MediWales and the Life Science Hub (LSH), with our Chief Executive continuing to be a board advisor.

The relationships with local universities and the business community have continued to grow through joint projects. This is demonstrated by joint post-grads (additional KESS2 project, Madeline Dementia Project and a Maths Post



Grad - on top of the 2 existing KESS2 masters students through SEWAHSP). The 5th Cohort/2019 of the Bevan exemplar has again submitted over 20 applications, of which 12 were successful.

**Process:** At the heart of the Clinical Innovation Partnership is the Innovation Multidisciplinary Team (iMDT). It meets at the Medicentre every month to accelerate the best innovations from academia, NHS, Industry or third sector. This includes the protection of IP, signposting expertise and funding opportunities, evaluation, tracking and the delivery to commercialisation.

The iMDT is supported by a group of volunteer experts and partners who cover most aspects of the innovation journey. This includes, the Engineering Department, Business School, School of Medicine, and RIS from Cardiff University; clinical entrepreneurs, an expert in medical devices, WIMAT, Cedar, Welsh Government and a commercial IP attorney. Importantly, if a gap in expertise is identified, this group can call on an unprecedented network of innovation talent. The iMDT has now supported over 90 projects and been exported to the Mayo Clinic.

**Infrastructure:** The health board has an established infrastructure with Exec, clinical and business management leadership. The Cardiff Medicentre is also the established front door for ideas and the home of the Cardiff Clinical innovation Partnership. It is a space to support the development of innovation, from ideas through to spinout companies. Its reputation has grown, for example, four start-ups being attracted this year and the occupancy of the Centre is now at 100% with a growing list of prospective tenants.

**Resource:** The Partnership has submitted over £45m of bids over the last three years (EU, ETTF, SBRI, Innovate UK, UKI ISCF, UKI SIPF, Bevan and Charities). The successful WEFO Accelerate Programme has enabled the Clinical Innovation Hub in Cardiff University (CU) to recruit 10 more experienced staff to the partnership. The first Accelerate project in the Integrated Diagnostic Theme has begun in the UHB, partnering with CU and Siemens. This funding will make a significant impact on the health board's ability to develop the best commercial ideas.

However, even with the great support from partners, the demand on the health board's innovation team has now grown beyond their capacity.

**Culture:** One of the health board's strategic objectives is to create a culture where innovation thrives. Innovation has now taken hold across all clinical boards from primary care to state-of-the-art neuro-surgery.

ACTION	OUTCOME	MEASURE
Dementia.	Whole system community led dementia innovation test bed developed (Madeline Project)	Madeline's Project Accelerated with successful funding award – linked to the Dementia Action Plan. - £3m ISCF EOI – AI, Radiology, Dementia - 2019-21
Integrated Diagnostics	Cardiff recognised as a centre of excellence for integrated diagnostics and precision medicine	- UKI SIP EOI, c£40m bid with CU, CaV, LSH, Creo Medical, Renishaw, Cardiff City Region deal - 2019-21. - ISCF EOI – Diabetes and POCT – 2019-21
Stroke	Develop comprehensive research and innovation test-bed.	Supported by SHW at Cardiff Met - Develop an innovative whole system VBHC Stroke Service & Model by 2021.
Theatre Project	Develop an innovation operating theatre test bed.	Team developed inc. Medtronic as industry partner • 2 x Projects scoped and delivery by 2021.

### Strategy Deployment; Our Approach to Change

A Healthier Wales challenges us to accelerate the delivery of our strategy. To enable this to happen we have developed a whole organisational approach to cultural change, under the banner of 'Amplify 2025'. We have taken the approach used by our learning partner, Canterbury Health and developed the Cardiff and Vale way to engage our staff to develop our healthcare system for the future.

We recognise that to achieve transformation in complex organisations you have to create the conditions for individuals, teams and networks to change and for approaches to be 'infectious' and spread. Amplify 2025 is focused on enabling change to happen in the organisation, driving both system level change and supporting continuous improvement in the organisation, for the benefit of our patients. Value based healthcare is fundamental to our approach. Our programme is about understanding the impact of our interventions on our system, using data to drive allocative efficiency and working in partnership through alliances to focus on value to the individual. As we work through the programme we are using operational issues to trial and develop our enabling approaches which is also testing our ability to spread success across the organisation and beyond. A Healthier Wales calls for Intensive Academies to support transformation: We are now implementing the Spread and Scale Academy approach to ensure good practice can be shared with internally and with our partner organisations. This is building capability through experiential learning and partnering with global experts, initially utilising Cardiff and Vale UHB as an 'incubator', for spread and scale. However it is seen as a resource across Wales.

### Transformation Programme- 'Making better systems'

Our transformation programme is focused on putting in place the enablers for change in the organisation:

- Establishing a pathways approach and methodology, growing the HealthPathways system (driving out variation and waste in clinical practice). We are collaborating with other healthcare systems across the UK to further

accelerate this programme by adopting and adapting existing pathways from our partners.

- Secure a refreshed programme for accessible information for clinical staff (including the necessary platform) to drive improvement.
- Creating a digitally enabled organisation and workforce (including a focus on digital dictation and electronic communication between staff and a patient portal).
- Embedding an alliance approach to service development which integrates with partner organisations. The falls alliance is up and running and proving to be a popular and successful process to bring about whole system change.
- The 'Cardiff and Vale approach' to management and leadership (including the learning partnership alliance with Canterbury) is now being delivered under the '8' programme, starting with Aceller8, as part of the move to accelerate towards our 2025 vision.
- Delivering the 'Me, My home, My Community' programme.
- Embed our vision (SoFW), values and behaviours.

*We have continue to monitor the impact of our interventions focusing on:*

- Outpatients (demand, new to follow up, shift to community, cost pre-referral).
- Length of Stay (RAMI, average length of stay, planned to unscheduled ratio).
- Theatre Utilisation (CEPOD compliance, productivity, cancellations).
- Waste and Variation (agreed pathways in place).

### Improvement & Implementation - 'Make it better'

The newly formed Improvement & Implementation team aims:

- Facilitate change for improvement, working alongside the frontline teams and focus on whole pathway projects.
- Translating performance information to support efficient service delivery- utilising our new live data system 'signals from noise'.
- Building the organisation's effectiveness by providing guidance, support and training in quality improvement skills.
- Growing pioneers in effective innovation, continually learning and translating great ideas from other sectors.

## GOOD GOVERNANCE

Core to our delivery is ensuring that appropriate and proportionate governance is in place across the organisation. In order to achieve this, the following objectives have been agreed to deliver good governance at Cardiff and Vale University Health Board.

- 1: Ensure the work of the board is focused upon strategy and delivery of objectives and gains appropriate assurance on delivery of corporate objectives from the committees of the board and executive directors.
- 2: Ensure that the committees of the board are providing assurance to the board on their duties and areas of responsibility.
- 3: Ensure there is an appropriate risk and assurance framework in place.
- 4: Ensure that the systems and processes operating at Cardiff and Vale UHB are operating efficiently and effectively.
- 5: Ensure end of year arrangements and the development of the annual report and annual governance are dealt with in a timely manner and in line with Welsh Government requirements.
- 6: Ensure that corporate governance resources are managed efficiently and effectively.

Progress has been made on objective 3, with the development of a Board Assurance Framework for Cardiff and Vale University Health Board. This received board approval in November 2018.

The [Board Assurance Framework](#) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important objectives. It provides the framework to map out the key controls to managing or mitigating those risks and to confirm the assurance about the effectiveness of those controls. The benefits of a working Board Assurance Framework are:

- A simple and comprehensive method for managing risks to achievement of objectives.
- It provides evidence to support the annual governance statement.
- It helps to simplify board reporting and prioritisation which allows more effective performance management.

- It provides assurances about where risks are being managed effectively and objectives delivered.
- It allows the board to determine where to make efficient use of resources.
- It allows the identification of priorities for the board to provide confidence that the organisation is able to understand its capacity to deliver.

The Board Assurance Framework has been developed by the Director of Corporate Governance and Executive Directors after discussion at Management Executive team meetings, where the following risks were agreed as the main risks to the achievement of Cardiff and Vale UHB's Objectives:

1. Workforce.
2. Financial Sustainability.
3. Sustainable Primary and Community Care.
4. Safety and Regulatory Compliance.
5. Sustainable Culture Change.
6. Capital Assets (including Estates, IT and Medical Equipment).

The risks associated with a no deal Brexit have been added to the risks being planned for in the light of current uncertainty, which could continue into 2019/20.

In addition to this, development work has been taking place over the last 12 months with clinical boards to develop and progress their risk registers to ensure consistency in the way risks are described, that controls are in place and assurance on those controls evidenced. This work should be completed within the next six months at which point the highest risks (corporately and from the clinical boards) will also be reported to the board. This will replace the Corporate Risk and Assurance Framework (CRAF). This will enable the board not only to see the principle risks to the achievement of strategic objectives but also to have oversight of key operational risks.

Corporate governance and assurance arrangements are reviewed annually by the Wales Audit Office in their Annual Structured Assessment. The recommendations which have been made this year in relation to corporate governance will be implemented during the next 12 months. In addition to this, any Internal Audits in relation to corporate governance will have all their recommendations implemented in a timely manner.

KEY ACTIONS 2019-22

Bringing the Plan Together

The next section of the plan sets out the core actions we will take over the next three years against our core priorities:

- 1. Primary Care: sustainability and the further development of community services.
- 2. Unscheduled Care: delivering a resilient and high performing system.
- 3. Planned Care: meeting standards.
- 4. Cancer Service: delivering the single cancer pathway and improved outcomes.
- 5. Achieving Financial Balance (Embedded throughout).

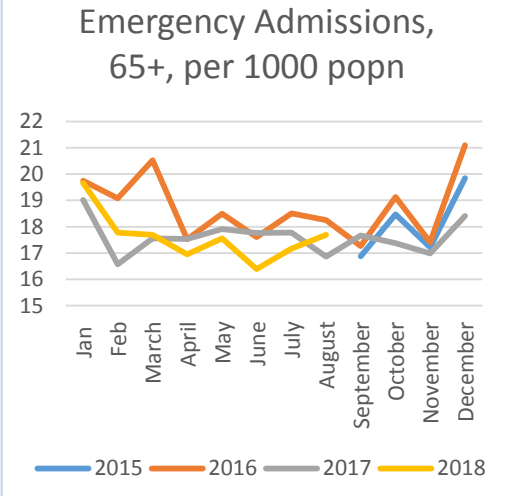
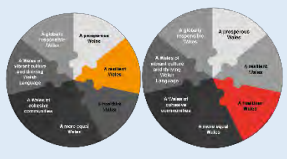
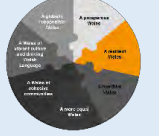
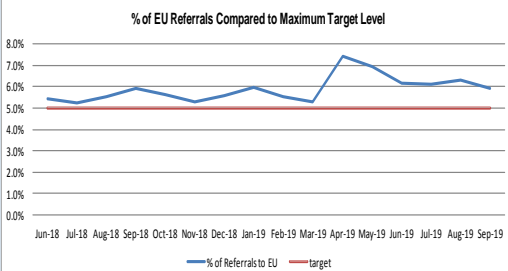
Our approach to delivering financial sustainability is set out in the finance chapter above. This sections does not contain all actions but focuses on the core priority areas that will support the achievement of Shaping Our Future Wellbeing. Further detail on wider health board activity will be published alongside this document in supporting plans and we are happy to share further plans and details as necessary to support peoples understanding our approach to delivery over the next three years.

As an integrated plan, we recognise the interdependencies of our actions. Although we have separated our actions into priority areas, we know there is impact across the organisation; the development of primary care services impacts on our planned and unscheduled systems. We are mapping through our activity to understand the core elements needed to turn our plan from rhetoric to action and understand the key enablers and core links we need to succeed.

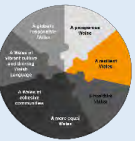
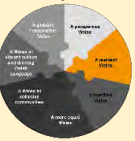



Key

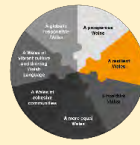
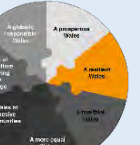

	Next step of 2019/20 action
	New in 2020/21
	New to corporate plan in 2020/21 Previously at clinical board level

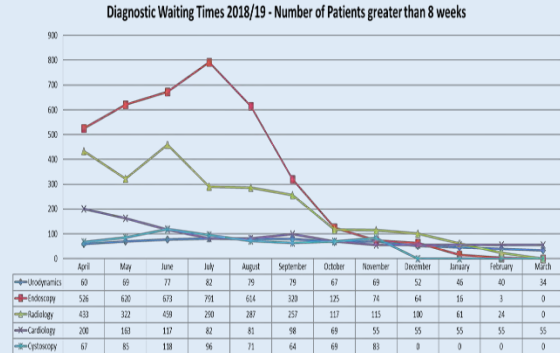

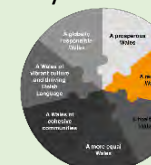

## SECTION FOUR: CORE ACTIONS

ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<b>PRIMARY CARE</b>				
<p><b>Support the resilience of General Medical Services through the implementation of changes to the GMS contract for 2020/21 and subsequent years.</b></p> <p>This will mean in 2020/21</p> <ul style="list-style-type: none"> <li>Implement and monitor contract revisions</li> <li>Support practices with quality improvement methodology and ensure assurance against quality improvement component of QAIF</li> <li>Establish a method for identifying vulnerable practices, developing a RAG rating, sustainability matrix, as part of a contractual performance management framework</li> <li>Explore opportunities to improve recruitment and retention of GPs and nurses in general practice, building on ongoing work</li> </ul> <p><b>Lead Board:</b> PCIC</p>	<p>This priority addresses issues of general practice workforce sustainability and service improvement.</p> <p>GMS contract and associated funding will be a key enabler, as will peer support and leadership from QI Clinical Lead. However, cluster maturity may provide a challenge in progressing QI work in some areas.</p> <p>The Primary Care team will require additional training to provide QI support. The recent restructure of the Primary Care Team along Locality lines will provide more local intelligence, but any gaps in establishment will provide challenges due to the small size of the team.</p> <p>Key partners include : GP Practices; Primary Care Clusters; HEIW; Transformation Team; Communications Team</p>	<ul style="list-style-type: none"> <li>No contract terminations</li> <li>No directly managed practices</li> <li>An increase in the number of practice mergers supported by the health board</li> </ul>	<p><b>Emergency Admissions, 65+, per 1000 popn</b></p> 	<p>Wyn has lower back pain and is starting to struggle getting out of his chair. Previously he would have had to wait for a GP referral to a physiotherapist. Wyn will now be able to see the cluster physio directly and receive support in his community. Delivering early preventative activity and reducing pressure on General Practice.</p> 
<p><b>Respond to LDP growth and ensure Primary Care estates are fit for purpose</b></p> <p>This will mean in 2020/21:</p> <ul style="list-style-type: none"> <li>Progress Primary Care and Community Services Estates Plan</li> <li>Support practices to respond to growth</li> <li>Progress revenue schemes for Pentyrch and Whitchurch Road primary care developments</li> <li>Support practices involved in Maelfa, Penarth and Park View capital schemes and the development of Health and Wellbeing Centres at Barry, Cardiff North and West, and Cardiff Royal Infirmary</li> <li>Explore opportunities to support practices make best use of their current premises</li> </ul> <p><b>Lead Board:</b> PCIC</p>	<p>Funding is a key risk to delivery, and successful delivery of the schemes will also be subject to suitable resourcing and management of the schemes through Cluster meetings and project teams.</p> <p>Key partners include : GP Practices; Primary Care Clusters; Locality Teams; Capital Planning; Local Authority; NWSPP; Patients; Welsh Government</p>	<ul style="list-style-type: none"> <li>Actions within Primary Community Care Estates Plan progressed</li> <li>Mapping of growth against practice and cluster capacity</li> <li>Monitoring of Cluster plans/IMTPs</li> <li>Progress of developments against timescales for completion</li> <li>Minimisation of identified risks</li> <li>Primary care contribution to planning process to facilitate practices relocating to these schemes</li> <li>Number of improvement Grants funded to improve practice premises</li> <li>Appropriate use of off-site medical records storage facilities</li> </ul>	<p>Sufficient GMS capacity to respond to LDP growth</p> <p>Primary care premises that are fit for purpose for future healthcare delivery</p>	<p>Wyn will have access to high quality premises which are fit for purpose. Wy will experience improved access to general medical services and have an improved patient experience. GMS services will be supported to be sustainable.</p> 
<p><b>Remodelling Urgent Primary Care Out of Hours and Develop new Urgent Primary Care Model</b></p> <p>This means in 2020/21 we will:</p> <ul style="list-style-type: none"> <li>Review new roles for introduction into service, including: dual/hybrid roles; mental health practitioners; pharmacists; and healthcare support workers</li> <li>Review and embed workforce training and</li> </ul>	<p>Cost: Delivered within clinical board budget</p> <p>Increasing skills available out of hours; increasing use of healthcare support staff working to top of competence</p>	<p>Number of urgent call, logged &amp; returned within set timeframes</p> <p>Target- 90% within 1 hours</p> <p>Baseline- 97%</p> <p>Number of routine calls logged and returned within set timeframes</p> <p>Target- 90% within 2 hours</p> <p>Baseline- 94%</p>	<p><b>% of EU Referrals Compared to Maximum Target Level</b></p> 	<p>Wyn will receive the right help at the right time, within a timely manner. Wyn will have improved access to urgent primary care services during the out-of-hours period and be able to contact the most appropriate practitioner for his care.</p>

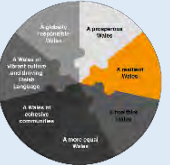


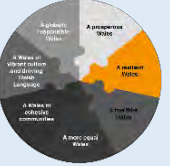



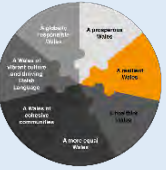
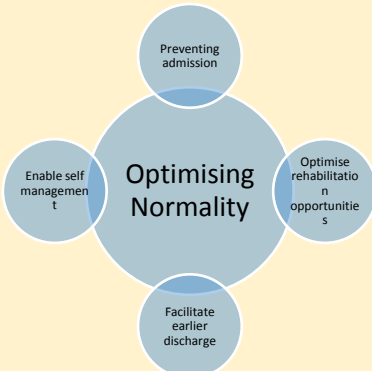


ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<p>development opportunities, including creating workforce plans and developing educational competencies</p> <p><b>Lead on regional Out-of-Hours dental triage model:</b></p> <ul style="list-style-type: none"> <li>Develop OOHs dental model as a 24/7 model and pilot within Cwm Taf UHB and Aneurin Bevan UHB</li> <li>Work with dental contract managers to ensure suitable daytime provision of service</li> </ul> <p><b>Urgent Primary Care</b></p> <ul style="list-style-type: none"> <li>Explore options to develop an Urgent Primary Care 24/7 model</li> </ul> <p><b>Lead Board:</b> PCIC</p>				<p>Wyn will be aware of the range of service delivered through primary care contractors and so will choose to access the most appropriate service for his healthcare needs.</p> 
<p><b>Dermatology and Rheumatology integration into primary care</b></p> <p><b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"> <li>Setting up minor surgery within GP Practices</li> <li>Upskilling / running training sessions with GPs regarding management of dermatological and rheumatological disease management</li> <li>Set up a community outreach service within Rheumatology</li> <li>Increase Health Pathways across the Specialised Medicine Directorate, to improve knowledge and referral quality</li> </ul> <p><b>Lead Board:</b> Medicine</p>	<p>Delivery within clinical board budget</p>	<ul style="list-style-type: none"> <li>Continue reduction in DNA rate to achieve &lt;8% of all Out Patient Appointments</li> <li>Improve benchmarking data to help to drive down clinical variation</li> <li>Reduction in first outpatient waiting time to &lt;30 weeks</li> </ul>	<p>We will introduce Patient Knows Best to enable the capture of Patient Report Outcomes- this will enable a value based assessment of the service to be made</p>	<p>Wyn requires a mole removed, currently his practice do not offer this service therefore Wyn is required to access the service at UHW, this requires him to take two buses or rely on family for a lift. With the development of the community service will be able to have the mole removed in his local practice.</p> 
<p><b>Implementation of the Rehabilitation Strategy Rehabilitation Model</b></p>  <p>Build on the Community Neurological Rehabilitation Service model of rehabilitation and develop coproduced behavioural change programmes focusing on prevention and self-management for people with chronic conditions delivered in leisure centres / community rooms. Widen use of technology</p>	<ul style="list-style-type: none"> <li>Development of robust partnership arrangements with leisure centres and community services.</li> <li>Financial support to develop TRAC and workforce training.</li> <li>All Therapy staff MECC trained.</li> </ul>	<p>Baseline Measures and indicators to be established as programme develops (update for January)</p>	<p>Impact on core Therapy outpatient services.</p> <p>People accessing local services for self-management.</p>	 <p>Wyn will access self-management and prevention support for chronic conditions in a location that is closer to home.</p>
<p><b>Establish Mental Health Single Point of Entry, involving multidisciplinary input into regular meetings where every referral will be discussed and appropriately signposted</b></p>	<p>Delivered within Mental Health Clinical Board budget</p> <p>MDT attendance will require medical, admin, psychology and therapies attendance.</p>	<ul style="list-style-type: none"> <li>Patients seen by right person, first time</li> <li>Efficient patient flow</li> <li>Supports reduced ALOS and DTOC</li> <li>Effective team working to avoid</li> </ul>	<ul style="list-style-type: none"> <li>Patient and carer satisfaction</li> <li>Improved communication</li> <li>Supports care planning</li> <li>Improved quality of referral</li> </ul>	 <p>Wyn will be seen by the right person, first time. Currenly Wyn has to tell is story multiple times to different teams as the correct service is</p>



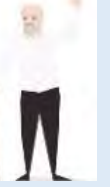

ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<p>This will involve in 2020-21:</p> <ul style="list-style-type: none"> <li>Setting up a Steering Group to redesign the current 4pm meeting into a MDT SPOE meeting</li> <li>Staff Consultation</li> <li>Determine frequency of meetings</li> <li>Develop PARIS report to capture all referrals</li> <li>Develop Admin system to capture actions required</li> <li>Begin SPOE meetings</li> </ul> <p>2021-2023:</p> <ul style="list-style-type: none"> <li>To continue to review SPOE meetings for efficiency and effectiveness, including attendance, actions and outcomes</li> </ul> <p><b>Lead Board:</b> Mental Health</p>	<p>Time saved by discussing referrals in one place Effective signposting and consideration of caseloads of each team.</p> <p>Improved integration of community teams and inpatient service</p> <p>One recording mechanism (PARIS), which will avoid duplication and loss of information, recoding all referrals in one place until a single IT system is in place in MHSOP community</p>	<p>unnecessary inpatient admission</p> <ul style="list-style-type: none"> <li>Effective recording of referrals and referral data</li> <li>Improved communication and clarity around referrals into MHSOP service from non-MHSOP teams and clinicians</li> <li>Workload / caseload reviews</li> </ul>	<p>information</p> <ul style="list-style-type: none"> <li>Reduced duplicated referrals</li> <li>Improved patient flow</li> <li>Inpatient admission avoidance</li> </ul>	<p>identified to meet his need. The MDT approach and integrated of community and inpatient teams will mean faster decision making with Wyn to get Wyn into the right service to meet his need.</p> 
<p><b>Ensure that systems and processes are put in place in community child health to respond to Additional Learning Needs (ALN) Act</b> and measure performance against the statutory timescales so that the UHB is able to comply with the legislation</p> <ul style="list-style-type: none"> <li>Confirmation of an early years multidisciplinary process which will lead to the development of a Health Individual Development Plan (IDP) which can feed into multiagency arrangements</li> <li>Develop a PARIS module which will capture the IDP and measure performance against statutory timescales</li> <li>Develop a business case to support the growth of children with complex needs requiring support in school and growth in special school places to ensure that the UHB complies with its legal requirements under the Act</li> </ul> <p><b>Lead Board:</b> Children and Women</p>	<ul style="list-style-type: none"> <li>The UHB are required to support the appointment of a Designated Education Clinical Lead Officer (DECLO) who will work with key professionals to ensure that systems are in place</li> <li>Work through the Regional Partnership Board to identify funding requirements for additional staffing required to support the growth of ALN provision</li> </ul>	<ul style="list-style-type: none"> <li>IDP's for early years will need to be in place from September 2020</li> <li>At that time the PARIS module will need to be designed</li> <li>This will allow the directorate to measure time from request to delivery of the health plan once this is finalised and the statutory code is issued</li> <li>Appointment of a DECLO</li> </ul>	<p>Proxy measure: number of Individual Development Plans in place</p> <p>Baseline: new requirement, therefore no baseline this year</p>	<p>Sam and his family will have confidence that the health advice and support required for him to meet his full potential is in place</p> <p>The Cardiff Local Development Plan indicates an additional 400 specialist needs school places will be opened over the next 5 years. Working through the RPB and Cardiff PSB, we will develop rounded service provision for these children and young adults.</p> 
<p><b>Develop Welsh Gender Service:</b> <b>This will mean in 2020/21</b></p> <ul style="list-style-type: none"> <li>Increase activity and being to reduce waiting times</li> <li>Continue to engage stakeholders</li> </ul> <p><b>2021-23</b></p> <ul style="list-style-type: none"> <li>Develop business case with WHSSC for funding from 2021 (current 3 year funding from WG for interim service ends March 2021)</li> <li>Work with Local Gender Teams</li> <li>Work with provider of Peer Support Service</li> </ul> <p>Work with London GIC <b>Lead Board:</b> Medicine</p>	<p>Welsh Government funded programme via WHSSC</p> <ul style="list-style-type: none"> <li>Produce business case for WHSSC for provision of service April 2021</li> </ul>	<ul style="list-style-type: none"> <li>Waiting times</li> <li>Referral Rate</li> </ul> <p>This was a new service in September 2019 therefore baseline to be established</p>	<ul style="list-style-type: none"> <li>Waiting list reduces</li> <li>Peer Support Service for all Welsh patients attending London GIC or Welsh Gender Service</li> </ul> <p>This was a new service in September 2019 therefore baseline to be established</p>	<p>Wyn gets seen as soon as possible by expert team and treatment plan activated with Local Gender Teams. Peer Support Service is provided for all Welsh patients.</p> 




ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact																																																																	
PLANNED CARE																																																																					
<p><b>Expansion of Endoscopy Unit- Estate expansion, achieving standards, supporting the national programme</b></p> <p><b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"><li>Expand Endoscopy unit and development of diagnostics centre to enhance patient experience and reduce LOS</li><li>Maintain waiting times standards for;<ul style="list-style-type: none"><li>Cancer</li><li>Diagnostic (8 weeks)</li><li>Bowel Screening Wales</li><li>Surveillance</li></ul></li><li>Achieve JAG accreditation, all standards met 19/20 apart from the surveillance backlog</li></ul> <p><b>Continued involvement with the National Endoscopy Programme (NEP)</b></p> <ul style="list-style-type: none"><li>There are a number of workstreams within the NEP and through our involvement we will share best practice and learn from others, ensuring that there is an All Wales approach to the challenges within Endoscopy e.g. Demand and Capacity modelling – using a standard model, training programmes for upskilling and attracting workforce and pathway to ensure clinical best practice.</li></ul> <p><b>Lead Board:</b> Medicine</p>	Resourcing requirements to be further developed- with some support from the NEP	<p>Diagnostic Waiting Times 2018/19 - Number of Patients greater than 8 weeks</p>  <table><tr><th></th><th>April</th><th>May</th><th>June</th><th>July</th><th>August</th><th>September</th><th>October</th><th>November</th><th>December</th><th>January</th><th>February</th><th>March</th></tr><tr><td>Endoscopy</td><td>526</td><td>620</td><td>673</td><td>791</td><td>614</td><td>339</td><td>125</td><td>74</td><td>64</td><td>45</td><td>1</td><td>0</td></tr><tr><td>Radiology</td><td>433</td><td>322</td><td>439</td><td>290</td><td>387</td><td>257</td><td>117</td><td>115</td><td>130</td><td>61</td><td>24</td><td>0</td></tr><tr><td>Cardiology</td><td>200</td><td>183</td><td>117</td><td>82</td><td>81</td><td>98</td><td>69</td><td>55</td><td>55</td><td>55</td><td>55</td><td>55</td></tr><tr><td>Gynaecology</td><td>67</td><td>85</td><td>118</td><td>96</td><td>71</td><td>64</td><td>69</td><td>83</td><td>8</td><td>0</td><td>0</td><td>0</td></tr></table>		April	May	June	July	August	September	October	November	December	January	February	March	Endoscopy	526	620	673	791	614	339	125	74	64	45	1	0	Radiology	433	322	439	290	387	257	117	115	130	61	24	0	Cardiology	200	183	117	82	81	98	69	55	55	55	55	55	Gynaecology	67	85	118	96	71	64	69	83	8	0	0	0	<ul style="list-style-type: none"><li>Sustainment of the diagnostic target</li><li>Surveillance backlog to zero</li><li>Zero 36 week breaches and delivery of an overall waiting time for treatment (baselined – with a continuous improvement)</li><li>JAG accreditation</li></ul>	<p>Cerys requires an endoscopy and has had two cancellations, one as a result of a lack of understanding of the necessary preparation. The review of nursing will free capacity to support Cerys to understand the preparation required, reducing anxiety and the risk of cancellations. Improvement in efficiency will speed up Cerys waiting time.</p> 
	April	May	June	July	August	September	October	November	December	January	February	March																																																									
Endoscopy	526	620	673	791	614	339	125	74	64	45	1	0																																																									
Radiology	433	322	439	290	387	257	117	115	130	61	24	0																																																									
Cardiology	200	183	117	82	81	98	69	55	55	55	55	55																																																									
Gynaecology	67	85	118	96	71	64	69	83	8	0	0	0																																																									
<p><b>Embed Acute Frailty Assessment Model:</b></p> <p><b>This will mean in 2020/21</b></p> <ul style="list-style-type: none"><li>Embed acute frailty assessment pathways and beds</li><li>Specialist pathways in place</li><li>Embedding D2A pathways 2 and 3 at St David’s</li><li>Implementation of D2A pathways at UHL</li></ul> <p><b>Lead Board:</b> Medicine</p>	Delivered within core budget	<ul style="list-style-type: none"><li>Frailty score 100% of frail patients attending EU/AU/MEACU/MEAU</li><li>&gt;85% of patients directly admitted to acute frailty assessment beds at UHL/UHW</li></ul> <p><b>Bed Efficiency Group – Programme Indicators</b></p> <ul style="list-style-type: none"><li>Acute Frailty UHW occupied bed days for frail elderly 0-4 days</li><li>Acute Frailty UHW occupied bed days for frail elderly 4-14 days</li><li>Acute Frailty UHW occupied bed days for frail elderly over 14 days</li></ul>	<p>Acute Frailty metrics within current acute frailty viewer (Lightfoot supported)</p> <p><b>Include SPC in January update</b></p>	<p>Currently following a hospital procedure Wyn is spending too long in hospital and not receiving appropriate rehabilitation. These actions will provide access to ‘get me home’ services that are helping people to go home earlier following his hospital stay and improving access to rehabilitation to prevent deconditioning during hospital stays.</p> 																																																																	
<p><b>Respiratory Pathway</b></p> <p><b>This will mean in 2020/21:</b></p> <ul style="list-style-type: none"><li>Ensure greater resilience around respiratory services – Asthma, Bronchiectasis, Hi-flo nasal</li></ul>	<ul style="list-style-type: none"><li>Take students for new MSc. Clinical Science (Respiratory and Sleep Sciences – Scientific Training Programme) – mitigates against workforce challenges within Lung Function</li></ul>	<ul style="list-style-type: none"><li>SAFER/R2G metrics on AU/A1/B7 – evidence of daily senior review in morning.</li><li>RTT performance – 26 week performance sustainability</li></ul>	<ul style="list-style-type: none"><li>Improved staff satisfaction.</li><li>Reduced staff turnover within challenged services.</li></ul>	<p>If Wyn attends hospital as an emergency with an acute respiratory problem that potentially warrants NIV, he has 24/7 rapid access to a</p> 																																																																	



ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<p>oxygen, Thoracoscopy, TB.</p> <ul style="list-style-type: none"> <li>Address single run clinics/leads within services and our reliance on these. Undertake full workforce establishment/skill mix review – focus on risks/gaps, and explore new roles and different ways of working (alongside clinical pathway review/service redesign) before making a case for further investment.</li> <li>Setting up of additional 2 NIV beds to provide 6-bedded NIV unit at UHW (this needs to build on what was in 2019/20 plan – we have delivered a 4 bedded NIV Unit on ward B7 UHW April 2019, next stage is to expand the unit by a further 2 beds to provide a total of 6 beds)</li> </ul> <p><b>Lead Board:</b> Medicine</p>	<p>service.</p> <ul style="list-style-type: none"> <li>There is a need for respiratory group Consultant job planning to address issues with ward cover.</li> <li>Additional resilience may require additional medical and nursing staff investment.</li> </ul>	<p>Cancer performance – lung cancer pathway – including 8 week diagnostic performance.</p>	<ul style="list-style-type: none"> <li>Compliance with NICE/Royal College Guidance and equivalent</li> </ul> <p>% NIV cases started within 1 hour of indicative ABGs (gas to mask time) Reduced mortality Times spent In AU/EU (&gt;1 hour) % patients transferred to NIV unit from critical care within 4 hours of referral Patient and Family experience % in post staff on B7 completing NIV competencies</p>	<p>team of specialists, a range of appropriate diagnostic tests and emergency appropriate treatments. Wyn will have a diagnosis quickly confirmed and get the right treatment (NIV) in the right place by experts to enable a best chance of survival and recovery.</p> 
<p><b>Prehab to Rehab:</b> To improve population wellbeing and improve access to curative intent cancer treatments</p> <p><b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"> <li>Primary Care Workstream- optimising cancer patients at point of suspicion, completing a wellbeing assessment signposting to support services</li> <li>Community Based Prehab- pre-treatment support to optimise patients for treatment, through targeted therapies intervention</li> <li>Enhanced Recovery After Surgery- embedding ERAS</li> </ul> <p><b>Lead Board:</b> Surgery</p>	<p>Health Board revenue support in partnership with Velindre NHS Trust</p> <ul style="list-style-type: none"> <li>Development of workforce plan to be phased through tail end of 2019-2020 into new financial year.</li> <li>Benefit and cost analysis critical for impact analysis</li> <li>Link to external bodies being explored to increase funding available for service</li> </ul>	<ul style="list-style-type: none"> <li>Fewer cancelled procedures (operations, investigations, radiotherapy etc.) for patients being 'unfit',</li> <li>Reduction in hospital stay (including critical care),</li> <li>Fewer post-operative complications</li> </ul>	<p>Patient Reported Outcome measures to be established as part of the programme</p>	 <p>Surgical tumor removal is the equivalent of running a marathon, to achieve the best possible outcomes, physical and emotional preparation is needed. Wyn will be helped to improve his fitness, carb load, improve iron levels and emotionally prepare for tumor removal. This will in term help recovery after surgery leading to improved outcomes.</p> <p>For patients who don't have cancer the programme provides a teachable moment at the point of suspicion of cancer.</p>
<p><b>Pre Assessment:</b> Further development of pre assessment services across the health board for all specialities. Increasing current capacity by at least 30%</p> <p><b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"> <li>Develop clinical specification for estates and planning to accommodate a fully functional services</li> <li>Highlight workforce gap for all clinical disciplines based on best practise</li> <li>Set key performance indicators to monitor outcomes for patient population</li> </ul> <p><b>Lead Board:</b> Surgery</p>	<p>Revenue implications will be worked through- <b>Update for January</b></p> <ul style="list-style-type: none"> <li>Funding sources being explored to included "invest to save" option</li> <li>Benefits analysis mapped based on decrease in on the day cancellations</li> </ul>	<ul style="list-style-type: none"> <li>Decrease of on the day cancellation of medically unfit patients</li> <li>Number of patients assessed per speciality</li> </ul>		 <p>Wyn has his operation when he needs it and is assessed appropriately to ensure he is fit for surgery</p> 
<p><b>Vascular Regionalisation (AAA):</b></p> <p><b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"> <li>Planning has been underway for some time to develop a South East Wales Vascular Network which centralises the delivery of services in the</li> </ul>	<p>This will be funded across University Health Boards on a risk share basis</p>	<ul style="list-style-type: none"> <li>Standards set by vascular network.</li> </ul>	<ul style="list-style-type: none"> <li>Improved patient outcomes</li> <li>Timely access to theatre with IR</li> <li>Length of Stay</li> <li>Reduced complications</li> <li>Functioning MDT</li> </ul>	 <p>Centralisation of certain services have been evidenced to improve patient outcomes and experiences. The delivery of vascular services in the south east region will support</p>

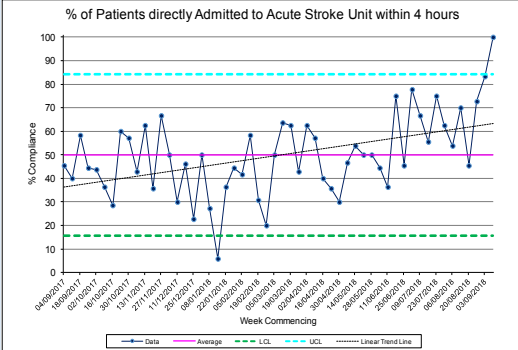
ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<p>University Hospital of Wales. The business case is being rewritten now that the infrastructure and estate has been clearly identified. There is further work needed around developing rehab beds in Llandough to support the seamless flow of patients who do not need to be cared for in an acute setting, aligned to right patient, right place, and right time.</p> <p><b>Lead Board:</b> Surgery</p>				<p>improved care and the sustainability of a service for Wyn and the regional population</p> 
<p><b>Develop Therapies Clinical Strategy- to support Health System Efficiency</b>  <b>This will involve in 2020/21:</b>            Develop a programme to create an ongoing evidence base of how support services can implement changes to pathways and workforce models to deliver system wide efficiency. This programme will ensure that an alternative to the traditional method of managing cost reduction programmes can be implemented.</p> <p>The initial review will look to develop a Therapies Clinical strategy, initial workshops will be in October of 2019 in order to develop evidence for implementation in 2020.</p> <p><b>Lead Board-</b> CD&amp;T</p>	<p>Traditional models of care need review in order to maximise the efficiency potential of the system through better utilisation of supporting services.</p> <p>Allied Health Professionals, Therapies diagnostics and administration services are core to the long term sustainability and efficiency of the health care system.</p> <p>Through this process there will be a need to invest in these staff groups in order to release organisational efficiency.</p>	<p>Through the last quarter of 2019 we will develop the evidence base within therapies services in order to demonstrate the impact of therapies intervention throughout the health care system.</p>  <p>The concept of optimising normality through active intervention throughout the pathway will ensure that patients are enabled to manage themselves in all possible cases reducing the overall burden to secondary health care services.</p> <p>Where patients do require this level of specialist care, ensuring that the therapies services are of the right size to continue this ethos will ensure that moving care back to the community is facilitated more quickly.</p>	<p>The process of evidence development will look to provide system change that can positively impact on areas such as:</p> <ul style="list-style-type: none"> <li>• Length of stay</li> <li>• Demand management in outpatients</li> <li>• Proportion of patients managed in primary care</li> <li>• Released clinical time through efficient administrative and clinical systems</li> <li>• Patient reported outcomes</li> </ul>	<p>Wyn has access to therapies services within the community ensuring that he is able to self-manage and increase his own health care accountability. When he is admitted therapies teams are focussed on early and targeted intervention to move him through the healthcare system reducing reliance on specialist care and reducing the likelihood of needing enhanced social care</p> 
<p><b>Develop Medicines and Technology Appraisal Systems- to support Value Based Healthcare and optimisation</b>  <b>This will involve in 2020/21:</b>            CD+T currently have two services that undertake appraisals work on an all Wales basis and wider. The All Wales Therapeutics and Toxicology service and CEDAR have an excellent reputation for the development of robust academic evidence for Health care improvement. Traditionally focussed on medicines and technology there is a need to move this focus to health care optimisation. This resource should incrementally move towards testing the evidence on an academic basis of the improvements that can be delivered to optimise Health care more</p>	<p>The availability of robust evidence to support the implementation of health care change will ensure that initially a focus on medicines optimisation will enable implementation of change to support the medicines management agenda. This will support the need to reduce medicines associated costs. The focus on the wider health care optimisation will support the system efficiency agenda as detailed in action 1. Robust evidence will ensure that implementation and sustained change will be more successful reducing overall health care cost.</p>	<p>In partnership with Welsh government up to April 2020 implement a change in structure of the current AWTTTC service in order to support a move to an increase focus on medicines optimisation. Incrementally through 2020 commission additional review of the wider Health care optimisation.</p>	<p>Evidence produced and validated to support health care change across the system initial focus on medicines optimisation in order to support the medicines management agenda.</p>	<p>Wyn will be supported to ensure that the care given and medicines utilised are optimised and ultimately reduced where safe and effective to do so.</p> 

ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<p>generally in order to support the implementation of system wide change.</p> <p><b>Medicines Management</b> Support across the organisation in the medicines management agenda ensuring reduced prescribing costs and implementation of safe and effective systems for the use of medicines.</p> <p><b>Lead Board-</b> CD&amp;T</p>				
<p><b>Antimicrobial Stewardship</b> <b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"> <li>Develop an invest to save plan for the implementation of an antimicrobial stewardship team within the Health Board.</li> </ul> <p><b>Lead Board-</b> CD&amp;T</p>	<p>The cost associated with the use of antibiotics is not only in the cost of the medication, but the improper use of antibiotics and the associated impacts on patients. Antimicrobial stewardship has the potential to ensure significant cost reduction within the health care system</p> <p>An investment of £146k in additional workforce in pharmacy has will have the target of reducing antimicrobial prescribing costs by 5% in Year 1.</p>	<p>Develop business case for the investment of an antimicrobial team by April 2020, for the investment in a team with the aim to reduce antimicrobial prescribing and HCAI.</p>	<p>Currently expenditure on antimicrobials is c£6m pa in Cardiff and Vale UHB. Target to reduce costs by 5% in year 1, in addition to recducing HCAI, which have an anticapted additional cost of £3k per case</p>	 <p>Wyn should only be given antibiotics where there is robust evidence that supports it will improve his outcome. The reduced use of antibiotics innapropriately will ensure that Wyn is receiving the most appropriate care and unintended consequences such as HCAI are reduced.</p> 
<p><b>Development of Quality Led Governance Programme</b> <b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"> <li>Development of an independent, overarching Quality function.</li> <li>Development of a single Quality Management System, including implementation of Enterprise Q-pulse across all CB services.</li> <li>Harmonisation of accreditation schemes across diagnostic services in partnership with UKAS.</li> <li>Development of Performance Indicators and Quality Indicators.</li> </ul> <p><b>Lead Board:</b> CD&amp;T</p>	<p>The workforce plan solution needs to respond to the shortfall in current quality resource, implementation and validation requirements as well as the leadership of the function. In addition to this the MHRA has signalled that our existing current Quality Control Pharmacist resource is insufficient for the current operation.</p>	<p>The measurement and use of 'quality indicators' are the foundations of Quality Led Governance.</p> <p>Indicators can be defined in a number of ways:</p> <ul style="list-style-type: none"> <li>As a measure that assesses a specific healthcare process or outcome.</li> <li>As quantitative measures that can be utilised to monitor and evaluate the quality of important governance, management, clinical and support functions that affect patient outcomes.</li> <li>As measurement tools, dashboards or flags that are used as guides to monitor, evaluate and improve the quality of patient care, clinical support services and organisational functions that affect patient outcomes.</li> </ul>	<p>The intended outcomes of the Quality Led Governance approach gives a strong focus on integrated quality, operational and financial governance.</p> <ul style="list-style-type: none"> <li>A culture focused on the patient at the centre.</li> <li>Maintenance of accreditation and regulatory compliance .</li> <li>Risk management processes which identify, understand, monitor and address current and future risks.</li> </ul>	 <p>The impact of this team will support the organisation is improving its quality standards, enabling the health board to deliver new and novel therapies through robust laboratory support.</p>
<p><b>Delivery of advanced cellular therapies – CAR-T</b> <b>This will involve in 2020/21:</b></p> <ul style="list-style-type: none"> <li>Recruitment of key clinical and non-clinical staff</li> <li>Secure appropriate ambulatory care accommodation to safeguard patients in the 3-4 weeks following discharge from in-patient care.</li> <li>Establish the MDT</li> <li>Set up the CAR-T medical on-call rota for out of hours patient management</li> </ul>	<p>Cost: 2019/20 PYE £468,076 investment from WHSSC</p> <p>Increase WTE across all staff groups Establish new models of working and provide appropriate levels of education and training. Cost: FYE £1,379,787 investment from WHSSC</p>	<p>CAR-T therapy to be delivered to 15 -20 patients per year</p> <ul style="list-style-type: none"> <li>Adoption of additional advanced therapies</li> </ul>	<p>We will establish PROMS</p>	 <p>Wyn will have access to novel therapies that offers the genuine chance of a long-term cure for patients who otherwise would have no other treatment options.</p> <p>NHS patients will benefit from Europe's first full access deal on breakthrough therapy.</p>

ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<ul style="list-style-type: none"> <li>Review the pathway after treatment of the 1<sup>st</sup> patient</li> </ul> 2021/23 Continue to roll out the service <b>Lead Board:</b> Specialist				
<b>Improve compliance against the WHSSC Neurosciences strategy</b>  This will involve in 2020/21 <ul style="list-style-type: none"> <li>Appointment to key Senior Nurse post</li> <li>Work with the surgical clinical board to increase surgical capacity</li> <li>Work with the CD&amp;T clinical board to increase imaging capacity</li> </ul> 2021/23 <ul style="list-style-type: none"> <li>Continued development of the service in line with the WHSSC strategy – dependent on future funding arrangements</li> </ul> <b>Lead Board:</b> Specialist	WHSSC funded programme in total. £700k allocated in 2019/20.  Additional senior nursing support. Investment in theatres and anaesthetics staffing to support increasing theatre capacity to meet demands from the neurosurgical service. Maintaining ward based nursing workforce to safeguard bed capacity across neurosurgery.	<ul style="list-style-type: none"> <li>Increased compliance with the dimensions outlined in the WHSSC Neurosciences Strategy</li> <li>Improved flow through surgical wards resulting from more senior support for the repatriation process</li> <li>Increased compliance with RTT targets. 0 patients waiting more than 36 weeks by Q3 of 2019-20. Continue to strive to meet 26 week target.</li> </ul>		 Wyn's wait between referral and surgery has reduced. Wyn has access to sub specialised advice in Cardiff if required and is nursed on a neurosurgical ward.
<b>Critical Care- Capacity Workforce and Infrastructure</b>  <b>This will involve in 2020-21:</b> <ul style="list-style-type: none"> <li>Opening of an additional 3 beds at UHW, as part of the MTC business case</li> </ul> 2021-23: <ul style="list-style-type: none"> <li>Increase capacity incrementally to 50 beds based on modelled demand.</li> </ul> <b>Lead Board:</b> Specialist	Cost: Delivered via funding for the C&V MTC business case alongside additional activity income from WHSCC and Welsh HBs for patients  Additional nursing and AHP workforce will be recruited from additional funding provided from business cases to WHSSC	<ul style="list-style-type: none"> <li>Additional 3 beds opened by April 2020</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in DTOCs</li> <li>Reduced APACHE score at point of admission</li> </ul>	 Additional capacity will allow Critical Care to cope with the additional uplift of patients following go-live of the Major Trauma network anticipated in April 2020.  Additional capacity will also increase the ability to admit critically ill patients from across the Health Board, however this is short of the 50 beds that modelling has shown to be required.
<b>Develop a cross-site, pan-health board Outreach team</b> <b>This will involve in 2020-21:</b> <ul style="list-style-type: none"> <li>Meeting with key stakeholders to develop shared vision for outreach</li> </ul> 2021-23: <ul style="list-style-type: none"> <li>Implementation of a unified service to identify and respond to the deteriorating patient</li> </ul> <b>Lead Board:</b> Specialist	Cost: There would be a cost to recruit additional nursing staff to allow a 24/7 service across 2 sites, this could potentially be offset by reviewing the existing resource within the Outreach and Medical Rapid Response Teams and pooling resource.  Model to be agreed and developed, however it is anticipated that revenue funding would be required to recruit additional workforce to support this model.	Development of the service will be co-ordinated and via the newly constituted Critical Care Delivery Group, who will produce tracking measures as part of its remit.	<ul style="list-style-type: none"> <li>Reduction in NEWS scoring on first visit</li> <li>Increase compliance with Care Bundles</li> <li>Reduced admissions to Critical Care</li> <li>More appropriate admissions to Critical Care</li> <li>Increased staff satisfaction and wellbeing on the wards as a result of systematic support in the management of deteriorating patients.</li> </ul>	 Early identification of deteriorating patients is proven to avert admissions to Critical Care, and reduce length of stay for those patients who require admission. Currently, patients within the Health Board will receive differing outreach services depending on the specialty of their ward. Neither of these services are 24/7 and do not have direct access to an ITU consultant. In UHL there is no outreach service. The FICM review undertaken in January 2019 recommended a 24/7 outreach service, across both sites.
Continue to develop complementary genetic and genomic services complimentary to the NHSE test directory recognising local health ecosystem requirements.	All services will be aligned to WHSSC funding streams. Workforce development plan in place for 20/21	Availability of new tests and monitoring for WHSSC funding spend profile.	<ul style="list-style-type: none"> <li>Health and wellbeing outcomes in Wales linked to genetic / genomics testing comparable with the rest of the UK</li> </ul>	Wyn has been tested for Lynch syndrome and he has received timely clinical support to make informed decisions about how he wants to manage his condition. His family



ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<b>Lead Board:</b> All Wales Medical Genetics Service				will now have access to this test so that, if required, monitoring programmes can be put in place to enable earlier detection of disease and better treatment outcomes. Wyn feels supported through difficult times and he know his family will be well looked after. This supports his emotional wellbeing.
Continue to develop integrated workforce plans across all professional group within the AWMGS. Mainstream genomic literacy to other healthcare professionals including physicians, GPs, Nurses and Pharmacists. Develop a programme to support population genomic and digital literacy  <b>Lead Board:</b> All Wales Medical Genetics Service	Working closely with HEIW to develop AWMGS workforce plans and training and education programmes funded by GPW.	<ul style="list-style-type: none"> <li>Strengthened AWMGS workforce resilience and improved clinical consultation turnaround times.</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened AWMGS workforce resilience and improved clinical consultation turnaround times.</li> </ul>	Increasing the range of skilled professionals available will mean Cerys is able to access expert advice and support to help her manage information provided as a result of genetic and genomic testing within her family. She feels confident to make the right decisions for her through understanding the options available and the potential health and wellbeing effects associated with each option.
Strengthen collaborative precision medicine Research Development and Innovation across Wales using new genomic technologies  <b>Lead Board:</b> All Wales Medical Genetics Service	Increased translational research opportunities for NHS Wales with HEIs and third sector and industry partners.	<ul style="list-style-type: none"> <li>Increased inward investment opportunities through the Cardiff City Region Deal, UKRI and Strength in Places Funding. Increased trade with national and international partners enabling reinvestment in services.</li> </ul>	<ul style="list-style-type: none"> <li>The AWMGS plays a full role in the regional life science industry sector and contributes to the economic prosperity of Wales. Income increases to reinvest in NHS services.</li> </ul>	Wyn's family members have access to employment opportunities linked to economic growth in the life science sector in their communities. Employment is a key determinant of health and well-being outcomes. Precision medicine data is used to help Wyn and his family make healthier lifestyle choices based on their own personal health profiles. Also Wales has access to clinical trials and novel and emergent technologies reducing further poor health outcomes.
<b>Improve timely access to diagnosis and support for children with neurodevelopmental conditions</b> <b>This will involve in 2020-21:</b> <ul style="list-style-type: none"> <li>Work with the core neurodevelopment team and wider community team to confirm clinical pathways</li> <li>Progress development of independent prescribers (nurse/pharmacist) to deliver ADHD follow-up care</li> <li>Establish a young persons ADHD service in partnership with specialist CAMHS</li> <li>Develop a sleep pathway to ensure that sleep advice is provided prior to any medication being considered</li> </ul> <b>Lead Board:</b> Children and Women	<ul style="list-style-type: none"> <li>Once the cleansing of data and caseload work is complete, the service will be in a better position to identify demand and capacity for any future business case development</li> <li>The aim will be to increase the numbers of independent prescribers</li> <li>There may be the opportunity to develop a spend-to-save case regarding sleep advice and the projected increase in cost for melatonin preparations</li> </ul>	<ul style="list-style-type: none"> <li>Target 80% of children to wait less than 26 weeks for first appointment</li> </ul>	<ul style="list-style-type: none"> <li>Timely process in place so that families are clear how long the process will take and when they can expect a diagnostic outcome</li> <li>Diagnostic pathway in place</li> <li>Evidence based treatment packages identified</li> <li>Co-produced goals and improved self-management</li> <li>Reduction of complaints associated in delays in diagnosis</li> </ul>	Sam and his family will be supported to provide the required information on the difficulties they are experiencing as soon as possible into the assessment and treatment pathway
<b>Work with the Medicine Clinical Board to review the development of a paediatric single point of entry</b> that will provide unscheduled, urgent and emergency care for children and young people	<ul style="list-style-type: none"> <li>Development of a skilled workforce that can manage all aspects of unscheduled and emergency paediatric care</li> <li>Potential for cross-departmental working, teaching, training, research and peer support</li> </ul>	<ul style="list-style-type: none"> <li>Fewer patients in EU waiting more than 4-hours to access the CHfW</li> <li>Likely reductions in admissions to CHfW inpatient beds (leading to reduce cancellations and improved RTT)</li> </ul>	<ul style="list-style-type: none"> <li>Delivery of tier 1 targets</li> <li>Reduction in clinical incidents (Datix)</li> <li>Inpatient Length of Stay (LoS)</li> </ul>	Sam will see the most appropriate clinician, in the most appropriate part of the UHW/CHfW campus, with reduced unwarranted variability and an

ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
<b>Lead Board:</b> Children and Women		<ul style="list-style-type: none"> <li>Likely reductions in LoS due to the patient reaching the right-bed-first-time</li> <li>Likely improvements in clinical care (guideline adherence, paediatric care bundles etc.)</li> </ul>		increased likelihood of admission avoidance
<b>Establishment of a UHB wide venous access service:</b> <b>This will mean in 2020/21:</b> A centralised vascular access team for the UHB will standardise practice, reduce insertion delays and complications, and overall positively enhance the patient experience and safety. We believe, this could be a nurse led initiative with consultant support.	<b>Phase One</b> is based on one Nutrition Nurse Specialist (NNS) inserting IV access devices, Midline or PICC in patients requiring Parenteral Nutrition	<ul style="list-style-type: none"> <li>Number of referrals</li> <li>Waiting times for line insertion</li> <li>Standardisation of equipment –lines and insertion devices</li> <li>Use of CEPOD time for line insertion</li> <li>Post insertion complications</li> <li>Earlier discharge from ICU</li> </ul>	Reduction in the number of referrals for repeat insertions	Currently is Wyn requires a IV line for parenatal nutrition he may have to wait to have this fitted in a theatre. The IV service will be able to place these lines outside of a theatre setting, resulting in improve timliness of the service and better care
<b>UNSCHEDULED CARE</b>				
<b>Emergency General Surgery Pathway (Admission to discharge):</b> The key is to implement the second phase of the emergency general surgery plans which will focus on the following: <b>This will involve in 2020/21:</b> <ul style="list-style-type: none"> <li>Surgical team triage from GP, AU and EU directly to 7 day SAU – ultimate goal is to create a 24/7 <b>Emergency ambulatory surgical care unit</b></li> <li>Direct to theatre Cat 1 patients</li> <li>Assess to admit within 12 hours</li> <li>Short stay area for 12-36 hour observation</li> <li>Specialist “designated” and protected ward used to provide expert care for surgical and non-surgical patients</li> <li>Additional CEPOD (light) theatre sessions (3 lists per week) in SSSU to support patient flow</li> </ul> <b>Lead Board:</b> Surgery	Resource implications being worked through Benefits identified in terms of both outcome measures and financial <ul style="list-style-type: none"> <li>Risk around theatre staffing given demand on service due to a considerable number of developments over the forthcoming year</li> <li>Redesign of medical workforce to appropriate manage patient flow</li> </ul>	<ul style="list-style-type: none"> <li>Track patients through emergency pathway highlighting delays</li> <li>EU/AU times</li> <li>Track discharge levels</li> <li>Track admissions of general surgery patients</li> <li>Length of stay split between procedural and non-procedural patients</li> <li>Occupancy through <b>lightfoot</b></li> <li>Track readmissions</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in length of stay</li> <li>Reduction in occupancy</li> <li>Reduction in readmission rates</li> <li>Reduction in waits in both EU /AU</li> <li>Reduction in complications</li> <li>Reduction in admissions</li> </ul>	The development of a seamless and effective pathway through our emergency services would considerably improve both the patient experience and outomce for Wyn. Many times patients are admitted when they would be better of being assessed quickly and sent home. Also often they are waiting to long for access to a bed or theatres. Wyn would benefit from a standardise pathway putting the patient first and creating a culture of “ <b>right place / right time</b> ”
<b>Establish HASU at UHW:</b> <b>This will mean in 2020/21:</b> <ul style="list-style-type: none"> <li>Work with regional partners on the establishment of HASU</li> </ul>	<ul style="list-style-type: none"> <li>Identification of suitable location for HASU, estates, facilities and equipment requirements</li> <li>Workforce configuration estimations across the stroke pathway with identification of resource gap for HASU</li> <li>Submission of business case for investment consideration.</li> </ul>	Achievement of Quality Improvement Measures: Thrombolysis: <ul style="list-style-type: none"> <li>Access - 100%</li> <li>Time - 90%</li> </ul> 12 Hours: CT Scan – 95%		If Wyn attends hospital as an emergency with a suspected Stroke, he has 24/7 rapid access to a team of specialists, a range of appropriate diagnostic tests and emergency appropriate treatments. Wyn will have a diagnosis quickly confirmed and get the right treatment by experts to enable a best chance of survival, recovery and rehabilitation.
<b>Major Trauma Centre ‘go live’ April 2020</b> This will involve in 2020-21: <ul style="list-style-type: none"> <li>Go Live 1 April 2020</li> <li>Support for capital requirements to create additional resuscitation space</li> </ul> 2021-2023 <ul style="list-style-type: none"> <li>A sustainable MTC workforce</li> </ul>	<ul style="list-style-type: none"> <li>Cost: Requires WHSSC Funding for revenue case</li> <li>Capital costs for works to create additional resus capacity</li> <li>Workforce with the appropriate education and training to a level required for a MTC</li> </ul>	<ul style="list-style-type: none"> <li>Patient satisfaction</li> <li>Clinical outcomes for all patients not just MTC – Sepsis, Stroke etc</li> <li>Tarn data</li> <li>Concerns</li> <li>LOS in departments</li> <li>Reduction in temporary workforce costs</li> </ul>	Improved survival rates - evidence shows that if you are severely injured, you are 15% to 20% more likely to survive if you are admitted to a major trauma centre (19% improvement in survival in England over 5yrs ( <i>Lancet</i> , 2018))	At 18 Sam was involved in a hit and run with injuries including a punctured lung, a broken pelvis, five broken ribs and a fractured collarbone. The development of a Major Trauma Centre means the specialist skills and equipment needed to treat these multiple injuries are collocated in the Major Trauma Centre at UHW, the major trauma unit in Hywel Dda means following

ACTION	Finance and Workforce Implications	Core Tracking Measures and Trajectory	Core Outcome Measure and trajectory	Patient and System Impact
				initial treatment Sam is able to undertake rehabilitation close to his home.
<b>CANCER</b>				
<b>Single Cancer Pathway- See Section Above</b>  Work with internal and external partners/stakeholders to ensure compliance with 62 day target, including increased operating capacity, timely diagnostics and development of one-stop outpatient consultations		<ul style="list-style-type: none"> <li>Compliance with SCP targets through increased capacity and improvements to pathways allowing patients to commence definitive treatment within 62 days</li> </ul>		
<b>ENABLERS</b>				
<b>Data to Knowledge</b> Maximising the use of accessible information for clinicians to drive change using Lighfoots ‘Signals from noise’ platform which provides tools that links all aspects of patient care to pathways, process current and predicted states  <b>Investing in Data and Intelligent Information</b> <ul style="list-style-type: none"> <li><b>National Data Resource (NDR)</b></li> </ul> Development of an agreed operation model for a national data resource (NDR): Implementation of SNOMED CT nationally that enables, interoperability across health care systems, enables and extends the scope of reporting outcomes.  <b>Investing in Data and Intelligent Information</b> <ul style="list-style-type: none"> <li><b>Develop C&amp;V Data Repository (CDR)</b></li> </ul> Develop C&V Data Repository & Interoperability Hub as local spoke of National Data Repository / Welsh Health & Care record exemplar	3 year programme – direction and priorities to be determined by the steering group Initial target areas: <ul style="list-style-type: none"> <li>➤ Acute admissions avoidance</li> <li>➤ Assisted discharge</li> <li>➤ Effective &amp; efficient pathways</li> </ul> <b>All Wales Funding proposal:</b>  <b>2019/20</b> Capital : £2.60 Revenue : £1.40 <b>2020/21</b> Capital : £5.20 Revenue : £3.30	Mapping IT systems linked to pathways & processes Access to data /timeliness  Development of architecture & capability for storing all data in a way that it can be used to support the patient, professional and system leads needs User / steering group across care sectors to be established	Integrated pathways developed which focus on patient need  Critical enabler to delivery of Once for Wales - supporting improvements in care & the Welsh care systems ability to deliver care around and tailored to the citizen / patient	Increasing efficiency and quality of patient care, our staff will have: <ul style="list-style-type: none"> <li>Applications can be plugged into a basic EHR operating system and feed information directly into the provider workflow – streamlining care</li> <li>Provides a future pathway to handling &amp; connecting patient-generated health data</li> <li>Enables access to meaningful data across the UK for clinicians and patients</li> <li>As an international standard, we will be in a much better place to realise the benefits from AI and the tools appearing from across the world.</li> <li>Enables rebuild of the CRT “One List”, improving communication and consequently flow between inpatient wards and the CRTs.</li> </ul>



# CARING FOR PEOPLE, KEEPING PEOPLE WELL

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



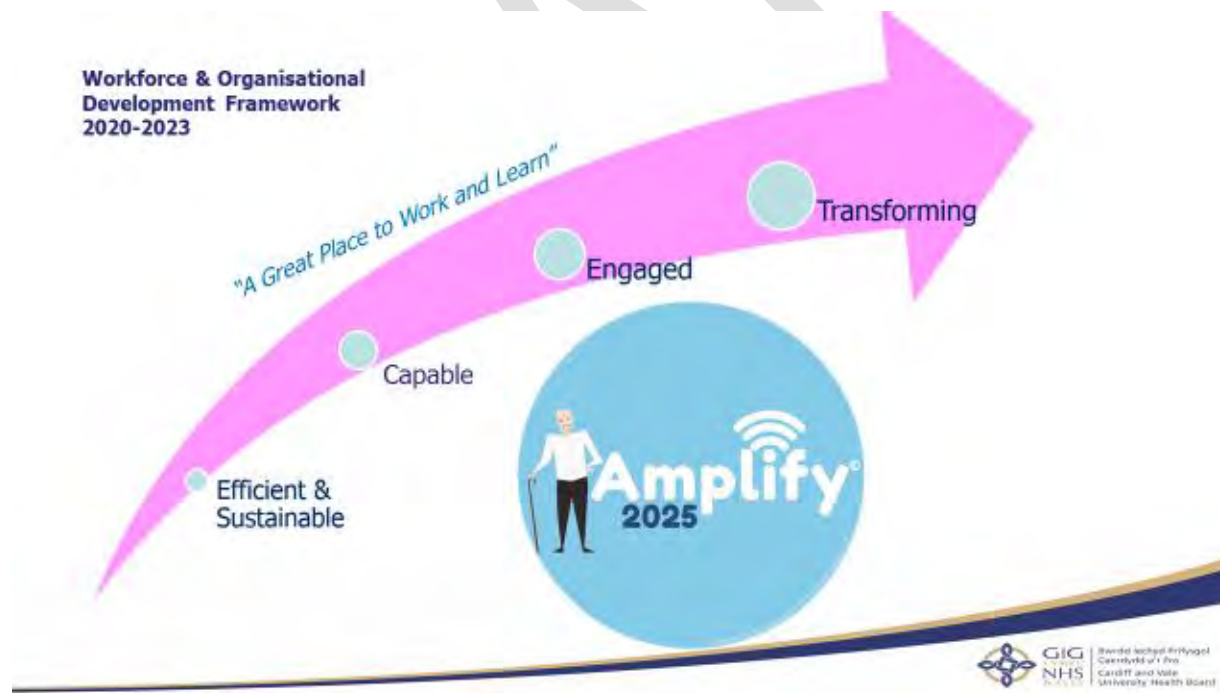


## Workforce and Organisational Development

The organisation's workforce delivery plan supporting our overall aim of “**caring for people, keeping people well**” is embedded throughout the IMTP due to the *integrated* nature of the Plan. It is strategically aligned to prudent healthcare principles; *A Healthier Wales* and the organisation's ten year strategy, **Shaping Our Future Wellbeing 2015-25**. This workforce plan is supported by detailed Clinical Board and departmental led plans which have ownership within the business units of the UHB.

Last year we focussed on designing the transformation road map, **Amplify 2025**, and this year sees us moving into implementation stage. Amplify 2025 is designed to bring life to the *Shaping our Future Wellbeing* strategy and in Workforce & OD it is the overarching framework that pulls together our 4 key objectives: Transforming, Engaged, Capable, Efficient workforce, as illustrated below.

Our people are critical to achieving our vision.





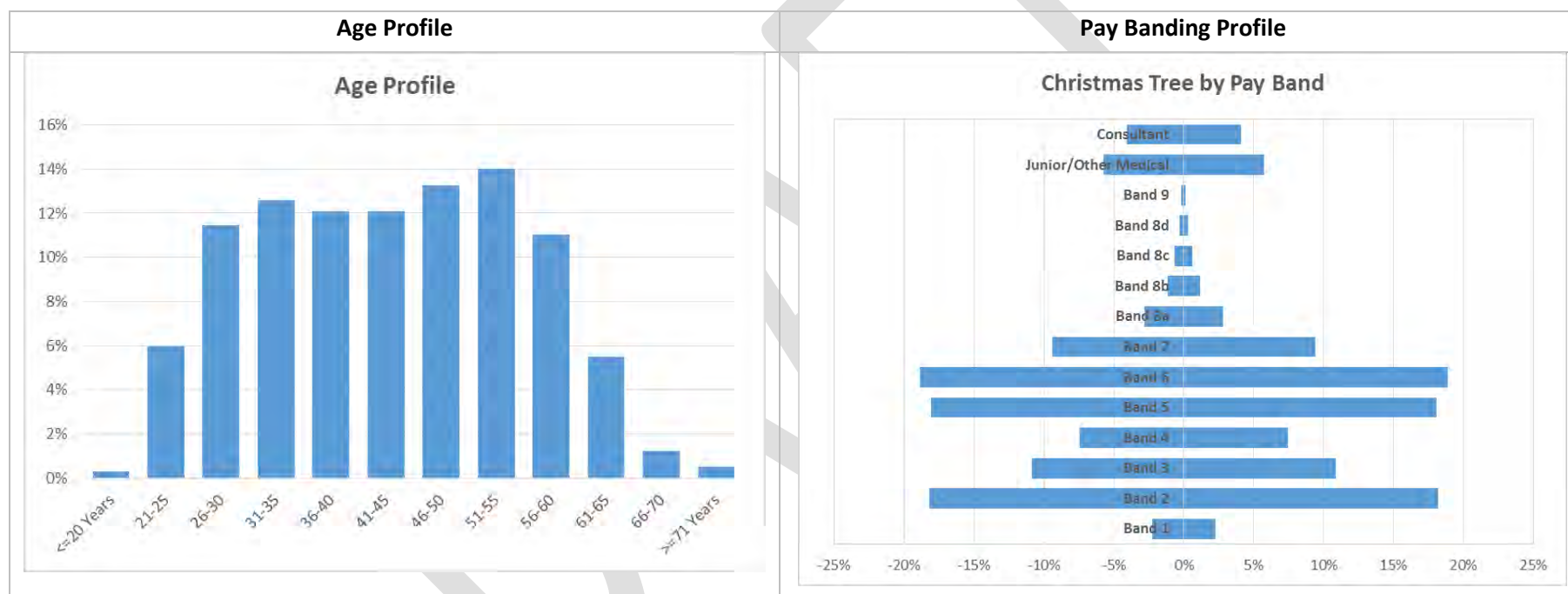
## Workforce Planning Assumptions, Priorities and Risk

Informing the development of the Workforce Plan are risks and assumptions which include the following:

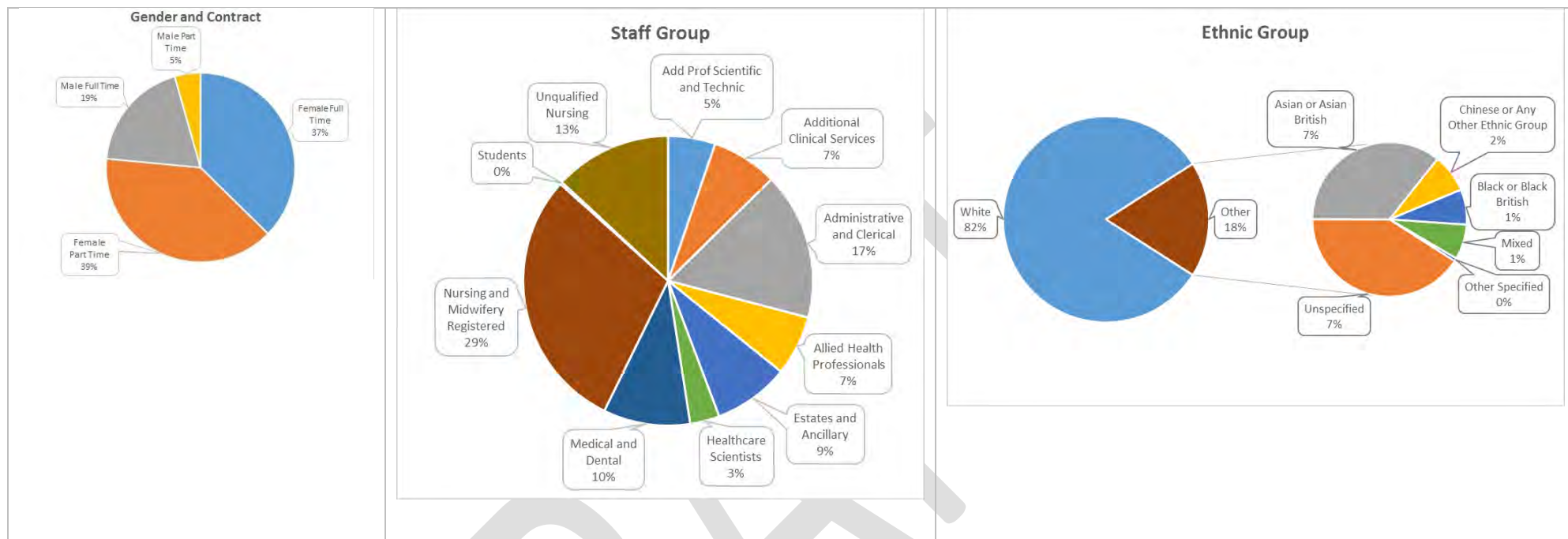
- Increasing need to innovate and develop a future workforce; new ways of working and workforce transformational change
- Increasing need to engage and motivate our workforce as demand for service increase
- Increasing need to develop organisational leadership and management skills
- Increasing need to embrace new technology and equip our digital workforce
- Increasing need for accurate workforce information and analytics

- Continuing requirement to reduce workforce cost to underpin financial framework
- Ensure sustainability and recruit to substantive posts to provide continuity and effective clinical care
- Workforce impact and drivers associated with ongoing reconfiguration of Acute Services in South Wales and of the development of the Major Trauma Centre and Network
- Working more closely in partnership with primary care, local authority and nursing homes to find creative workforce solutions to ensure patients are cared for out of hospital and closer to home

### Current Workforce Overview and Analysis (data @ 30.6.2019)



Gender	Distribution by Staff Group	Ethnicity
--------	-----------------------------	-----------



The data above indicates the following challenges when determining optimal ways to deploy the current and future workforce and how to consider future supply against the service priorities as laid out within this Plan:

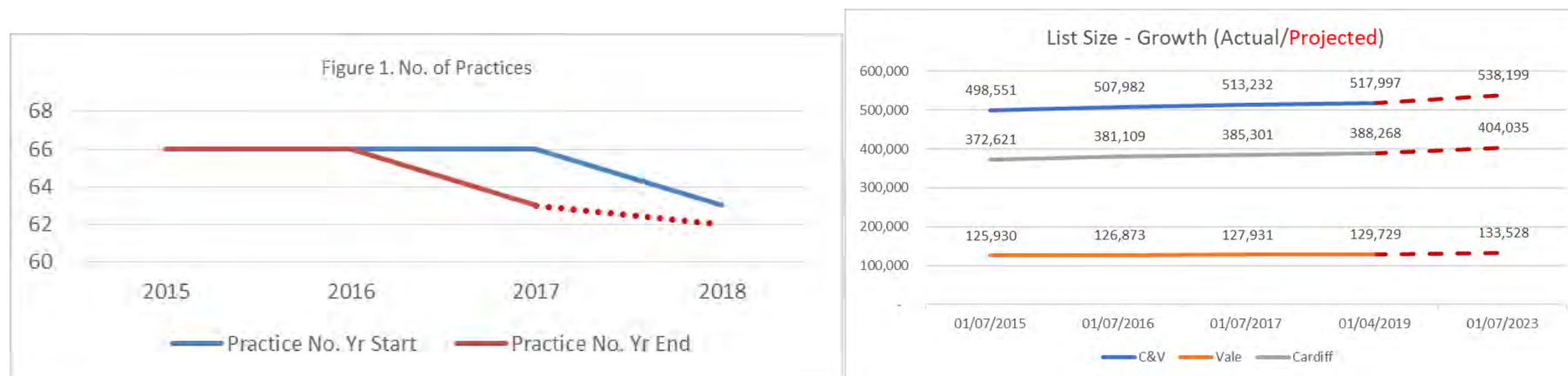
- The UHB has an aging workforce similar to the all-Wales position with the largest age categories being aged 46-50 years and 51-55 years (approximately 2000 staff in each of these categories). The impact of employees retiring from service critical areas is key in Clinical Boards undertaking local workforce planning and we are supporting them by making the Retire and Return and other flexible retirement options more accessible in 2020.
- The largest grade categories are staff in Agenda for Change Bands 2, 5 and 6. Continually reviewing skill mix and new ways of working is important in ensuring adequate future supply of skills in the right place and grade.
- The majority of the workforce is female (77%) with an almost even split in this group of full-time (37%) and part-time working (39%). Use of our employment policies, such as the new Adaptable Workforce Policy which was approved in 2019 and our Flexible Working, Redeployment and Retirement Procedures are crucial to retaining talent and keeping staff engaged.
- The majority of the workforce is white (82%) with 11% Black and Minority Ethnic categories and 7% not stated. The Strategic Equality Plan has a number of actions to continue review of our workforce in this regard to ensure it strives to reflect the local population where relevant e.g. in recruiting practices.
- The nursing and midwifery qualified staff and unqualified nursing staff make up just over 42% of the total workforce. Given there is a recognised national shortage of qualified nurses, the UHB has made nurse sustainability a high priority on its workforce agenda as detailed later in the plan.
- The overall capture of equality data is reported as 63% in September 2018.

### **Primary Care Workforce Profile:**

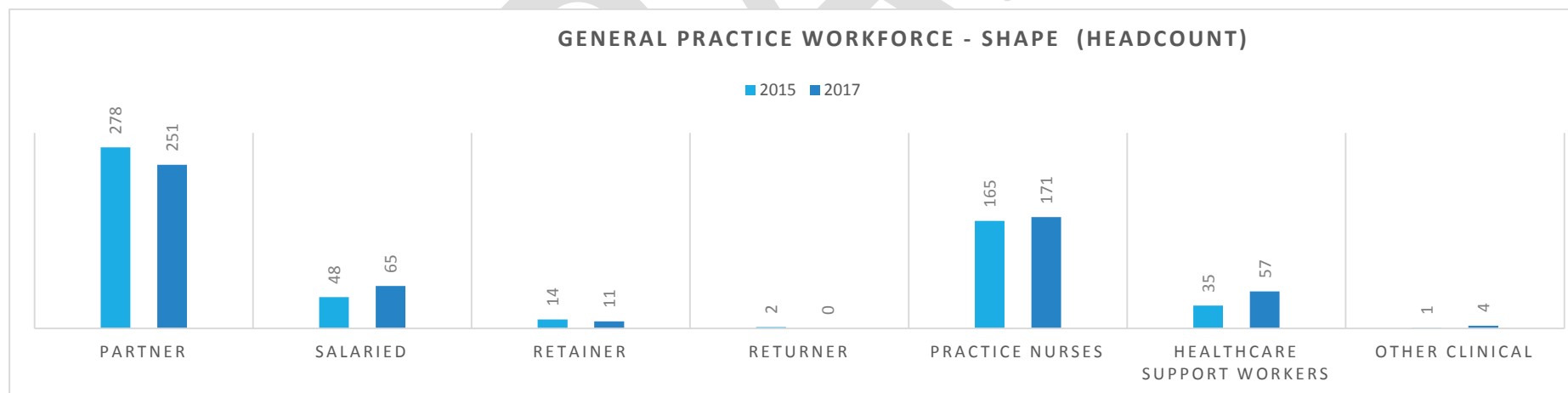
Primary care, as the first point of contact for the majority of citizens accessing health services, has a key role in maximising the opportunities for prevention and self-management and work continues across our Clusters in the delivery of the Primary Care Model for Wales, which places a great emphasis on working closely with partners to promote the social model of care. The model has placed more responsibilities on Health Boards to support the maturity development of Primary Care Clusters (9 in Cardiff and the Vale) and the sustainability of independent GP contractors. The PCIC Clinical Board itself is complex and made up of a directly employed workforce and a wider workforce that are not employed by the Health Board but are key to the delivery of the Clinical Board key objectives. Our previous workforce analysis (2017) compared to the data extracted from the National Primary Care Workforce Reporting Tool indicates a further decline in the number of GP Partners across Cardiff and Vale by 14%. Whilst we recognise the continued growth of the salaried GP role our total GP workforce appears to be in decline by a headcount of 20



(6.12% reduction). We will continue to assess this decline further in line with the introduction of Partnership premiums as an incentive to attract more GPs to Partnerships.



Profiling based on practice development plans, and validated workforce submissions in 2017 provides a baseline to make comparisons on the changing shape of the Medical and Clinical workforce:



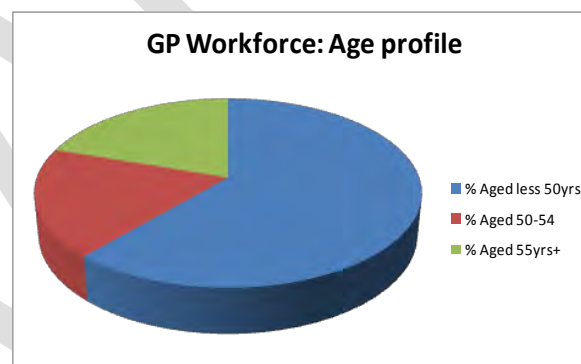
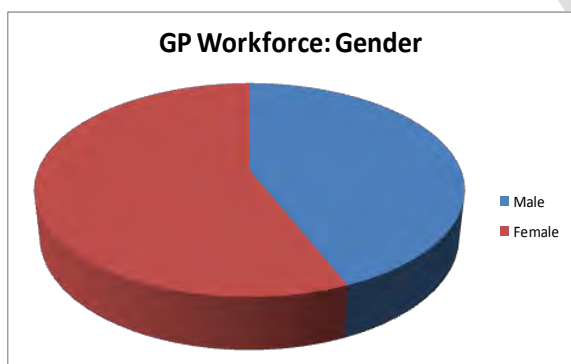
Further analysis demonstrates the change by Locality Area as follows:

Cardiff North	Role/ Year	2015	2017	Difference	% inc /- dec	Cardiff South &	2015	2017	Difference	% inc /- dec	Vale	2015	2017	Difference	% inc /- dec

West	Partner	124	119	-5	-4.03	East	78	66	-12	-15.38		76	63	-13	-17.11
	Salaried	20	21	1	5.00		20	26	6	30.00		8	17	9	112.50
	Retainer	6	5	-1	-16.67		5	4	-1	-20.00		3	2	-1	-33.33
	Returner	0	0	0			2	0	-2	-100.00		0	0	0	
	Practice Nurses	73	70	-3	-4.11		50	50	0	0.00		42	49	7	16.67
	Healthcare Support Workers	18	28	10	55.56		10	14	4	40.00		7	10	3	42.86
	Other Clinical	1	1	0	0.00		0	0	0			0	3	3	

In the absence of a Quality Outcomes Framework for 2019, we have been unable to extend the analysis beyond 2017 at this time.

Further analysis of the GP workforce identifies that 56% are female and 39% of the total GP workforce is aged 50 years and over (20% aged 55 years+) which is in line with national predictions indicating that the GP workforce is becoming increasingly younger and more female. It's also evident that many GP's are working part time hours.



## Workforce & OD Objectives

Below is a summary of the key priorities within the **4 objectives** of the Workforce and Organisational Development Framework.

### 1. TRANSFORMING WORKFORCE

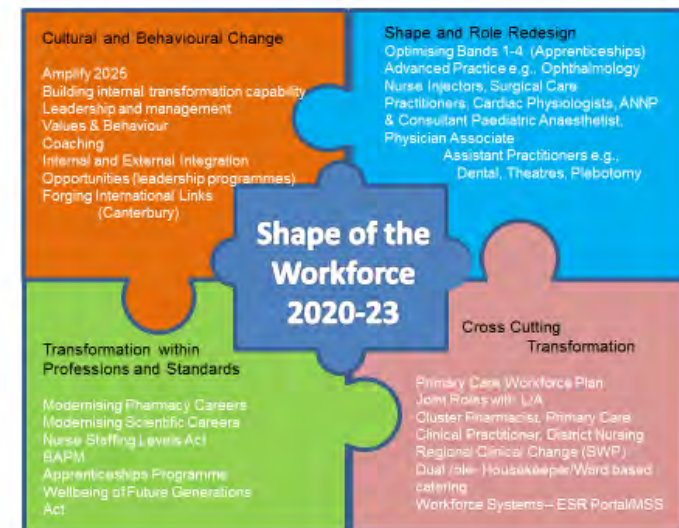
Enable quality, productivity & continuous improvement through innovation

Workforce Transformation is necessary to underpin the achievement of the ten-year vision for the UHB **Shaping Our Future Wellbeing. Amplify 2025** is aimed at creating a working environment where people can challenge and change and have permission to do so. Holistically, Amplify 2025 brings together:

- ❖ Social movement to unleash capability within the organisation – via the **Wyn** Showcase
- ❖ Leadership & Succession Planning
- ❖ Effective Appraisal for the individual and talent management (PADR)

### Cultural and Leadership

We will continue to build **internal transformation capability** in 2020/21 to ensure we can promote the **Cardiff and Vale Way**. We are drawing upon evidence-based practice from other organisations and recognise the true value of our internal expertise to build this capability. The use of organisational development principles will be key to successful implementation of change. We continue to work collaboratively with our learning alliance partners both in Christchurch Health Board, Canterbury New Zealand and with South Tyne Side, North East England. In 2020 we will continue to drive the improvement methodology through the new up-to-date system approach suite of leadership programmes.







The UHB continues to be a member of **Quest learning and sharing of best practice network**, which allows collaborative working with 15 other high performing Healthcare Trusts in England. The organisations work together in line with the triple aim principles of improving patient safety and quality; to be recognised as the employer of choice; and to improve innovation through greater enabled technology. Whilst the UHB's involvement in Quest is in its infancy it is apparent that we can benchmark and learn from others, allowing us to introduce and inherit processes other organisations have already benefitted from. Quest are visiting the UHB in September 2019 to learn from our good practice.

### **Shape and Role Redesign**

#### **Optimising roles within Bands 1-4**

Primary Care have a number of action plans in place during 2020 to continue to maximise the skills of all our workforce. Examples include: continuing to define and train all Health Care Support Workers to embed the HCSW Skills and Career Framework and the development of a Band 4 role to release District Nurse Capacity. Nursing HCSWs now have the opportunity to develop their knowledge and skills to undertake a undergraduate nursing degree whilst employed by the UHB. A flexible earn as you learn approach is now provided by two universities to cater to the adult and mental health branch. CD&T are developing the Health Care Support Worker workforce linked to radiology in order to utilise the skills of this workforce more effectively, centred around the needs of the patient.

#### **Physician Associates**

The UHB have committed to student PAs in some areas, and this will continue to grow. We are also developing substantive posts within a number of areas and exploring a rotational programme with Swansea University and other Health Boards to inform the approach. We are working with HEIW and Birmingham University to develop training in Wales for Physician Associates Anaesthesia (PAA). In 2020 we hope to support our staff in the Anaesthesia Assistant course and supported by HEIW, hold a series of task and finish groups to explore further appetite across Wales.

#### **Advanced Practice**

**Nursing Advanced Practitioner** roles remain well established within: Paediatric and Neonatal Critical Care; Acute and Emergency Medicine: Critical Care; Haematology; Acute Oncology; Acute Child Health (medicine, surgery and oncology); GP out of hours services; and in GP Practices. Trainee advanced practitioners continue to be developed in Acute Child Health, GP Out-of-Hours

service; Critical Care; Mental Health and Haematology. Advanced skills development is also being provided for new Major Trauma Centre Nurse Practitioner roles and the Hospital at night service.

For Allied Health Professions, the implementation of the advanced **First Contact Physiotherapist** role continues and numbers will increase throughout 2020/21. Post holders appointed to this advanced role work in **GP practices** and provide expert musculoskeletal care to patients instead of GPs. Post holders are undertaking advanced practice development e.g. non-medical prescribing and joint injections, and are working towards undertaking the advanced practice portfolio. Community advanced practitioner roles are also being developed in OT and Podiatry.

The governance of non-medical prescribing, as an advanced skill, remains a priority as we will now see the implementation of our **Non-Medical Prescribing Governance Framework** across secondary and primary care; in collaboration with University and HEIW partners.

### Cross Cutting Transformation across the UHB

#### Primary Care Workforce Plan

Over the last 12 months significant work has been undertaken in workforce planning and OD to support primary care through dedicated expertise. The Team have identified a three year Workforce operating model.



The strategic programme includes the following:

- Workforce planning and modelling – developing local population based modelling based upon demand analysis.
- A good place to work – addressing the issues of recruitment and retention, pay and employment terms as well as a focus on well-being.
- Specific Role Development – priority areas include developing a national framework and training for the community navigator role and triage roles.
- Education, training and skills – this includes developing mechanisms to increase opportunities for education and training within primary care settings, including mentoring and supervision requirements and career pathways.
- Sharing best practice – building on the compendium of models and roles produced to date with the development of workforce elements of evaluation of new models.

## Cluster Development

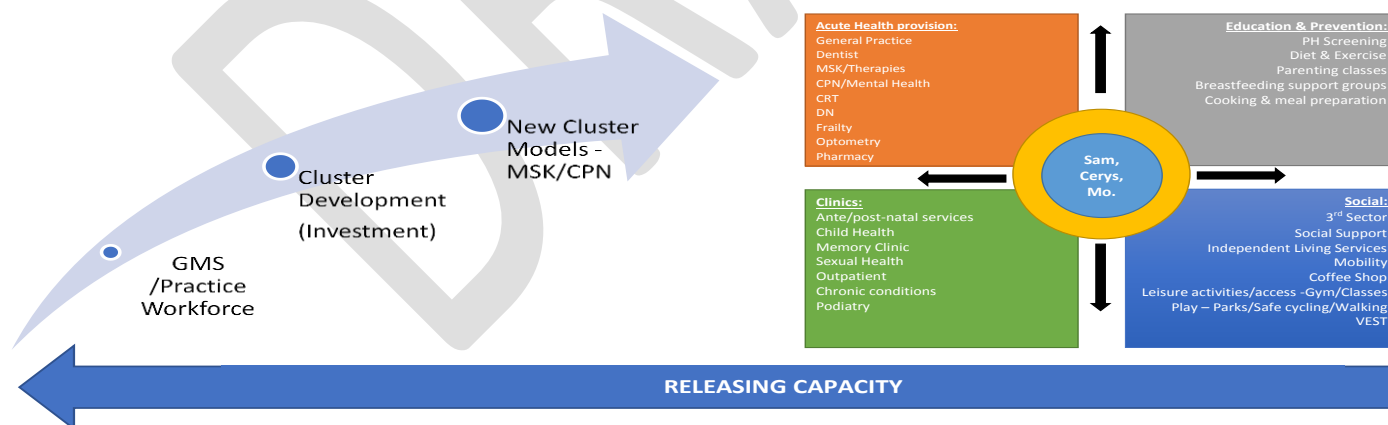
We continue to grow the workforce employed by the Health Board to work directly with practices/clusters to support sustainability and to release GP capacity, however pressures on existing leadership structures, and supervision arrangements remain. We have embedded a Cluster Partnership agreement to provide governance and structure to these models and we continue to learn and develop from our evaluation work as our clusters continue to evolve and mature.

The last 12 months has seen the rollout of Musculoskeletal (MSK) and Mental Health (MH) practitioners throughout many of the Clusters. While the rollout of the MSK practitioners still continues, the benefits of both are already being experienced throughout practices and clusters.

## Locality/Cluster Wellbeing Hub Development:

Work continues in the North West Locality to respond to the challenges of the Cardiff Local Development Plan (LDP). All partners were actively engaged in a series of workshops as part of the Shaping our Future Wellbeing Strategy and in response to the challenges of the Cardiff LDP. The focus and the priority of the work is the development of the wellbeing Hub within the Cardiff West Cluster area. The workshops were designed collaboratively with stakeholders using the population health needs assessment to ensure that future services are designed, modelled and delivered around the patient to identify a range of scenarios/options to inform decision making, estates and planning.

The following diagram illustrates the journey towards sustainability based on the engagement and inclusion of partners to date.



**Health & Social services Transformation Fund:**

Work is progressing in the Cardiff South West Cluster with the implementation and development of social prescribing. Organisational Development (OD) support will be provided by the Clinical Board who will actively work with the 3rd Sector Service Providers to identify processes and criteria to inform the implementation of an IT system. The IT system will assist service users in signposting and referral.

The Cardiff South West Cluster is also giving consideration as to whether it will further develop and become an entity in its own right, or establish a form of co-operative society. The Clinical Board will continue to support the Cluster with this work by providing a dedicated Project Manager and OD Support as necessary. The implementation of an entity or co-operative may influence and enhance integrated working within the Cluster.

**Urgent Primary Care (OOH):**

We have delivered against a number of the workforce priorities. A comprehensive demand and capacity exercise has supported the development of the workforce plan and future service model, which supports the continued growth of a skilled multi-disciplinary team. We have developed a competence framework, supported by appropriate education to ensure all clinicians have the core skills required to work and grow. Our work has been used to inform the development of the All Wales Urgent Primary Care Competency Framework and we continue to work closely with the 111 Project Team on developing appropriate education that delivers the skills required for the future.

**District Nursing:**

Succession planning continues to ensure the service continues to meet the SPQ requirements as outlined within the Principles and we continue to work with HEIW to identify the staff and funding requirements to expedite the number of staff achieving SPQ through 2020/21. Further aspirations include the journey towards a 'Community Nurse' which would incorporate the nursing provision currently situated in separate services (CRT Nurse, Frailty Nurse & DN Nurse) taking account of the learning from Community Nursing Pilots across Wales. Further workforce planning activities are to include specialist areas of work including Acute Response (ART), Continence and Nurse Assessor Teams.

General Practice Nursing (GPN) continues to be a challenge to recruit to due to the time to skill up nurses to work within this field. As a direct response we successfully launched a jointly funded initiative, working with partners in General Practice, to introduce a 12 month GPN training scheme for Cardiff and Vale to increase the supply of trained GPNs for Primary Care practices as part of the solution to sustaining and developing the primary care nurse workforce of the future. The scheme will be evaluated in due course to identify success/lessons learnt and opportunities to grow the scheme further during 2020/21.



## A Healthier Wales – Regional Partnership Board Proposal

“Me, My Home, My Community” ambition for Cardiff and the Vale of Glamorgan provides for significant opportunity. Engaging staff and partners will be critical to its success, in addition to the development of integrated workforce plans across our health and social care system.

### Regional Collaboration/Clinical Change Programme

Formal Joint Regional Planning and Delivery Committees are in place for the South Central and South East Region (Cwm Taf, Cardiff and Vale and Aneurin Bevan, with representation from ABMU for the Bridgend population) and the South West Region (ABMU and Hywel Dda). The workforce transformation required to support these change programmes is embedded within each of the two streams and no longer sits alone. These include Vascular; ENT; Paediatrics, Obstetrics, Neonatal and Gynaecology (PONG); and Regional Priority programmes covering Orthopaedics, Ophthalmology and Diagnostics. A specific Workforce work-stream has been developed to support the **Major Trauma Network and Centre** and this group has already established Workforce Principles which will underpin our collaborative working so that we build a strong network across South, Mid and West Wales.

As part of its role in the **Cardiff and Vale Regional Partnership Board**, the UHB participated in a Workforce Planning Development Session. The purpose of this was to review, in partnership, the strategic workforce context across the health and social care region, noting the working already taking place in each of the 3 areas at a local, regional and national level and considering further strategic priorities and action plans. Coming out of this, last year, the senior leadership teams in Workforce & OD in the UHB and Cardiff Council met informally in order to develop working relationships and share practice across sectors.

**Workforce systems - ESR and Rosterpro** – during 2020/21 our priorities for further developments are:

- Review and update the nurse e-rostering system
- Continue local implementation of the national digital workforce programme
- Migrate to the occupational health bi-directional interface of the Cohort and ESR system
- Maximise use of Learning and Development functionality available within ESR to update PADR Values Based Appraisal, Talent management and succession planning and link to pay progression
- Progressing online booking for training through ESR
- Develop the ESR Learning Path functionality
- Continue to remove barriers to using ESR through developing single sign on functionality
- Survey users to ensure we offer tailor made training and education to maximise usage and efficiency

## Transformation within Professions and Standards

**The Apprenticeship Academy** is now established and underpins our commitment to the *Well-being of Future Generations Act*; a *prosperous Wales*. This investment in apprenticeships, internships placements and graduate opportunities remains a key development in our workforce plan for 2020/21. Our ambition is to develop 100 entry level apprenticeships and also continue to



upskill our current workforce with opportunities to study apprenticeship courses. This will ensure we obtain a return on investment from the £2.4m apprenticeship levy contribution we make each year. We continue to support the Cardiff Commitment Pledge which aims to ensure that all young people in Cardiff are provided with the support, choices and opportunities to make a successful transition from compulsory schooling to ongoing education, training and the world of work, and are enabled to reach their full potential.



To support this we are continuing to support the widening access agenda by attending Careers Events and visiting schools across Cardiff and Vale to publicise the Academy and the varied roles and opportunities that are available in the Health Board. We intend to provide further NHS work observation programmes to promote the UHB as a 'great

place to work and learn' and to #TRAINWORKLIVE in Wales.

**Modernising Pharmacy Careers** - this work has been transitioned into the Pharmacy Deanery of HEIW. The UHB is embracing the pharmacy workforce changes required to support the vision in Healthier Wales, initially by ensuring that all pre-registration training is delivered across primary community and secondary care, from 2019 intake. Further pharmacy workforce development (from early 2020) will include cross sector career pathways for pharmacists, pharmacy technicians and support staff wherever appropriate, including Foundation and Advanced practice and supportive job planning to reflect the needs of patients, the public and healthcare in Wales.

**Modernising Scientific Careers (MSC)** – we continue to develop and implement service and workforce plans in Cellular Pathology including a successful programme to develop Consultant Reporting Biomedical Scientists, and Laboratory and Clinical Genetics. Genetics staff (Clinical Scientists, Bioinformaticians, Genetic Technologists, Genetic Counsellors) who are receiving further training to meet the increasing demands of the growing **Genomic service**. Genomic medicine workforce plans will have a particular focus



on the recommendations of the 2019 **Topol Review**. The Genetics Department is organising a clinical workforce planning session with HEIW and will look to develop an integrated Bioinformatics workforce plan through Genomics Partnership Wales. We aim to provide training to non-genetic healthcare professionals (across Wales) in the delivery of clinical Genomic Medicine services and how they are 'main streamed' into routine clinical practice.

The UHB is also progressing analogous integrated workforce planning in Radiology which is outside MSC. This has resulted in new structures and skill mix to support 7 day working and change in service pathways. The UHB will develop plans to respond to the challenges and opportunities for healthcare science and healthcare scientist as described in "Healthcare Science in NHS Wales – Looking Forward".

## 2. ENGAGED WORKFORCE

**Create conditions which unleash more potential, and commitment to the goals and values**

**Improving levels of staff engagement** improves performance and outcomes, including: mortality rate; health and wellbeing; absenteeism; patient satisfaction; quality of services; and financial management (NHS Employers, 2013). We have a comprehensive programme of engagement work at both organisational and Clinical Board level.

Theme	Cardiff and Vale University Local Health Board			NHS Wales		
	2018	2016	2013	2018	2016	2013
Intrinsic psychological engagement	4.02	3.90	3.77	4.02	3.91	3.80
Ability to contribute towards improvements at work	3.65	3.31	3.16	3.65	3.35	3.14
Staff advocacy and recommendation	3.81	3.71	3.37	3.79	3.68	3.37
<b>OVERALL ENGAGEMENT INDEX SCORE:</b>	<b>3.83</b>	<b>3.64</b>	<b>3.43</b>	<b>3.82</b>	<b>3.65</b>	<b>3.43</b>

Our surveys – Medical Engagement, Staff Survey and Values Survey – are one way in which our staff can share their views and they have given us a clear picture of the work we need to do to improve staff engagement. Although our staff are feeling more engaged, improvement is required. The results of the NHS 2018 survey for Cardiff and Vale continue to show positive improvements in

most areas since 2016 survey and the Board is above the overall NHS Wales scores on many questions. However, there are some scores which have declined and some which are below average which include stress at work and harassment, bullying and abuse. See paragraphs below for actions to address these issues following a recent successful Employee Well-being bid. The Executive

Director of Workforce and OD leads a task and finish group with a range of staff throughout the UHB to develop a response and action plans to deliver against the themes from staff feedback. Delivery of this action plan is overseen by the Staff Survey Steering Group which will continue to meet in 2020 to improve staff engagement, promote good work and successes and encourage greater participation in the next survey through the **#CAVYourSay** strapline.

### The Quadruple Aim for All



In 2020/21 we will continue to invest in reward and recognition of staff; improve staff involvement in change activity; improve the quality of our appraisals; improve our response to complaints of bullying; and reduce the number of stress-related absences. In 2020/21 we will enhance our understanding of the drivers of engagement, bringing together the 'key diagnostic indicators' of engagement, such as selection of workforce measures, medical engagement results, and data from our Values programme. We have recently been working with Professor Michael West in the mission to continue to develop the culture in our Health Board for High Quality Care.

**Medical Engagement** has been a particular focus in recent years and in 2020/21 we will continue to evaluate our progress in order to develop further the Engagement Charters at team level.

We recognise that staff wellbeing is key to staff feeling engaged. A multi-disciplinary group leads a strategic action plan for **improving staff health and wellbeing**. Dietetics, physiotherapy, health and safety, transport and travel, occupational health, employee well-being and the Public Health team developed a collaborative plan, which realised improvements across a range of areas. We have achieved great success with achieving both Gold and Platinum Corporate Health Standards and being recognised as an exemplar organisation. In 2020/21 we will continue to use the learning from these standards to stretch our health and wellbeing activity even further, achieving further reductions in sickness absence through whole-system approaches.

As a signatory of both the **Time to Change Wales** (TTCW) Campaign and **Mindful Employer Charter**, the UHB is aware of the importance of improving and maintaining mental health in the workplace. In 2019 the UHB's Health Charity has provided a two year financial investment in the **Employee Wellbeing Service** which will double the number of counsellors and introduce a new assistant psychological therapy practitioner role which will increase access to low intensity support and reduce waiting times for staff. In addition, **we have trained over 40 TTCW wellbeing champions** with further training planned and introduced the **CAV a Coffee Campaign** which encourages staff to take time out and talk about their wellbeing.



As an organisation we strongly believe it is vital our leaders exhibit the behaviours and values we expect from all our staff. In recent years these behaviours have been integrated in to all workforce processes, including recruitment, promotion, appraisals, induction and performance management. Each of our core value comes with a set of behaviours that are measurable and specific. Incorporating core values as part of the performance management process will enable employees to be recognised whenever they behave in alignment with core values. Reviewing people based on values is interrelated with rewarding people for demonstrating the values. All leadership and Management training in Cardiff & Vale now incorporates training on a coaching style and managers are encouraged to coach and support employees on how to demonstrate the core values which eventually lead to recognition and rewards.



#### **Year 4 of the Strategic Equality Delivery Plan.**

This is the last year of the current four year Strategic Equality Plan. As we approach 2020, we have continued our work to become an inclusive organisation. In partnership with Delsion, an award winning equality consultancy, and Cardiff and Vale College, this year we delivered a **“Leading through Inclusion”** training package for managers. We also started to use theatre through the AFTA Thought theatre company, as a way of communicating the inclusive message amongst staff. We are looking to build on both initiatives in 2020.

Consultation has commenced on a new **four year Strategic Equality Plan: Caring about Inclusion 2020-2024**. As the title suggests this plan will focus on taking a more inclusive approach. It will look to make inclusion an explicit aspect of **AMPLIFY 2025**.

Although we have fallen out of the **Stonewall Workplace Equality Index Top 100**, we are still one of two top Health and Social Care organisations in Wales and are in the **top 5 Health and Social Care** organisations in the UK as well as being in the **Top 10 Employers in Wales**. Our continued presence at the annual PRIDE Cymru Parade, led by our Chief Executive and other Board members continues to grow. Plans for PRIDE 2020 are already underway. This year we have consolidated our **Disability Confident** Employer status and will be looking to achieve Disability **Confident Leader** status during 2020. Workshops on **Trans** related issues, which include content on terminology and discrimination has been successfully piloted and will be made available to staff on an on-going basis. A further review of some of our employment policies has led to them becoming more inclusive and we will be looking for more appropriate opportunities to continue this work, including reviewing our Equality, Diversity and Human Rights Policy.

## Welsh Language



The Welsh Language Standards, after a very comprehensive and systematic consultation process undertaken by staff, was placed with the UHB at the end of November 2018. The implications of their content and implementation means that there are challenges that the UHB must meet if the standards are to be achieved. Issues such as providing training opportunities to staff and working with local dementia networks to develop a reminisce resource for staff to use with Welsh speaking dementia patients are examples of the work that we are and will continue to develop in the coming year. The Standards also provide us with opportunities and not just challenges. Through our work in meeting the Standards, we will be able to identify good practice with the More Than Just Words Awards taking place in 2020. This can be used a measurement tool to see how far we have progressed.

Most recently we have:

- ✓ Held a number of workshops to develop an implementation plan to meet the Standards
- ✓ Secured new translation services in partnership with Cardiff City Council
- ✓ Delivered more welsh language courses than ever - free for staff, comprising
  - Work Welsh Taster courses
  - Intensive Welsh courses
  - Residential courses
- ✓ Signposting our staff to the breadth of on line learning resources at our disposal
- ✓ Encouraged our staff to register their skills on ESR so we have informed data on the language skills across the UHB
- ✓ Appointed two switchboard operators with welsh language fluency to our main UHW switchboard
- ✓ Worked closely with Clinical Boards to support the development of Patient Management Systems that record welsh language preferences of our patients

### 3. CAPABLE WORKFORCE

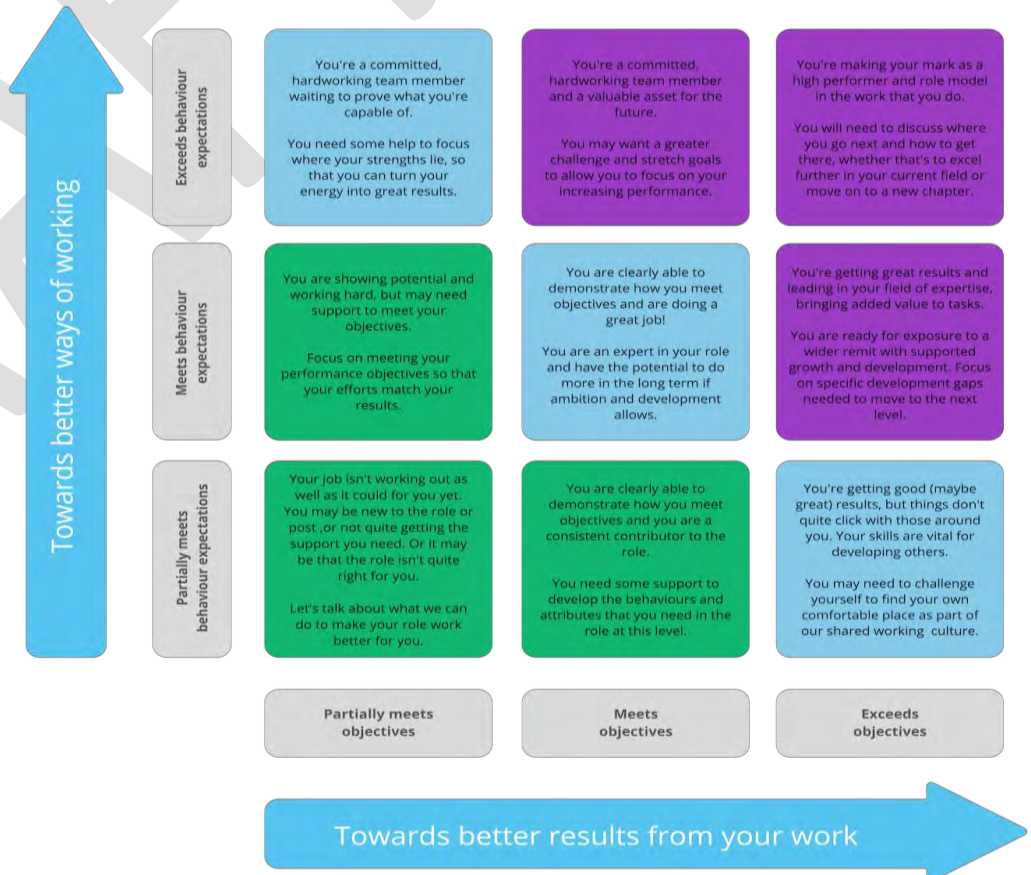
Meet learning & leadership skills needs through delivery of quality training & development.

Investing in our workforce to build capability and capacity is central to the UHB's ambition to be a **Great Place to Work and Learn**. Much of this is coordinated through the Learning, Education and Development Department, working collaboratively with Clinical Boards and Executive Departments.



**Talent Management and succession planning** are integral to our appraisal, recruitment, development and retention plans for 2020/21. The vision for the organisation is to develop and nurture engaged and motivated staff with the skills and confidence to live up to our values every day. Last year we

redesigned our appraisal process to bring it in line with the business objectives and develop a **Career Conversation Framework** to allow a structured approach to incorporate our values and behaviours into the measurement of staff performance. Succession planning review meetings have begun initially in areas of most need which include Directors of Nursing and Therapies. We have also increased the number of graduate placements in the organisation. Along with the Apprenticeship Academy, this will move us towards our aim of integrating talent through different levels of the organisation. Talent management tools and bespoke development programmes will continue to be developed using feedback from the early adopters of the Values Based Appraisal and Succession Planning Reviews. Further outcomes will include: a post-graduate scheme and a career-pathway brochure. Benefits will be identified through a reduction in hard-to-fill posts and reduction in expenditure on interim staffing arrangements.



**Leadership and Management** skills development is a key focus as we continue to invest in development to build leadership capability. Following a review of the leadership development offer it is now aligned with the UHB Strategy and renewed transformation programme. The focus of our leadership development at all levels is on networking; not only across the organisation but also across healthcare and Third Sector organisations in Cardiff and Vale, supporting each other and stimulating leaders to solicit new ideas and innovative solutions from each other and their teams and encouraging them to present ideas that are different from their own.

Two new Management programmes have been developed and will begin in 2019/20 which are open to all grades and job roles with the aim of increasing management capability across the organisation; **First Steps to Management** aimed at aspiring managers and supervisors, and **Essential Management** skills for new and existing managers.

A suite of management and leadership development modules will be rolled out in 2020/21 to allow skills to be gained in line with personal development need and linked to the Talent Management and Succession Planning Strategy. These may include; Understanding the Organisation, Understanding your Personal Leadership Style, Setting up a new Team, Team Development, Workplace Coach, Project management, Financial Skills.

New Leading Change Programmes have been developed and will continue through 2020/21. The three programme are

- ❖ **Acceler8** designed to change mind-set and reduce silo working through cross departmental projects
- ❖ **Integr8** designed to give LEAN skills and complete small projects
- ❖ **Collabor8** aims to develop alliancing skills

The leadership pathway for all roles will be mapped and accessibility to programmes increased. We will also participate actively in the development of **public sector partnership leadership programmes** through our involvement in the Public Services Board.

**Mandatory Training** compliance is monitored and reported monthly to ensure we are moving towards 85% compliance target. We are seeing improvement. During 2018/19 the ESR system was utilised to develop a training needs analysis for all level 1 and 2 awareness raising mandatory training. This has replaced the previous blanket approach and now provides a system for staff to identify the modules and refresher periods they are required to undertake, deemed essential for their role. This will now identifies



the roles that require the relevant training, therefore avoiding duplication and unnecessary time undertaking training not relevant to role.

**Nurse capability:** Significant progress has been made regarding the development of the 'Nursing and Midwifery Education and Development Framework' with active work streams including: the pathway of HCSW developing to registered nurses; implementation of the new NMC education standards; and the development of UHB standards for preceptorship. A revised 12 month preceptorship programme has been tested and launched in 2019 and the work stream has been extended to encompass the preceptorship of newly registered Midwives and a new branding: the Nursing and Midwifery Preceptorship Programme (NMPP). We are also developing the Major Trauma Centre Nurse Education Framework with induction pathways being developed and tested to support associated new roles. The Adaptation programme for Overseas Nurses, launched in 2018, has proved successful with 9 nurses achieving NMC registration and another 25 due to register in 2020. The development of an in-house OCSE preparation programme has brought significant savings to the organisation and has proved a robust approach; now used to support 50 nurses recruited from overseas. The new ESR competency module is now being used to document the achievement of competence for nursing clinical skills and this will continue to be implemented for all clinical skills programmes.

**Non-registered nurse capability:** clear development pathways are now in place for non-registered nurses across all settings in the UHB. Compliance with the HCSW Skills and Career Framework is measured annually and 49% compliance has been maintained for 2019. An interactive development pathway has been launched in 2019, providing managers and educators with guidance to support HCSW wishing to develop to registered nurses. HCSW continue to access undergraduate nurse training through the traditional route or through one of the newer flexible routes as 9 individuals have joined cohorts of the University of South Wales and Open University flexible undergraduate programmes. The UHB is working in partnership with HEIW in 2019/20 to pilot a new HCSW learning pathway for ESR.



#### 4. EFFICIENT & SUSTAINABLE WORKFORCE

##### Achieve target workforce metrics (KPI's)

Delivering against the UHB's **Workforce Metrics**; ensuring the total pay-bill remains within budget; reducing temporary agency and locum expenditure; continued reduction of sickness absence and promotion of staff wellbeing remain key priorities for the UHB in **2020**. The UHB has made significant improvements in many of these areas but our challenge of reducing expensive high premium agency costs remains a key focus.

Key Performance Indicator	2018-19 Outturn	YTD	Monthly Actual - Jun-19	2020-21 Target	2021-22 Target	2022-23 Target
Sickness Absence (12-month Cumulative)	5.11%	5.18%	4.93%	4.60%	4.40%	4.40%
YTD Sickness Absence (Financial Year)	5.11%	4.84%	4.93%	4.60%		
Job Plan Compliance (12 month review)	31.44%	27.41%	27.41%	85.00%		
Voluntary Resignation Turnover	6.57%	6.53%	6.53%	Reduction		
Pay Bill Over/Underspend	-0.31%	-0.32%	-0.31%	Underspend		
Variable Pay	8.55%	8.64%	8.74%	Improvement		
Actual (Contracted) WTE	12962.53	12924.25	12924.25	As per IMTP Predictions		
Fire Safety Mandatory Training	67.97%	68.69%	68.69%	85.00%		
PADR	56.37%	55.75%	55.75%	85.00%		

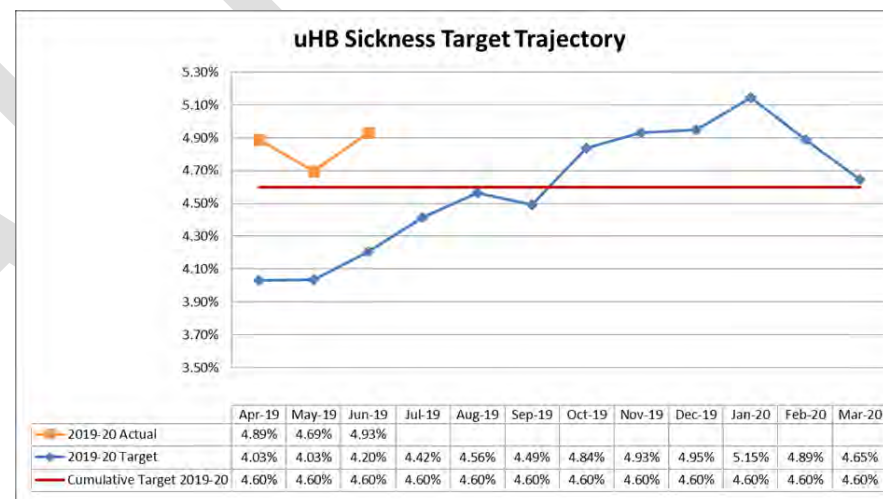
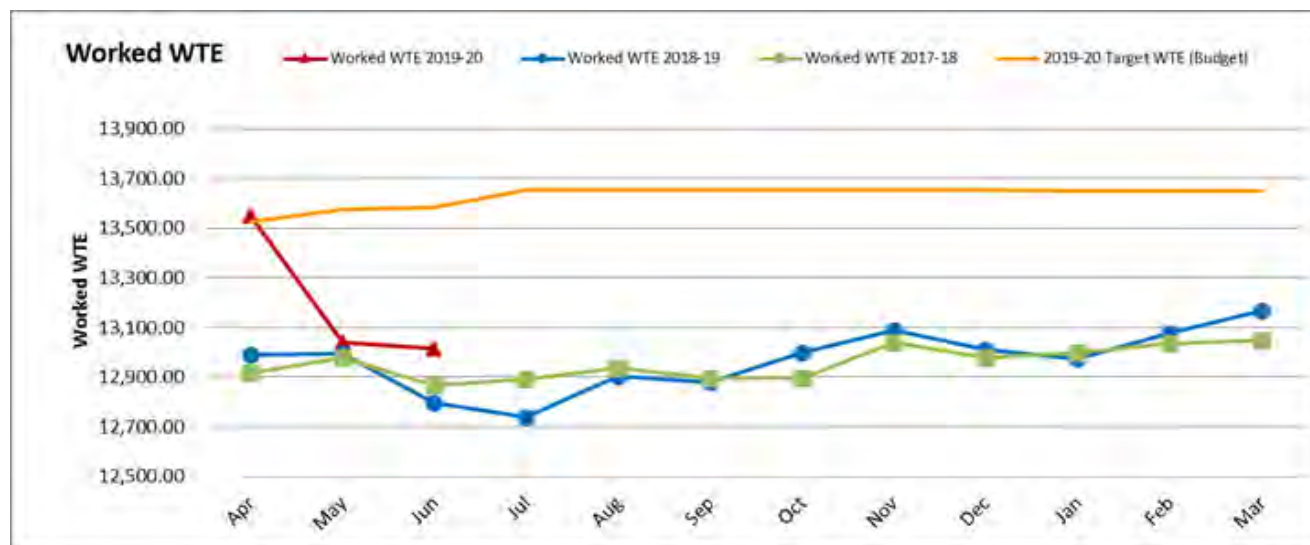


Table: monthly sickness rates 2019/20 compared to 4.60% target:

Table: NHS Wales Absence Benchmarking (NHS Wales Performance dashboard data May 2019)

	Contracted FTE	12-Month Cumulative Sickness
Aneurin Bevan uHB	11,388	5.38%
Betsi Cadwaladr	15,505	5.06%
Cardiff & Vale	12,859	5.16%
Cwm Taf	10,304	5.89%
Hywel Dda	8,443	4.89%
Powys	1,775	4.50%
Public Health Wales	1,631	3.78%
Swansea Bay uHB	11,235	5.97%
Velindre	3,905	4.13%
Welsh Ambulance Services	3,215	7.10%
NHS Wales	80,261	5.34%

The financial year to date **Sickness Absence** figure to June 2019 is 4.84%. The cumulative sickness absence rate for the 12-month rolling period to June 2019 is 5.18%. The 12-month cumulative sickness rate for the UHB has been at or around the same rate since April 2018. The strategic action plan for **improving staff health and wellbeing** is described within the Engaged Workforce section.



**Workforce costs** have been tightly controlled during 2019/20, seeing a continuing trend to reduce variable pay and expensive agency costs. This is illustrated by a cumulative month 6 budget underspend of £1.190m (-0.33%).

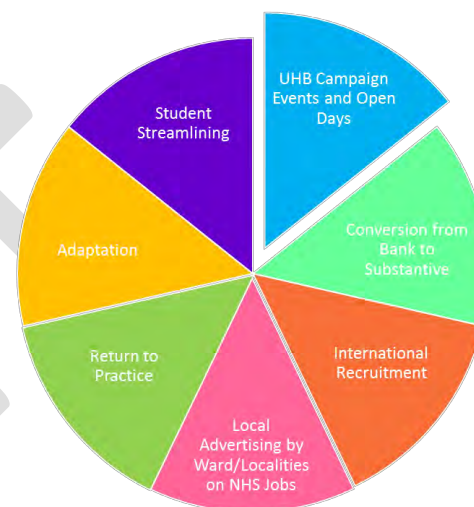
The focus in 2020/21 will be to continue to drive these unnecessary costs out to ensure an affordable and sustainable pay-bill. Clinical Boards and corporate functions continue to refine their workforce saving opportunities, controlling vacancies, temporary spend, skill mix, sickness absence costs and alternative ways of working. Reducing UHB wide workforce costs forms part of the UHB's tactical efficiency savings in 2020/21 and is being driven through the Nursing Productivity Group, Medical Productivity Group, Workforce Productivity Group that feed into the Cross Cutting Steering Board.

Ensuring **sustainability** of current and future workforce supply, especially in nursing and medical roles, remains a priority for the UHB. Specific actions identified within the plan are: deliver Project 95% and sustain Project Switchover; continue to deliver Medical Training Initiative (MTI) strategy; continue to monitor the implementation of the Welsh Government Agency and Locum Circular, recruit hard to fill vacancies; develop talent management and succession planning for senior management posts.

**Project 95%** has held a number of very successful recruitment campaigns in 2019 and continues to fill substantive nursing posts. Recent work has been focussed on the development of a **Nurse Retention Plan** to ensure that when we recruit we also retain our nurses. We are also having great success with our international nurse campaign and nurse adaptation programmes and have a "waiting list" of people who wish to join these. Further cohorts are planned for 2020.

Cardiff and Vale UHB			
Band 5 & 6 Nurse Recruitment (including ODPs)			
		Actual	Forecast
	BAND 5	Jul-19	Dec-19
UHB	Establishment	2147.42	2137.47
UHB	Forecast Actual	1759.75	1870.27
UHB	Forecast Vacancy	387.67	267.20
UHB	%	82%	87%
		Actual	Forecast
	BAND 6	Jul-19	Dec-19
UHB	Establishment	1412.17	1413.27
UHB	Forecast Actual	1507.40	1537.97
UHB	Forecast Vacancy	-95.23	-124.70
UHB	%	107%	109%
		Actual	Forecast
	TOTAL BAND 5 & 6	Jul-19	Dec-19
UHB	Establishment	3559.59	3550.74
UHB	Forecast Actual	3267.16	3408.24
UHB	Forecast Vacancy	292.43	142.50
UHB	%	92%	96%

Includes Clinical Boards: Children and Women, Medicine, Mental Health, PCIC, Specialist, Surgery



**Project Switchover** has continued to sustain its position of eradicating 100% off contract agency usage.

**Nurse Staffing Levels (Wales) Act 2016 – 25B, C and E** commenced in April 2018. Guidance has been implemented to enable us to comply with the Act.

**Medical Locums** remains a priority for the UHB in 2020 and control measures in place and monitored through the established Medical Productivity Project Team.

**MTI** – in 2020 the UHB is aiming to continue to hire more MTI doctors through the BAPIO initiative.

**Hard to fill vacancies** - As at end of December 2018, there were 4 hard to fill consultant vacancies and 25 hard-to-fill trainee and higher grade HB medical vacancies. Whilst the UHB have had a number of successes in 2018 in filling key roles in Emergency Medicine and Paediatrics, our recruitment strategies continue to be reviewed especially in Medicine, Paediatrics and Psychiatry. Our plans to address other professions include: newly qualified nurses, Sonographers, Radiologists, qualified mechanical and electrical trades, Perfusionists, Cardiac scrub nurses and Advanced Nurse Practitioners.



As outlined within the transformation section, the appraisal process and documentation is being thoroughly reviewed which will improve **PADR compliance** which has remained static at around 56-60% for many years. The process is being aligned with the talent management process and fundamentally this new approach will enhance the staff experience and improve the career conversation.

**Brexit** – we are continuing to support our staff who require EU settlement by providing them with as much information and guidance as is available.

**The Workforce and OD Delivery Plan which outlines the actions identified to deliver against the above objectives, is available at this link:**

[IMTP 20120-23 Workforce & OD Delivery Plan Only.docx](#)

<b>Report Title:</b>	<b>NHS Funded Nursing Care - September 2019</b>					
<b>Meeting:</b>	Board Meeting				<b>Meeting Date:</b>	28.11.19
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	✓ <b>For Information</b>
<b>Lead Executive:</b>	<b>Robert Chadwick</b>					
<b>Report Author (Title):</b>	<b>Assistant Director of Finance - PCIC</b>					

## SITUATION

To seek Board approval for:

- Extending the current methodology used to calculate the FNC rate for a further two years;
- Confirming the FNC rate for 2019/20 and 2020/21.

## BACKGROUND

Funded Nursing Care (FNC) refers to the NHS funding of Registered Nursing (RN) care within care homes, where this has been assessed as necessary. In addition to funding RN time the rate also includes a component to fund any continence provisions that may be necessary.

Board members will recall from previous papers, most recently in March and December 2018, the background to this and the work commissioned by HBs from Laing & Buisson that was used as the basis for uplifting the FNC rate. Following this, legal challenges culminated in 2017 with a Supreme Court hearing.

The Supreme Court found that, in addition to the services already funded, HBs should fund some further services provided by the RN. The Judgment also resulted in Local Authorities being responsible for funding some of the RN time, where the RN is providing a service that is incidental and unconnected to the nursing care requirement. Previous Board papers have set out the Supreme Court judgment in detail and the work underway across Health Boards and with Local Authority representative partners to revise the funding model and address outstanding matters to reflect the Supreme Court's Judgment.

### 1. The Funding Methodology

In 2014, HB Boards approved the adoption of an Inflationary Uplift Mechanism (IUM) to be used when calculating the FNC rate. The IUM methodology linked the labour element of the FNC rate to mid-point Band 5 of the NHS Agenda for Change pay award, with the continence component of the rate uplifted in line with CPI. Uplifts have been made on an annual basis in line with this and, since 2014, have been adjusted to reflect the revised rates post Supreme Court Judgment. Boards approved the IUM in 2014 to apply for a period of five years, then review. The five years completed with 2018/19 and so Boards now need to consider the approach to apply from 2019/20 onwards.

### 2. The Recommended approach

Health Board professional and finance leads for longer term care have developed and considered a number of options regarding the methodology to apply from 2019/20 onwards and are all in agreement that the recommended approach be that the IUM be extended for a further

two year period – to cover 2019/20 and 2020/21. There are a number of reasons why this is viewed to be the most appropriate approach:

- The IUM as a process has operated successfully for the past 5 years;
- An extension of two years would cover the full 3 years of the current NHS Agenda for Change pay award;
- It allows for further time to consider alternative longer term approaches following an anticipated WG policy review and also work commissioned in England from Laing & Buisson;
- The opportunities/implications of pooled budgets as they further develop.

In addition to the expert advice from HB professional/finance leads the HB Deputy Directors of Finance and Directors of Finance have also considered this matter and agree that the extension of the current methodology for a further two years is the most appropriate option.

CEOs have also considered the advice from the professional and finance leads and support the proposal to extend the IUM for a further two years – to cover 2019/20 and 2020/21.

HB Boards across Wales are now asked to ratify the proposal.

### 3. The 2019/20 rate

Setting the 2019/20 rate using the IUM has been more complex than usual. The three year NHS pay award has included revisions to the actual pay spines, with some incremental points being realigned and different percentage uplifts applied to some points within the Bands. It has emerged, following discussions with provider representatives, that this has an impact on the way the uplift could be calculated.

Two possible options were identified<sup>1</sup> and, following detailed discussions across HBs (and with WG colleagues) there is a majority consensus that the uplift applied should appropriately reflect the changes to the pay scale.

The revised option derives an inflation rate to ensure the resulting uplift is in line with the Midpoint of Band 5, including the effect of both inflation and the pay scale restructure. Adopting this approach ensures that the uplift applied to the nursing pay element of the fee results in the derived salary being in line with the Mid Point of Band 5 over these years and is thus more robust and in line with the way the IUM has been used since 2014. This results in a 3.1% uplift for 2019/20 and a 3.7% uplift for 2020/21. This will have an in year unplanned financial impact of circa £818k across Wales.

This can be demonstrated as follows:

Pay Point	18/19	19/20	20/21
19	24,915	26,220	26,970
20	25,934	26,220	27,416
<b>Average</b>	<b>25425</b>	<b>26220</b>	<b>27193</b>
<b>Actual % uplift</b>	<b>1.5%</b>	<b>3.1%</b>	<b>3.7%</b>

<sup>1</sup> The other option would have resulted in a 1.1% uplift in year based on the NHS Wales Pay Journey. When applying this the derived salary in 19/20 and 20/21 it would have been lower than the actual average of pay points 19 and 20.

Year	% uplift of RN labour component	RN component £	% uplift of continence component	Continence component £	Total HB FNC rate* £
2018/19	1.5%	156.30	2.5%	11.57	167.87
2019/20	3.1%	161.15	2.1%	11.81	172.96
2020/21	3.7%	167.11	**	tbc post February 2020	tbc post February 2020

\* Note: In addition the LA is responsible for an additional 0.385 hours of RN time. This is currently paid by the responsible LA utilising a WG Grant.

\*\* Note: The CPI uplift for 2020/21 will be based on the February 2020 published index for the previous 12 months, ensuring the rate can be calculated and becomes payable directly from the 1<sup>st</sup> of April 2020.

#### 4. Engagement

The lead HB CEO and the lead Executive Council Member of ADSS Cymru have met with sector representatives on a number of occasions over the past year to ensure appropriate engagement and also as a route to address and ongoing queries/issues. These meetings have been productive and helpful and sector representatives have indicated they are content with the extension of the IUM as the recommended approach along with a need to begin consideration of an appropriate longer term methodology.

#### 5. Conclusion

HB Boards have received a number of updates on FNC linked to the legal proceedings that have taken place over recent years. These updates have provided Boards with detailed information on the work underway following on from the Supreme Court Judgment in 2017.

This paper focuses on the need to consider the extension of the current methodology to calculate the annual FNC rate – the Inflationary Uplift Mechanism – for a further two years to cover 2019/20 and 2020/21. Lead professional and finance officers in each HB have considered the options and recommend extending the IUM for a period of two more years. Boards are now asked to ratify this recommendation as the approved approach.

This paper also sets out the FNC rate for 2019/20 and the approach to setting the rate for 2020/21. The 2019/20 rate calculation reflects the revisions to the Agenda for Change Pay Scale that form part of the three year pay award. Two options exist for setting the rate and the majority consensus view of HB finance leads, professional leads and Directors of Finance is to recommend the option that reflects the impacts of the revisions to the pay scale as set out in the tables above. This paper now seeks Board approval for this recommendation.

#### RECOMMENDATIONS

The Board is asked to:

- **Note** that the current Inflationary Uplift Mechanism (IUM) was approved by each HB Board in Wales in 2014 for a period of five years then review;
- **Note** that professional and finance leads from each HB in Wales have considered options and recommend that the IUM be extended for a further two year period, to cover 2019/20 and 2020/21, for the reasons set out in section 2 of this paper, and that CEOs support this Recommendation;
- **Approve** the proposal that the IUM be extended for a further two year period;
- **Note** and **approve** the FNC rate for 2019/20 and 2020/21.
- **Note** that further work will be undertaken to consider a longer term model following on from a WG review of the FNC policy position and that Boards will be updated on this work as it develops.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term		Integration		Collaboration		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>	Yes / No / Not Applicable <i>If "yes" please provide copy of the assessment. This will be linked to the report when published.</i>								



REPORT TITLE:	Standards of Behaviour Policy										
MEETING:	Board Meeting						MEETING DATE:	28.11.19			
STATUS:	For Discussion		For Assurance		For Approval	x	For Information				
LEAD EXECUTIVE:	Director of Corporate Governance										
REPORT AUTHOR (TITLE):	Corporate Governance Officer										
PURPOSE OF REPORT:											

## SITUATION:

Cardiff & Vale University Health Board (UHB) is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This Policy and the accompanying procedure set out those expectations and provide guidance so that all employees and Independent members are supported in delivering that requirement.

The primary source for dissemination of these Policies within the UHB will be via the intranet, clinical portal and also by requests made to the Corporate Governance Department.

## REPORT:

## BACKGROUND:

A new Standards of Behaviour policy was required as result of a 'limited assurance' internal audit report. Within Cardiff and Vale University Health Board (the UHB), employment policies are developed and reviewed in partnership via the Local Partnership Forum.

The policy was taken to Management Executive and HSMB and has been out for a 28 day consultation process across the UHB via the intranet with no feedback or amendments suggested.

The policy was also reviewed by Internal Audit and 'substantial assurance' was received.

This Policy and the accompanying Procedures have been developed to set out:

- The Standards of Behaviour expected from UHB employees, particularly in relation for declarations of interest, gifts/hospitality etc, and secondary employment
- The responsibilities of those working for the UHB and the arrangements in place to support Independent Members and Employees to uphold it.
- Arrangements for the appropriate declarations of interests
- Arrangements for the acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship.

- Declarations of outside employment and private practice
- Political activities and personal conduct that fall within the scope of this Policy

#### Other supporting documents are:

- Standing Orders.
- Scheme of Reservation and Delegation
- Standing Financial Instructions.
- Procedure for NHS Staff to Raise Concerns
- Social Media Policy
- Working Times Policy
- Data Protection Act Policy
- Dignity at Work Policy
- Disciplinary Policy and Procedure
- Information Governance Policy

#### RECOMMENDATION:

The Board is asked to:

- **APPROVE** the new Standards of Behaviour Policy
- **APPROVE** the full publication of these documents in accordance with the UHB Publication Scheme

#### SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1.Reduce health inequalities		6.Have a planned care system where demand and capacity are in balance	
2.Deliver outcomes that matter to people		7.Be a great place to work and learn	x
3.All take responsibility for improving our health and wellbeing		8.Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.Offer services that deliver the population health our citizens are entitled to expect		9.Reduce harm, waste and variation sustainably making best use of the resources available to us	
5.Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click [here](#) for more information

Sustainable development principle: 5 ways of working	Prevention	Long term	Integration	Collaboration	x	Involvement	
<b>EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:</b>	UHB Policies cannot be approved without an EHIA – relevant EHIAs are attached as appendices to this report						

Kind and caring  
Caredig a gofalgwr

Respectful  
Dangos parch

Trust and integrity  
Ymddiriedaeth ac uniondeb

Personal responsibility  
Cyfrifoldeb personol



**Reference Number:** UHB 064  
**Version Number:** 2

**Date of Next Review:** *To be included when document approved*  
**Previous Trust/LHB Reference Number:** T20

## **STANDARDS OF BEHAVIOUR POLICY**

### **Policy Statement**

This Standards of Behaviour Policy and the Procedures which accompany it describe the standards and public service values which underpin the work of Cardiff and Vale University Health Board (the UHB) and reflects current guidance and best practice which all those working in NHS Wales must follow.

It is a long and well-established principle that public-sector organisations must be impartial and honest in their business and that their officers must act with integrity.

As a publicly funded body the UHB has a duty to set and maintain the highest standards of conduct and integrity. The Board expects all Independent Members and officers of the UHB to demonstrate and maintain the highest standards of corporate and personal conduct, based on the recognition that the needs of patients must come first.

As well as promoting the standards of business conduct expected of public bodies, this policy aims to protect the UHB and its officers from any suggestion of corruption, partiality or dishonesty by providing a clear framework through which the UHB can provide guidance and assurance that its officers conduct themselves with honesty, integrity and probity.

### **Policy Commitment**

The UHB is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This Policy and the accompanying procedure set out those expectations and provide guidance so that all employees and Independent members are supported in delivering that requirement.

Independent Members and employees are expected to act at all times with the utmost integrity and objectivity and in the best interests of the organisation in performing their duties, and to avoid situations where there may be a potential conflict of interest. Officers must not use their position for personal advantage or seek to gain preferential treatment. Any actual or potential interests which may be perceived as conflicting with that overriding requirement must be declared.

Independent Members and employees should ensure that they are not placed in a position that risks, or appears to risk, compromising their role or the organisation's public and statutory duties or reputation. Officers must not, or be perceived to, secure valuable gifts and hospitality by virtue of their role. Any gifts, hospitality or sponsorship which could be perceived in this way must be declared and recorded.

Outside employment or private practice must neither conflict with nor be detrimental to the NHS work of the officer in question.

Any political activity should not identify an individual as an employee of the UHB. Conferences or functions run by a party political organisation should not be attended in an official capacity, except with prior written permission of the Chief Executive and Chair.

All Independent Members and Employees have a responsibility to respect and promote the corporate or collective decision the UHB, and to act in accordance with the UHB Values and Behaviours. They may comment as they wish as individuals however, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of the UHB.

When speaking as a member of the UHB, whether to the media, in a public forum or in a private or informal discussion, officers should ensure that they reflect the current policies or view of the organisation. For any public forum or media interview, approval should be sought in advance:

- in the case of the Board, from the Chairman and/or Chief Executive or their nominated deputies, and Communications Team;
- in the case of all other employees, the Communications Team

Independent Members and employees should be aware that social networking websites are public forums and should not assume that their entries will remain private. Employees communicating via social media must comply with the UHB [Social Media Policy](#). Individuals must not conduct themselves in a way that brings the UHB into disrepute or disclose information that is confidential to the UHB, staff or patients.

Employees at all times, be aware of the importance of maintaining confidentiality and security of information gained by you during the course of your duties. This will, in many cases, include access to personal information relating to service users. You must treat all information, whether corporate, staff or patient information, in a discreet and confidential manner in accordance with the provisions of Data Protection Legislation and organisational policy.

Any Board Member (Executive or Independent Member) who becomes bankrupt, insolvent, has active CCJ, or made individual voluntary arrangements with organisations must advise the Director of Corporate Governance without delay. Employees who are bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

From time to time situations may arise where a personal relationship exists between employees or prospective employees of the UHB. It is expected that where a personal relationship exists, employees will behave responsibly and not put themselves into a situation where their relationship may impact adversely on their work or the UHB.

### **Adherence to this Policy**

All employees have a role to play in ensuring compliance with this Policy and the accompanying procedure, and the following roles and responsibilities are important in achieving this:

- The Chief Executive is the “Accountable Officer” with overall responsibility for ensuring that the UHB operates efficiently, economically and with probity and will

ensure a policy framework is set and that arrangements are in place to support the its delivery.

- The Director of Corporate Governance has delegated responsibility for ensuring that the UHB is provided with competent advice and support regarding the contents and application of this Policy and the accompanying Procedures
- Executive Directors and Clinical Boards are responsible for ensuring that employees are aware of the requirements contained within this Policy. They are expected to lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- Line Managers are responsible for ensuring that this Policy and the accompanying Procedures are brought to the attention of all individuals for whom they are responsible, and that they are aware of their obligation to comply with it and any implications for their work.
- Line Managers are encouraged to discuss this Policy and accompanying Procedures at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate. They are expected to support individuals in the application of the Policy and accompanying Procedures, seeking advice from other managers or from the Directorate of Corporate Governance/Corporate Governance Team if required.
- Employees are responsible for ensuring they are aware of and are compliant with the requirements of this Policy and the accompanying procedures and for ensuring that the appropriate declarations are made in a timely fashion
- Independent Members are responsible for ensuring they are aware of and are compliant with the requirements of this Policy and the accompanying procedures and for ensuring that the appropriate declarations are made in a timely fashion

Failure to comply with the requirements set out in this Policy and the accompanying Procedures may result in action being taken in accordance with the UHB's Disciplinary Policy and Procedure. Such disciplinary action may include termination of employment (where applicable). Where the failure to comply relates to an individual that is not a direct employee of the UHB, this may result in action being taken in accordance with the relevant engagement procedures (e.g. termination of a secondment agreement).

Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery or corruption by any employee, will be reported to NHS Counter Fraud Authority in accordance with Standing Financial Instructions and the Counter Fraud and Corruption Policy, with a view to an appropriate investigation being conducted and potential prosecution being sought.

This Policy may be breached innocently, accidentally, or because of deliberate actions. Members of the Board and employees of the UHB should speak up about any genuine concerns they have in relation to compliance with this Policy. These can be raised directly with their own line manager, another senior manager or with the Director of Corporate Governance. Alternatively employees can contact the Freedom to Speak Up Helpline on 02921846000 or [F2SUCAV@wales.nhs.uk](mailto:F2SUCAV@wales.nhs.uk), or the Governance Directorates Standards of

Behaviour inbox, [CAV.Declarations@wales.nhs.uk](mailto:CAV.Declarations@wales.nhs.uk). All reported concerns will be treated with the appropriate confidentiality and investigated in line with the UHB's policies and procedures.

The Director of Corporate Governance will take a report on breaches and responses to the Audit and Assurance Committee and the Board on an annual basis.

### **Supporting Procedures and Written Control Documents**

This Policy and the accompanying Procedures have been developed to set out:

- The Standards of Behaviour expected from UHB employees, particularly in relation for declarations of interest, gifts/hospitality etc, and secondary employment
- The responsibilities of those working for the UHB and the arrangements in place to support Independent Members and Employees to uphold it.
- Arrangements for the appropriate declarations of interests
- Arrangements for the acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship.
- Declarations of outside employment and private practice
- Political activities and personal conduct that fall within the scope of this Policy

### **Other supporting documents are:**

- Standing Orders.
- Scheme of Reservation and Delegation
- Standing Financial Instructions.
- Procedure for NHS Staff to Raise Concerns
- Social Media Policy
- Working Times Policy
- Data Protection Act Policy
- Dignity at Work Policy
- Disciplinary Policy and Procedure
- Information Governance Policy

### **Scope**

All Independent Members and Employees of the UHB including those working for its hosted organisations are, without exception, within the scope of this Policy.

In the context of this policy the term 'employees' refers to all staff of the UHB and

- Consultants;
- Agency workers;
- Specialist Contractors;
- Those who have an honorary contract with the UHB;
- Seconded who carry out work for the UHB but are not directly employed by it;
- NHS Trainees on placement with the UHB;
- Jointly appointed staff

In addition, some individuals who work with, but are not employed by the UHB are required to comply with this policy, for example members of the UHB's advisory groups, such as its Stakeholder Reference Group and volunteers.	
<b>Equality and Health Impact Assessment</b>	<b>An Equality and Health Impact Assessment (EHIA) has no impact.</b>
<b>Policy Approved by</b>	UHB Board
<b>Group with authority to approve procedures written to explain how this policy will be implemented</b>	Health System Management Board
<b>Accountable Executive or Clinical Board Director</b>	Director of Corporate Governance
<p style="text-align: center;"><b><u>Disclaimer</u></b></p> <p>If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the <a href="#"><u>Governance Directorate.</u></a></p>	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	N/A	08/07/11	New policy to replace Trust Version 20
1.1	02/12/14	15/01/2015	Interim review approved by Audit Committee to take account of changes to role titles and amendments to Section 6.2.2 as follows:- Removal of Clinical Directors, Directorate and Assistant Directorate Managers, Lead Nurses or equivalent as a group of staff. Remove Internal Audit and Procurement staff as this group is employed by another organisation. Reference to change of role titles for Director of Governance and Divisional Teams (see below).
2	26/09/19	TBC	Policy discussed and reviewed with Stakeholder Reference Group and then approved by Board. New policy required as result of 'limited assurance' internal audit report.



<b>Report Title:</b>	<b>Approval of Model Standing Orders, Reservation and Delegation of Powers</b>					
<b>Meeting:</b>	<b>Board Meeting</b>				<b>Meeting Date:</b>	<b>28/11/2019</b>
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	<b>x For Information</b>
<b>Lead Executive:</b>	<b>Director of Corporate Governance</b>					
<b>Report Author (Title):</b>	<b>Interim Head of Corporate Governance</b>					

## SITUATION

The purpose of this report is to seek the Board's approval of the Welsh Government Model Standing Orders for Local Health Boards for adoption as the University Health Board's Standing Orders and Reservation and Delegation of Powers.

## BACKGROUND

The Welsh Government has undertaken a review of the Model Standing Orders (MSO's) for Local Health Boards, NHS Trusts and the Welsh Health Specialised Services (WHSSC) and Emergency Ambulance Services (EASC) Committees (WHSSC).

Model documents have been issued by the Minister for Health and Social Services pursuant to his powers of direction contained within sections 12(3) (for Local Health Boards) and 19(1) (for NHS Trusts) of the National Health Service (Wales) Act 2006.

The MSO's are to be used as a guide with amendments and adaptations being made to reflect the requirements of individual Boards and Trusts.

WHSSC and EASC Joint Committee MSO's have been formally approved by their respective Boards and will form Schedules 4.1 and 4.2 of the MSO's to be adopted.

A copy of the draft MSO's (including the WHSSC and EASC MSO's) are saved to the Personal Documents section of Ibabs and were circulated to all Board Members by email on the 12.11.2019.

Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in February 2019 and with a few exceptions, the health board's current Standing Orders reflect the previous MSO's issued in 2014.

## ASSESSMENT

A thorough review of the draft MSO's has been undertaken at National Level to ensure that they reflect the up to date legislative position and regulatory requirements.

It should be noted that the draft MSO's contain a package of amendments ranging from administrative changes to legislative updates. A summary of the key changes to the 2014 MSO's that have been incorporated into the draft 2019 MSO's is detailed in the table at Appendix 1.

## RECOMMENDATION

The Board is asked to:

**REVIEW** the draft Model Standing Orders.

**AGREE TO ADOPT** the draft Model Standing Orders.

**NOTE** that once approved by the Board the draft Model Standing Orders will be proof read and appropriately amended to reflect the requirements of the University Health Board.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term		Integration		Collaboration		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>		Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.							





**Review of NHS Wales Local Health Board Model Standing Orders – September 2019**  
**Table of Amendments, Cross Reference to Legislation and Confirmation of Sections which are not for variation by NHS Body**

\* = The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009

Page Number	Previous Paragraph Reference	New Paragraph Reference	Section Heading	Reason for Amendment (if applicable)	Cross reference to legislation	Requirement of legislation – local amendment not permissible	Issued under Direction – local amendment not permissible
2	1	1	Forward	To reflect regulations	*Part 3, Regulation 15(6)	✓	
2	2	2	Forward	LHB to add title of their local Standards of Behaviour Framework/Policy	n/a		
8	<b>Section A</b>						
8	i)	i)	Statutory Framework	To reflect different position of Powys Teaching Local Health Board	The Local Health Boards (Establishment and Dissolution) (Wales) Order 2003	✓	
8	v)	v)	Statutory Framework	Amendment to better reflect legislative position	NHS (Wales) Act 2006, para 4 of Schedule 2	✓	
8	v)	vi)	Statutory Framework	Paragraph v) split to form two paragraphs.	NHS (Wales) Act 2006, Sections 12 and 13/Local Health Boards (Directed Functions) (Wales) Regulations 2009		
8	vi)	n/a deleted	Statutory Framework	Paragraph deleted and moved relocated as reader has already been to the direction making powers in para v) so for clarity subsequent paragraphs set out the directions issued for joint working			
9	vii)	vii)	Statutory Framework	Joint Committee amended to read 'WHSSC' – previous SOs only referred to one joint committee	The Welsh Health Specialised Services Committee (Wales) Directions 2009	✓	

9	n/a	viii)	Statutory Framework	New paragraph added to include EASC in SOs	The Emergency Ambulance Services Committee (Wales) Directions 2014	✓	
9	viii)	ix)	Statutory Framework	Paragraph renumbered and new sentence added to capture deleted section vi)			
9	x)	xi)	Statutory Framework	Paragraph renumbered and amendment to better reflect legal position with regard to the 2000 Regulations which predate the power in the 2006 Act but the NHS (Consequential Provisions) Act 2006 provides for the continuity of the law as if made under the NHSWA 2006	National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000/NHS (Wales) Act 2006	✓	
9	x)	xi)	Statutory Framework	Sentence added to reflect change in legislation	Social Services and Well-being (Wales) Act 2014	✓	
10	xi)	xii)	Statutory Framework	Paragraph renumbered and sentence added by legal services to recognise this also includes working with English bodies.	NHS Act 2006, Section 72	✓	
10	n/a	xiv)	Statutory Framework	New paragraph added by to reflect new legislative requirement.	Social Services and Well-being (Wales) Act 2014/The Partnership Arrangements (Wales) Regulations 2015	✓	
10	n/a	xv)	Statutory Framework	New paragraph added by to reflect new legislative requirement.	Well-being of Future Generations (Wales) Act 2015	✓	
10	xiii)	xvi)	Statutory Framework	Paragraph renumbered and replaced to reflect new Welsh language requirements	The Welsh Language Standards (No.7) Regulations 2018	✓	

Previously on page 9	xv)	n/a moved to new para 1.4.4	Statutory Framework	Paragraph regarding indemnity moved to new para 1.4.4 under Responsibilities of Board Members			
11	xvi)	xviii)	NHS Framework	Paragraph renumbered and amendment to reflect current name of Welsh Government and to improve grammar			
11	xviii)	xx)	NHS Framework	Main paragraph renumbered and new paragraph with link to Governance eManual inserted to ensure clarity re what is meant by the NHS Wales Values and Standards of Behaviour Framework			
11	xix)	xxi)	NHS Framework	Paragraph renumbered and amended and reference added to the Well-being of Future Generations Act (WBFGA)			
11	xx)	xxii)	NHS Framework	Paragraph renumbered and amended to reflect change from Ministerial Letters to Welsh Health Circulars in 2014			
12	xxi)	xxiii)	Local Health Board Framework	Paragraph renumbered and reference added to SFI's forming part of SOs and Schedule 2.1			
12	xxii)-xxiv)	xxiv)-xxvi)	Local Health Board Framework	Paragraphs renumbered due to additional paragraphs being added			
12	xxv)	xxvii)	Applying Standing Orders	Paragraph renumbered and LHB to add title of their local Standards of Behaviour Framework/Policy.	*Part 3, Regulation 15(5)	✓	
				Wording also added to re-enforce need for individual LHB to agree arrangements for Joint Committees			
13	n/a	xxix)	Applying Standing Orders	Final paragraph regarding failure to comply with standing orders separated from previous paragraph to give emphasis.			

13	xxvii)	xxx)	Variation and Amendment of Standing Orders	Paragraph renumbered and cross reference in bullet point 3 amended from 6.5.14 to 7.5.14			
13 - 14	xxx)	xxxiii)	The role of the Board Secretary	Paragraph renumbered and additional sentence added to improve grammar			
13 - 14	xxx)	xxxiii)	The role of the Board Secretary	Paragraph renumbered and amended to reflect provisions within Model Role Profile issued in 2009			
14	xxxii)	xxxiv)	The role of the Board Secretary	Paragraph renumbered due to additional paragraphs being added			
15	<b>Section B : Standing Orders</b>						
15	1.0.2	1.0.2	The Local Health Board	To reflect different position of Powys Teaching Local Health Board	The Local Health Boards (Establishment and Dissolution) (Wales) Order 2003	✓	
15	1.1.1	1.1.1	Membership of Local Health Boards	Amendments regarding appointment of board members to better reflect regulations	*Part 2, Regulations 4(1), 4(2) and 4(6)	✓	
15	1.1.2	1.1.2	Membership of Local Health Boards	Amendment to delete typographical error			
16	1.1.3	1.1.3	Membership of Local Health Boards	<u>Officer Members [to be known as Executive Directors]</u> - No amendments	*Part 2, Regulation 3(2)	✓	
16	1.1.4	1.1.4	Membership of Local Health Boards	<u>Non Officer Members [to be known as Independent Members]</u> - No amendments			✓
16	n/a	1.1.5	Membership of Local Health Boards	<u>Associate Members</u> – new paragraph added to help clarify position with regard total number of Associate Members that may be appointed	*Part 2, Regulation s 4(3) and 4(4)		

16	1.1.5	1.1.6	Membership of Local Health Boards	Paragraph renumbered and amended to reflect legislation as Minister "may" appoint and therefore has a choice in the matter.	*Part 2, Regulation 4(4)	✓	✓
				Regulations are not specific re post holders but current arrangements have previously been determined.			
				To remain current until directed otherwise by the Minister.			
16	1.1.6	1.1.7	Membership of Local Health Boards	Paragraph renumbered	*Part 2, Regulation 4(4) and 4(5)	✓	
16	1.1.7	1.1.8	Membership of Local Health Boards	<i>Use of term "independent members"</i> - paragraph renumbered			
17	1.3.1	1.3.1	Tenure of Board Members	Amendment to make clearer that time served relates positions held on the Board even if these are different positions. It should also be noted that different arrangements are in place for Associate Members who are Chairs of the Stakeholder Reference Group and Health Professionals Forum who serve a shorter term. Refer to Schedule 5.1, Paragraph 1.4.6 for SRG and Schedule 5.2, Paragraph 1.4.6 for HPF.	*Part 2, Regulation 6 (5)	✓	
17	1.3.2	1.3.2	Tenure of Board Members	Amended to reflect reasons for appointment = necessary or expedient and to better reflect wording regarding holding a position on the same board and the total tenure that an individual can serve (which includes time appointed by Minister if relevant).	*Part 2, Regulations 4(4) and 7(5)	✓	
18	n/a	New 1.4.4	Responsibilities of Board Members	Paragraph moved from page 10, xiii) (see above)			

18 - 19	1.4.4-1.4.11	1.4.5-1.4.12	Responsibilities of Board Members	Paragraphs renumbered due to above insertion.			
20	2.0.3	2.0.3	Reservation and Delegation of LHB Functions	Sentences removed to ensure information is high level. Reference to SO 2.0.4 amended to SO 4.			
Previously on page 18	2.0.4	n/a	NHS Wales Shared Services	Information updated, deleted from this section and moved to Section 4			
20	2.2.1	2.2.1	Delegation of Board functions	'shall' replaced with 'may' as 'shall' implies that the board must delegate.			
				Sentence added to re-enforce that some functions cannot be delegated as issued under direction			
20	2.2.2	2.2.2	Delegation of Board functions	'shall' replaced with 'may' as 'shall' implies that the board must delegate.			
21	2.3.1	2.3.1	Delegation to officers	'will' replaced with 'may' as 'will' implies that the board musts delegate.			
21	2.3.2	2.3.2	Delegation to officers	Correction of typographical error			
21	3	3	Committees	No amendments	*Part 3, Regulation 14		
22	n/a	3.2.2	Joint Committees	Information moved from 3.5 – Joint Committees established by the LHB to ensure better flow within document.			
22	3.5.2	3.2.3	Joint Committees	Previously para 3.5.2 – reference to EASC added	The Welsh Health Specialised Services Committee (Wales) Directions 2009 and The Emergency Ambulance Services Committee (Wales) Directions 2014	✓	
22	3.5.3	3.2.4	Joint Committees	Previously para 3.5.3	*Part 3, Regulation 15(5)	✓	

23	3.3	3.3	Sub-Committees	No amendments	*Part 3, Regulation 14(a), Regulation 15(4)	✓	
23	3.4	3.4	Committees	No amendments	*Part 3, Regulation 14(a), Regulation 15(4)	✓	✓
							regarding committees to be established as a minimum in 3.4.1
23	3.4.2	3.4.2	Committees	Deleted paragraph relating to structures to reduce duplication			
23	3.4.3	3.4.3	Committees	No amendments except correction of typographical error - each Committee must have SOs	*Schedule 3	✓	
23	3.4.3	3.4.3	Committees	Deleted paragraph relating to structures to reduce duplication			
24	3.4.6	3.4.6	Committees	'normally' removed after discussion with Board Secretaries to avoid confusion Paragraphs deleted in 3.4.2 and 3.4.3 added to this section			
Previously on page 22	3.5	n/a moved	Joint Committees	Section deleted and moved to 3.2 above			
24	3.6 - 3.8	3.5 - 3.7	Other Committees, Confidentiality & Reporting to the Board	Paragraphs renumbered			
24 - 25	2.0.4	4	Shared Services	Section moved to improve flow and some historical information removed.			
25	4	5	Advisory Groups	All subsequent paragraphs renumbered as NHS Wales Shared Services Partnership moved to section 4.			✓ - requirement for 3 Advisory Groups
25	4.0.1	5.0.1	Advisory Groups	Paragraph renumbered and 'organisations' added following comments from WAO	*Schedule 3, 4(2)		
25	4.0.2	5.0.2	Advisory Groups	Paragraph renumbered			

25	4.0.3	5.0.3	Advisory Groups	Paragraph renumbered. No amendments - refers to requirement to meet in public	*Schedule 3, 8(1)		
25 - 26	4.1	5.1	Advisory Groups	Paragraph renumbered and information common to all Advisory Groups amended to ensure consistency and brought together in one section to avoid duplication			
26	n/a	5.2.1	Advisory Groups	Advice and Feedback - as above.			
27	4.3	5.6	Stakeholder Reference Group	Section renumbered and main body of text moved to Schedule 5.1 with Terms of Reference			
28	4.10.1	5.8.1	Relationship between SRG and others	Paragraph renumbered and Local Service Boards replaced with Regional Partnership Boards			
29			Stakeholder Reference Group	Line added regarding need to refer to Schedule 5.1 for detailed Terms of Reference			
29	4.13	5.10	Healthcare Professionals Forum	Main body of text moved to Schedule 5.2 with Terms of Reference			
30	4.20.2	5.13.2	Healthcare Professionals Forum	Paragraph renumbered and cross reference amended from 6.5.7 to 7.5.7			
30			Healthcare Professionals Forum	Line added regarding need to refer to Schedule 5.2 for detailed Terms of Reference			
30	4.23	5.15	Local Partnership Forum	Main body of text moved to Schedule 5.3 with Terms of Reference			
31			Local Partnership Forum	Line added regarding need to refer to Schedule 5.3 for detailed Terms of Reference			
31	5.0.1	6.0.1	Working in Partnership	Paragraph renumbered and language modernised to compliment <i>A Healthier Wales</i> and changes in legislation re plans			



31	5.0.2	6.0.2	Working in Partnership	Paragraph renumbered and Local Service Boards replaced with Regional Partnership Boards			
31 - 32	n/a	6.0.3	Working in Partnership	New paragraph added to reflect the SSWB and WBFG requirements			
32	5.0.3	6.0.4	Working in Partnership	Paragraph renumbered due to additional paragraph being added			
32	5.1.1	6.1.1	Community Health Councils	Paragraph renumbered and amended to reflect updated legislation	Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010/Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010 Amended by Community Health Councils (Constitution, Membership and Procedures) (Wales) (Amendment) Regulations 2015	✓	
33	5.1.5	6.1.5	Community Health Councils	Paragraph renumbered - Board shall make arrangements to meet with CHC	Community Health Councils (Constitution, Membership and Procedure) (Wales) Regulations 2010, Regulation 30	✓	
33	6.1.1	7.1.1	Putting the Citizen First	Paragraph renumbered and wording amended in response to comments from WAO and new Welsh Language requirements	Section 44, Welsh Language (Wales) Measure 2011	✓	

34	6.2.4	7.2.4	Annual Plan of Board Business	Paragraph renumbered and amended to include need to publish on website. Original intention to remove need to publish at organisations offices but this is required by legislation so not permitted.	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4	✓	
34	6.2.5	7.2.5	Annual General Meeting	Section amended to include need to publish on website			
34	n/a	7.2.6	Annual General Meeting	Added paragraph re information which must be presented to AGM to ensure consistency with Manual for Accounts			
34	6.3	7.3	Calling Meetings	Paragraph renumbered - 7.3.2 specifies timescale for notice when calling a meeting which is applicable under some circumstances	*Schedule 3, 2(1)	✓	
35	6.4.3	7.4.3	Notifying and Equipping Board members	Paragraph renumbered and 'calendar' added to clarify number of days for advance publication of papers. Regulations specify 'clear' days but Board Secretaries preferred term 'calendar'	*Schedule 3, 2(3)	✓	
35	6.4.4	7.4.4	Notifying and Equipping Board members	Paragraph renumbered and amended to reflect need for additional impact assessments. Previously only referred to equality			
36	6.4.6	7.4.6	Notifying and Equipping Board members	Paragraph renumbered - Board members calling meetings	*Schedule 3, 2(5)	✓	
36	6.4.7	7.4.7	Notifying the public and others	Paragraph renumbered, ref to para 6.3 amended to 7.3 'calendar' added to clarify number of days for advance notice papers and ensure consistency with 7.4.3.	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4	✓	

36	6.5.1	7.5.1	Admission of the public, press and observers	Paragraph renumbered - Deleted reference to induction loop - there are a number of alternative means for improving accessibility and adding this reference does not reflect this	Public Bodies (Admission to meetings) Act 1960, Section 1	✓	
36	6.5.2	7.5.2	Admission of the public, press and observers	Paragraph renumbered and Committees added to reflect legislation  Note: Letter issued in November 2009 advising that Audit Committees should 'operate in private'	* Schedule 3, 8 & Public Bodies (Admission to meetings) Act 1960, Section 1	✓	
37	6.5.7	7.5.7	Addressing the Board	Paragraph renumbered and correction of typographical error			
38	6.5.10	7.5.10	Quorum	Paragraph renumbered	*Schedule 3, 6	✓	
40	6.5.24	7.5.24	Voting	Paragraph renumbered and 'organisations' added following comments from WAO	*Schedule 3, 4(2)	✓	
40	6.5.25	7.5.25	Voting	Paragraph renumbered - refers to majority voting	*Schedule 3, 4(1)	✓	
40	6.6	7.6	Record of Proceedings	Paragraph renumbered - Amendments to some sub-sections	*Schedule 3, 5 and 7	✓	
40	6.6.2	7.6.2	Record of Proceedings	Paragraph renumbered - Data Protection Legislation updated			
40 - 41	6.7.1	7.7.1	Confidentiality	Paragraph renumbered - LHB to add title of their local Standards of Behaviour Framework/Policy			
41	7.0.1	8.0.1	Values and Standards of Behaviour	Paragraph renumbered - LHB to add title of their local Standards of Behaviour Framework/Policy			
41	7.1.1	8.1.1	Declaration of Interests	Paragraph renumbered - LHB to add title of their local Standards of Behaviour Framework/Policy and reference to reporting to Chair and Board Secretary added to reflect practice			

43	7.2.8	8.2.8	Members with pecuniary (financial) interests	Paragraph renumbered	*Regulation 17	✓	
44	7.5	8.5	Dealing with offers of gifts, hospitality and sponsorship	Paragraph renumbered and extended to include reference to sponsorship following discussions with Board Secretaries Network			
44	7.5.1	8.5.1	Dealing with offers of gifts, hospitality and sponsorship	Paragraph renumbered - LHB to add title of their local Standards of Behaviour Framework/Policy and requirement for Board to 'approve' rather than 'adopt'			
44	7.5.3	8.5.3	Dealing with offers of gifts and hospitality	Paragraph renumbered and reference to sport removed as specifically prohibited in LHB policies			
45	n/a	8.6	Sponsorship	New section added			
45 - 46	7.6, 7.6.1 and 7.6.2	8.7, 8.7.1 and 8.7.2	Register of Gifts, Hospitality and Sponsorship	Paragraphs renumbered and reference to sponsorship added			
46	7.6.3	8.7.3	Register of Gifts and Hospitality	Paragraph renumbered and wording added to ensure clear paragraph refers gifts and hospitality only. Cross reference to 7.5.3 amended to 8.5.3			
46	7.6.5	8.7.5	Register of Gifts and Hospitality	Paragraph renumbered and wording added to refer to sponsorship			
46	8.0.1	9.0.1	Signing and Sealing of Documents	Paragraph renumbered and reference to Committees removed as they do not have authority to seal documents	Schedule 3, Part 4, Para 33 of NHS (Wales) Act 2006 re Trusts. Does not appear to be a corresponding requirement for LHBs	✓	
47	8.0.2	9.0.2	Signing and Sealing of Documents	Paragraph renumbered	Schedule 3, Part 4, Para 33(1) of NHS (Wales) Act 2006 re Trusts	Reflects requirement for Trusts	

47	8.2.1	9.2.1	Signature of documents	Paragraph renumbered and removed word 'normally' after discussions with Board Secretaries Network			
47	9.0.3	10.0.3	Gaining Assurance on Conduct of LHB Business	Paragraph renumbered and reference to Shared Services amended with correct title of NWSSP			
48	n/a	10.0.4 and 10.0.5	Gaining Assurance on Conduct of LHB Business	Paragraphs added to strengthen need to gain assurance from EASC and WHSSC			
48	9.2.3	10.2.3	Reviewing the performance of the Board, its Committees and Advisory Groups	Paragraph renumbered and title of Welsh Government updated			
49	9.3.1	10.3.1	External Assurance	Paragraph renumbered and amended to provide correct terminology for Audit General for Wales			
49	9.3.3	10.3.3	External Assurance	Paragraph renumbered and amended to reflect correct title of Public Accounts Committee			
49	9.3.4	10.3.4	External Assurance	Paragraph renumbered and reference to legislation removed on advice of WAO			
50	11.0.1	12.0.1	Review of Standing Orders	Paragraph renumbered and reference to equality removed to reflect widening of impact assessments			
50	11.0.2	12.0.2	Review of Standing Orders	As above			
55			Individuals to who powers have been delegated	Paragraph 3 - 'normally' removed after discussions with Board Secretaries Network			
57	5	5	Schedule of Matters Reserved for the Board	LHB to add title of their local Standards of Behaviour Framework/Policy			

58	16	16	Schedule of Matters Reserved for the Board	Amended to say Board 'approves' appointment of Chief Executive in accordance with regulations	*Part 2, Regulation 4(2) and 4(6) (must have regard to guidance issued by WG)	✓	
64			Schedule 2	Reference to SFIs forming Schedule 2.1 added together with page for addition of SFIs			
64			NHS Framework	Amended to reflect re-introduction of Welsh Health Circulars in 2014			
67	Schedule 4	Schedule 4	Terms of Reference Joint Committees	Reference added to Schedule 4.1 - WHSSC and Schedule 4.2 - EASC			
68 - 89	Schedule 5	Schedule 5	Advisory Groups	Text added from main SOs to strengthen Terms of Reference and avoid duplication			✓ - requirement for 3 Advisory Groups
69 - 75	n/a	Schedule 5.1	Stakeholder Reference Group	See above			
76 - 81	n/a	Schedule 5.2	Health Professionals' Forum	See above			
82 - 89	n/a	Schedule 5.3	Local Partnership Forum	See above and Model Terms of Reference for Local Partnership Forum incorporated			

**Review of NHS Wales Trust Model Standing Orders – September 2019**  
**Table of Amendments, Cross Reference to Legislation and Confirmation of Sections which are not for variation by NHS Body**

Page Number	Previous Paragraph Reference	New Paragraph Reference	Section Heading	Reason for Amendment (if applicable)	Cross reference to legislation - Velindre NHS Trust	Cross reference to legislation - Welsh Ambulance Service NHS Trust	Cross reference to legislation - Public Health Wales NHS Trust	Requirement of legislation – local amendment not permissible	Issued under Direction – local amendment not permissible
2	1	1	Forward	Reference added to ability of Ministers to issue Directions and to ensure consistency with wording of LHB SOs					
2 onwards		2 onwards	Forward	Various amendments to ensure legislation references and citations are correct.					
2	2	2	Forward	Trust to add title of their local Standards of Behaviour Framework/Policy	n/a				
7	<b>Section A</b>								
7	i)	i)	Statutory Framework	Trusts to select appropriate paragraph	Velindre National Health Service Trust (Establishment) Order 1993	Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998	The Public Health Wales National Health Service Trust (Establishment) Order 2009		
7	iv)	iv)	Statutory Framework	Legislation citation amended	NHS Act 2006 and NHS (Wales) Act 2006	NHS Act 2006 and NHS (Wales) Act 2006	NHS Act 2006 and NHS (Wales) Act 2006		
8	v)	v)	Statutory Framework	Minor amendments and Trusts to select appropriate paragraph	The National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended	The National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended	The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009 as amended		
8	vi)	vi)	Statutory Framework	Some words amended	Sections 18 & 19 & Schedule 3 of the NHS (Wales) Act 2006	Sections 18 & 19 & Schedule 3 of the NHS (Wales) Act 2006	Sections 18 & 19 & Schedule 3 of the NHS (Wales) Act 2006		
8	n/a	vii)	Statutory Framework	New paragraph added referencing the Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015		
8	vii)	viii)	Statutory Framework	Paragraph re numbered due to above insertion. No amendments to paragraph	n/a	n/a	n/a		
8	viii)	ix)	Statutory Framework	Paragraph renumbered due to addition of vii). No amendments to paragraph	n/a	n/a	n/a		

8	n/a	x)	Statutory Framework	New paragraph added introducing the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC)	The Welsh Health Specialised Services Committee (Wales) Directions 2009 & The Emergency Ambulance Services Committee (Wales) Directions 2014	The Welsh Health Specialised Services Committee (Wales) Directions 2009 & The Emergency Ambulance Services Committee (Wales) Directions 2014	The Welsh Health Specialised Services Committee (Wales) Directions 2009 & The Emergency Ambulance Services Committee (Wales) Directions 2014		
8	n/a	xi)	Statutory Framework	New paragraph added referring to establishment of WHSSC.	The Welsh Health Specialised Services Committee (Wales) Directions 2009	The Welsh Health Specialised Services Committee (Wales) Directions 2009	The Welsh Health Specialised Services Committee (Wales) Directions 2009		
9	n/a	xii)	Statutory Framework	New paragraph added referring to establishment of EASC.	The Emergency Ambulance Services Committee (Wales) Directions 2014	The Emergency Ambulance Services Committee (Wales) Directions 2014	The Emergency Ambulance Services Committee (Wales) Directions 2014		
9	n/a	xiii)	Statutory Framework	New paragraph added referring to the required for Velindre to establish a Shared Services Committee	The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012	The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012	The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012		
previously page 8	ix) Deleted	n/a	Statutory Framework	Paragraph deleted as repetition of information contained in iii) and iv)					
9	x)	xiv)	Statutory Framework	Amendment to better reflect legal position with regard to the 2000 Regulations which predate the power in the 2006 Act but the NHS (Consequential Provisions) Act 2006 provides for the continuity of the law as if made under the NHSWA 2006	National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000/NHS (Wales) Act 2006				
9	xi)	xv)	Statutory Framework	Sentence added by legal services to recognise this also includes working with English bodies.	NHS Act 2006, Section 72				
10	xiii)	xvii)	Statutory Framework	Paragraph renumbered and amended to reflect new Welsh Language legislation	The Welsh Language Standards (No.7) Regulations 2018				
Previously page 9	xvi)	1.4.4 (page 21)	Statutory Framework	Paragraph relating to indemnity moved to new para 1.4.4 under Responsibilities of Board Members					
10	xvii)	xx)	NHS Framework	Paragraph renumbered and amendment to reflect current name of Welsh Government and to improve grammar					
10	xix)	xxii)	NHS Framework	Paragraph renumbered and link to Governance eManual inserted to ensure clarity re what is meant by the NHS Wales Values and Standards of Behaviour Framework					



11	xx)	xxiii)	NHS Framework	Paragraph renumbered and amended and reference added to the Well-being of Future Generations Act (WBFGA)	Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015		
11	n/a	xxiv)	NHS Framework	New paragraph to reflect status of individual organisations as "public bodies" under the Act.	Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015		
11	xxi)	xxv)	NHS Framework	Paragraph renumbered and amended to reflect change from Ministerial Letters to Welsh Health Circulars in 2014					
11	xxii)	xxv)	NHS Trust Framework	Paragraph renumbered and reference added to SFI's forming part of SOs and Schedule 2.1					
12	xxiv)	xxvii)	NHS Trust Framework	Paragraph renumbered and reference to para relating to role of Board Secretary updated to xxxv)					
12	xxvi)	xxix)	Applying Standing Orders	Paragraph renumbered and Trust to add title of their local Standards of Behaviour Framework/Policy.					
12	n/a	xxxi)	Applying Standing Orders	Final paragraph regarding failure to comply with standing orders separated from previous paragraph to give emphasis.					
13	xxvii)	xxxv)	The role of the Board Secretary	Additional sentence added to improve grammar					
13	xxvii)	xxxv)	The role of the Board Secretary	Paragraph amended to reflect provisions within Model Role Profile issued in 2009					
15	<b>Section B : Standing Orders</b>								
15	1.0.1	1.0.1	The Trust	Velindre - additional paragraph to reflect addition of Wales Infected Blood Support Scheme [article 3(2)(f) amendment]	Velindre NHS Trust (Establishment) Amendment Order 1999, Article 3 (2)(a) & (b), amended 2002 and Article 3(2) ( c ) added, amended 2012, and Article 3(2)(d) & ( e ) added, amended 2017 and Article 3(2)(f) added			✓	
15	1.0.1	1.0.1	The Trust	WAST - additional paragraphs to reflect status as National Contact Point under EU legislation and access to information and triage services.		WAST (Establishment) Order 1998 (as amended)		✓	
16	1.0.1	1.0.1	The Trust	PHW - no amendments			Public Health Wales (Establishment Order) 2009	✓	
17	1.0.2	1.0.2	The Trust	Minor amendments to reflect citation of legislation	Velindre NHS Trust (Establishment) Amendment Order 1999 (as amended)	WAST (Establishment) Order 1998 (as amended)	Public Health Wales (Establishment Order) 2009	✓	

17	1.1.1	1.1.1	Membership of the Trust	No amendments	The National Health Service Trusts (Membership and Procedure) Regulations 1990, amended Velindre National Health Service Trust (Establishment) Order 1993, Amendment Order 2002, Amendment (No. 2) Order 2002 and Amendment) Order 2018	The National Health Service Trusts (Membership and Procedure) Regulations 1990, amended by Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998 and (Amendment) Order 2009	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, as amended in 2011 and 2016	✓	
17	1.1.3	1.1.3	Membership of the Trust	Amendment to reflect arrangements for appointment of all non-officer members only.	NHS Trust (Membership and Procedure) Regulations 1990, Reg 3(2)	NHS Trust (Membership and Procedure) Regulations 1990, Reg 3(2)	PHW Public Health Wales Membership Regs 2009, Regulation 3(1)	✓	
18	n/a	1.1.4	Membership of the Trust	New paragraph to confirm appointment arrangements for Chief Executive	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 3(2) and 17	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 3(2) and 17	PHW Public Health Wales Membership Regs 2009, Regulation 3(1) and 21	✓	
18	n/a	1.1.5	Membership of the Trust	New paragraph to confirm appointment arrangements for Executive Directors	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 3(2) and 18	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 3(2) and 18	PHW Public Health Wales Membership Regs 2009, Regulation 3(1) and 22	✓	
18	1.1.4	1.1.6	Membership of the Trust	<i>Executive Directors</i> - Paragraph renumbered and minor amendments to improve grammar	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 4(1)	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 4(1)	PHW Public Health Wales Membership Regs 2009, Regulation 4	✓	
18	1.1.5	1.1.7	Membership of the Trust	<i>Non-Executive Directors (to be known as Independent Members)</i> - Paragraph renumbered and amendments to reflect changes numbers or designation of Non-Executive Directors	Velindre NHS Trust (Establishment) Order, Article 4, as amended in 2002 and 2018	Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998, Article 4, as amended in 2009	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, as amended in 2011 and 2016	✓	

19	1.1.6	1.1.8	Membership of the Trust	Use of Term Independent Member - paragraph renumbered and correction of minor typographical correction					
19	1.2	1.2	Joint Directors	No amendments	The National Health Service Trusts (Membership and Procedure) Regulations 1990, Part 2 Regulation 6	The National Health Service Trusts (Membership and Procedure) Regulations 1990, Part 2 Regulation 6	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Part 2, Regulation 7	✓	
19	1.3	1.3	Tenure of Board Members	Amendments to sections as specified below, otherwise no change.	See below			✓	
19	1.3.1	1.3.1	Tenure of Board Members	Public Health Wales - Amendment to make clearer that time served relates to positions held on the Board even if these are different positions. <b>Note:</b> Limitation of 8 years does not apply under the NHS (Membership and Procedure Regulations 1990, therefore no limitation for Velindre and WAST	The National Health Service Trusts (Membership and Procedure) Regulations 1990, Part 2 Regulation 6	The National Health Service Trusts (Membership and Procedure) Regulations 1990, Part 2 Regulation 6	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Part 2, Regulation 8(1) and 14(3)	✓	
20	1.3.2	1.3.2	Tenure of Board Members	No amendments	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 7(2)	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 7(2)	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Part 2, Regulation 8(2)	✓	
20	1.3.3	1.3.3	Tenure of Board Members	Reference to Regulations deleted as these are only specific to Non-Executive Directors					
21	n/a	1.4.4	Responsibilities of Board Members	Paragraph moved from page 9, xvi) (see above)					
21	1.4.3-1.4.8	1.4.5-1.4.10	Responsibilities of Board Members	Paragraphs renumbered due to above insertion.					
22	2.0.3	2.0.3	Reservation and Delegation of Trust Functions	Paragraph re-worded to reflect responsibilities when working with other Trusts and Local Health boards					
Previously page 22	2.0.4	4	NHS Wales Shared Services	Information updated, deleted from this section and moved to Section 4, page 26.					
23	2.2.1	2.2.1	Delegation of Board functions	'shall' replaced with 'may' as 'shall' implies that the board must delegate.					
				Sentence added to re-enforce that some functions cannot be delegated as issued under direction					
23	2.2.2	2.2.2	Delegation of Board functions	'shall' replaced with 'may' as 'shall' implies that the board must delegate.					

24	2.3.1	2.3.1	Delegation to officers	'will' replaced with 'may' as 'will' implies that the board must delegate.					
24	2.3.2	2.3.2	Delegation to officers	Correction of typographical error					
24	3	3	Committees		NHS Trust (Membership and Procedure) Regulations 1990, Part 3, Regulation 15	NHS Trust (Membership and Procedure) Regulations 1990, Part 3, Regulation 15	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Part 3, Regulation 19	✓	
25	3.4.1	3.3.1	Committees	Paragraph renumbered and inserted [as appropriate] after Charitable Funds Committee as PHW do not have a charity					
25	3.4.2	3.3.2	Committees	Paragraph renumbered and sub-paragraph deleted to avoid duplication.					
25	3.4.3	3.3.3	Committees	Paragraph renumbered and sentence deleted to avoid duplication.					
25 - 26	3.4.4 & 3.4.5	3.3.4 & 3.3.5	Committees	Paragraphs renumbered					
26	3.4.6	3.3.6	Committees	Paragraph renumbered and 'normally' removed after discussion with Board Secretaries to avoid confusion Paragraphs deleted in 3.4.2 and 3.4.3 added to this section					
26	3.6.1	3.4.1	Other Committees	Paragraph renumbered					
26	3.7.1	3.5.1	Confidentiality	Paragraph renumbered					
26	3.8.1	3.6.1	Reporting activity to the Board	Paragraph renumbered					
26 - 27	2.0.4	4	Shared Services	Section moved from earlier in SOs to improve flow					
27	4	5	Advisory Groups	All subsequent paragraphs renumbered as NHS Wales Shared Services Partnership moved to section 4.					✓ - requirement for Local Partnership Forum
27	4.1.1	5.1.1	Advisory Groups	Paragraph renumbered and 'Local Partnership Forum added as the only Advisory Group relevant to Trusts					
28 - 30	4.2 - 4.12	5.2 - 5.8.3	Terms of Reference and Operating Arrangements	Section amended to avoid duplication with Terms of Reference and to ensure consistency with flow of LHB SOs					
30	4.12.4	5.8.4	Advisory Groups	Paragraph renumbered and correction of typographical error - LPG to LPF					
30	n/a	5.8.5	Local Partnership Forum	Line added regarding need to refer to Schedule 4 for detailed Terms of Reference					

30	5.0.1	6.0.1	Working in Partnership	Paragraph renumbered and language modernised to compliment <i>A Healthier Wales</i> and changes in legislation re plans					
30	5.0.2	6.0.2	Working in Partnership	Paragraph renumbered and Local Service Boards replaced with Regional Partnership Boards					
31	n/a	6.0.3	Working in Partnership	New paragraph added to reflect the SSWB and WBFG requirements					
31	5.1.1	6.1.1	Community Health Councils	Paragraph renumbered and amended to reflect updated legislation	Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010/Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010 Amended by Community Health Councils (Constitution, Membership and Procedures) (Wales) (Amendment) Regulations 2015			✓	
32	5.1.5	6.1.5	Community Health Councils	Paragraph renumbered No amendment - Board shall make arrangements to meet with CHC <b>Note</b> - Trusts are not under a requirement to meet under Regulation 30 - this applies to LHBs only.				✓	
32	6.1.1	7.1.1	Putting the Citizen First	Paragraph renumbered and wording amended in response to comments from WAO and new Welsh Language requirements	Section 44, Welsh Language (Wales) Measure 2011			✓	
33	6.2.4	7.2.4	Annual Plan of Board Business	Paragraph renumbered and amended to say that plan should be published on internet and not as part of SOs					
33	6.2.5	7.2.5	Annual General Meeting	Paragraph renumbered and amended to include need to publish on website. Original intention to remove need to publish at organisations offices but this is required by legislation so not permitted.	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4	✓			
33	n/a	7.2.6	Annual General Meeting	Added paragraph re information which must be presented to AGM to ensure consistency with Manual for Accounts					

34	n/a	7.2.7	Annual General Meeting	New paragraph added re submitting record of meeting to next ordinary meeting of Board to ensure consistency with LHB SOs					
34	6.3	7.3	Calling Meetings	Paragraph renumbered - 7.3.2 specifies timescale for notice when calling a meeting which is applicable under some circumstances	NHS Trust (Membership and Procedure) Regulations 1990, Schedule	NHS Trust (Membership and Procedure) Regulations 1990, Schedule	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Schedule 2, 2(1)	✓	
34	6.4.3	7.4.3	Notifying and Equipping Board members	Paragraph renumbered and 'calendar' added to clarify number of days for advance publication of papers. Regulations specify 'clear' days but Board Secretaries preferred term 'calendar' <b>Note</b> - Trust Regs state 3 days, PHW Regs state 10 days	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 2(3)	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 2(3)	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Schedule 2, 2(3)	✓	
35	6.4.4	7.4.4	Notifying and Equipping Board members	Paragraph renumbered and amended to reflect need for additional impact assessments. Previously only referred to equality					
35	6.4.6	7.4.6	Notifying and Equipping Board members	Paragraph renumbered - Paragraph relates to Board members calling meetings	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 2(5)	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 2(5)	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Schedule 2, 2(5)	✓	
35	6.4.7	7.4.7	Notifying the public and others	Paragraph renumbered and 'calendar' added to clarify number of days for advance notice papers and ensure consistency with 6.4.3.	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4	✓	
35	6.5.1	7.5.1	Admission of the public, press and observers	Paragraph renumbered and deleted reference to induction loop - there are a number of alternative means for improving accessibility and adding this reference does not reflect this					
36	6.5.2	7.5.2	Admission of the public, press and observers	Paragraph renumbered and committees added to reflect legislation  <b>Note:</b> Letter issued in November 2009 advising that Audit Committees should 'operate in private'	Public Bodies (Admission to meetings) Act 1960, Section 1	Public Bodies (Admission to meetings) Act 1960, Section 1	Public Bodies (Admission to meetings) Act 1960, Section 1	✓	

37	6.5.10	7.5.10	Quorum	Paragraph renumbered	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 3(5)	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 3(5)	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Schedule 2, 3(5)	✓	
39	6.5.24	7.5.24	Voting	Paragraph renumbered and 'organisations' added following comments from WAO <b>Note:</b> Legislation does not require Trusts to take account of views					
40	6.5.25	7.5.25	Voting	Paragraph renumbered. Paragraph refers to majority voting	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 3(3)	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 3(3)	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Schedule 2, 3(3)	✓	
40	6.6	7.6	Record of Proceedings	Paragraph renumbered and some amendments to some sub-sections	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 3(4) and 3(6)	NHS Trust (Membership and Procedure) Regulations 1990, Schedule, 3(4) and 3(6)	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Schedule 2, 3(4) and 3(6)		
40	6.6.2	7.6.2	Record of Proceedings	Paragraph renumbered and Data Protection Legislation updated					
40	6.7.1	7.7.1	Confidentiality	Paragraph renumbered. Trust to add title of their local Standards of Behaviour Framework/Policy					
40	7.0.1	8.0.1	Values and Standards of Behaviour	Paragraph renumbered. Trust to add title of their local Standards of Behaviour Framework/Policy					
41	7.1.1	8.1.1	Declaration of Interests	Paragraph renumbered and Trust to add title of their local Standards of Behaviour Framework/Policy and reference to reporting to Chair and Board Secretary added to reflect practice					
43	7.2.8	8.2.8	Members with pecuniary (financial) interests	Paragraph renumbered	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 20	NHS Trust (Membership and Procedure) Regulations 1990, Regulation 20	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Regulation 24	✓	
44	7.5	8.5	Dealing with offers of gifts, hospitality and sponsorship	Paragraph renumbered and extended to include reference to sponsorship following discussions with Board Secretaries Network					
44	7.5.1	8.5.1	Dealing with offers of gifts, hospitality and sponsorship	Trust to add title of their local Standards of Behaviour Framework/Policy and requirement for Board to 'approve' rather than 'adopt'					

44	7.5.3	8.5.3	Dealing with offers of gifts and hospitality	Paragraph renumbered and re Frequency - Additional paragraph added to ensure consistency with LHB SOs					
45	n/a	8.6	Sponsorship	New section added					
45	7.6, 7.6.1 and 7.6.2	8.7, 8.7.1 and 8.7.2	Register of Gifts, Hospitality and Sponsorship	Paragraphs renumbered and reference to sponsorship added					
46	7.6.3	8.7.3	Register of Gifts and Hospitality	Paragraph renumbered and wording added to ensure clear paragraph refers gifts and hospitality only and cross reference updated from 7.5.3 to 8.5.3					
46	7.6.5	8.7.5	Register of Gifts and Hospitality	Paragraph renumbered and wording added to refer to Sponsorship					
46	8.0.1	9.0.1	Signing and Sealing of Documents	Paragraph renumbered and reference to Committees removed as they do not have authority to seal documents	Schedule 3, Part 4, Para 33 of NHS (Wales) Act 2006 re Trusts. Does not appear to be a corresponding requirement for LHBs			✓	
47	8.0.2	9.0.2	Signing and Sealing of Documents	Paragraph renumbered	Schedule 3, Part 4, Para 33(1) of NHS (Wales) Act 2006 re Trusts			✓	
47	8.2.1	9.2.1	Signature of documents	Paragraph renumbered and removed word 'normally' after discussions with Board Secretaries Network					
47	9.0.3	10.0.3	Gaining Assurance on Conduct of Trust Business	Paragraph renumbered and reference to Shared Services amended with correct title of NWSSP					
48	n/a	10.0.4	Gaining Assurance on Conduct of Trust Business	Paragraph added to reference arrangements with WHSSC and EASC as an attendee					
48	n/a	10.0.5	Gaining Assurance on Conduct of Trust Business	Paragraphs added to strengthen need to gain assurance when services delivered by others on behalf of the Trust					
49	9.2.3	10.2.3	Reviewing the performance of the Board, its Committees and Advisory Groups	Paragraph renumbered and title of Welsh Government updated					
49	9.3.1	10.3.1	External Assurance	Paragraph renumbered and amended to provide correct terminology for Audit General for Wales					



49	9.3.3	10.3.3	External Assurance	Paragraph renumbered and amended to reflect correct title of Public Accounts Committee					
49	9.3.4	10.3.4	External Assurance	Paragraph renumbered and reference to legislation removed on advice of WAO					
50	11.0.1	12.0.1	Review of Standing Orders	Paragraph renumbered and reference to equality removed to reflect widening of impact assessments					
50	11.0.2	12.0.2	Review of Standing Orders	As above					
55			Individuals to who powers have been delegated	'normally' removed after discussions with Board Secretaries Network					
57		5	Schedule of Matters Reserved for the Board	LHB to add title of their local Standards of Behaviour Framework/Policy					
58		17	Schedule of Matters Reserved for the Board	Amended to say Board will 'ratify' appointment etc. of Executive Directors in accordance with regulations	NHS Trust (Membership and Procedure)Regulations 1990, Regulation 3(3)	NHS Trust (Membership and Procedure)Regulations 1990, Regulation 3(3)	The Public Health Wales NHS Trust (Membership and Procedure) Regulations 2009, Regulation 3(2)	✓	
64			NHS Framework	Amended to reflect re-introduction of Welsh Health Circulars in 2014					
64			Schedule 2	Reference to SFIs forming Schedule 2.1 added together with page for addition of SFIs					
67 - 75		Schedule 4	Advisory Groups	Text added from main SOs and Model Terms of Reference to strengthen Terms of Reference and avoid duplication					✓ - requirement for Local Partnership Forum

**Review of Welsh Health Specialised Services Standing Orders, Schedule 4.1, Local Health Board Model Standing Orders – September 2019**  
**Table of Amendments, Cross Reference to Legislation and Confirmation of Sections which are not for variation by NHS Body**

Page Number	Previous Paragraph Reference	New Paragraph Reference	Section Heading	Reason for Amendment (if applicable)	Cross reference to legislation	Requirement of legislation – local amendment not permissible	Issued under Direction – local amendment not permissible
2	1	1	Forward	Paragraph added to reflect need to make SOs in accordance with Directions issued by Ministers - to ensure consistency with LHB/Trust SOs Change to legal citation to ensure consistent style across SOs Correction of typographical error  Note: When making SOs must also be regard to legislation	WHSSC (Wales) Regulations, Part 3, Regulation 12 and The LHB (Constitution, Membership and Procedures) Regulations, Regulation 14(b) and 15(5)	✓	
2	2	2	Forward	Name of host body changed throughout to Cwm Taf Morgannwg University Local Health Board (CTMUHB)			
7	<b>Section A - Introduction</b>						
7	i)	i)	Statutory Framework	Amendment made to reflect the establishment of Emergency Ambulance Services Committee which led to amendment of the WHSSC Directions	Welsh Health Specialised Services Committee (Wales) (Amendment) Directions 2014	✓	
7	iv) & v)	iv) & v)	Statutory Framework	Amendment to ensure consistency of legal citation	NHS (Wales) Act 2006, para 4 of Schedule 2	✓	
8	viii)	viii)	Statutory Framework	As above			
8	xi)	xi)	NHS Framework	Amendment to reflect current name of Welsh Government and to improve grammar			

8	xiv)	xiv)	NHS Framework	Paragraph amended and reference added to the Well-being of Future Generations Act (WBFGA) Removed reference to "restructured" NHS	Well-being of Future Generations (Wales) Act 2015	✓	
9	n/a	xv)	NHS Framework	New paragraph to reflect the need to meet the requirements of the WBFGA	Well-being of Future Generations (Wales) Act 2015	✓	
9	xv)	xvi)	NHS Framework	Paragraph renumbered due to above insertion and amended to reflect change from Ministerial Letters to Welsh Health Circulars in 2014			
9 to 11	xvi) to xxv)	xvii) to xxv)	Joint Committee Framework	Paragraphs renumbered following addition of new paragraph above.			
11	xxv)	xxvi)	Role of Committee Secretary	Italics removed for the 'Committee Secretary' as this does not require emphasis.			
12	Section B : WHSSC Standing Orders						
12	1.1	1.1	Purpose and Delegated Functions	Refer to legislation before making amendments	The WHSSC (Wales) Directions 2009 and The WHSSC (Wales) Regulations 2009	✓	
12	n/a	1.1.3	Purpose and Delegated Functions	Added new paragraph to ensure LHBs ensure Chief Executive is equipped to represent the views of the Board and has the relevant delegated authority			
13	1.1.4	1.1.5	Purpose and Delegated Functions	Paragraph renumbered and amendment following issuing of Ministerial Direction re no-longer a requirement to ensure unanimous decision for funding decisions			✓ MA-P /VG/3794/18 - 121118
13	1.1.5 & 1.1.6	1.1.6 & 1.1.7	Purpose and Delegated Functions	Paragraphs renumbered due to above insertion.			

13	1.2	1.2	Membership of Joint Committee	Refer to legislation before making amendments	The WHSSC (Wales) Directions 2009, 5.1 and The WHSSC (Wales) Regulations 2009, Part 2	✓	
13	1.2.1	1.2.1	Membership of Joint Committee	Refer to legislation before making amendments	The WHSSC (Wales) Regulations 2009 Regulation 4(1) & 4(2)	✓	
13	1.2.2	1.2.2	Membership of Joint Committee	<i>Non Officer Members [to be known as Independent Members]</i> - No amendments, refer to legislation before making amendments	The WHSSC (Wales) Regulations 2009 Regulation 4(3)	✓	
13	1.2.3	1.2.3	Membership of Joint Committee	<i>Chief Executives</i> - No amendments, refer to legislation before making amendments	The WHSSC (Wales) Regulations 2009 Regulation 3(1)	✓	
14	1.2.4 & 1.2.5	1.2.4 & 1.2.5	Membership of Joint Committee	<i>Officer Members</i> - No amendments, refer to legislation before making amendments	The WHSSC (Wales) Regulations 2009 Regulation 3(1)(d) & 3(2)	✓	
14	1.2.6	1.2.6	Membership of Joint Committee	<i>Associate Members</i> - No amendments, refer to legislation before making amendments	The WHSSC (Wales) Regulations 2009 Regulation 3(3)	✓	
14	1.2.7	1.2.7	Membership of Joint Committee	<i>In Attendance</i> - correction of typographical error			
14	1.2.8	1.2.8	Membership of Joint Committee	<i>Use of term independent member</i> - correction of typographical error			
15 - 16	1.3.7 & 1.3.8	1.3.7 & 1.3.8	Membership responsibilities and accountabilities	<i>Vice-Chair</i> - correction of typographical error	The WHSSC (Wales) Regulations 2009 Regulation 13	✓	
16	1.3.9	1.3.9	Membership responsibilities and accountabilities	<i>Non-Officer Members</i> - correction of typographical error			

16	1.3.11	1.3.11	Membership responsibilities and accountabilities	Correction of typographical error			
16	1.4.1	1.4.1	Appointment and Tenure of Joint Committee Members	<u>Chair</u> - No amendments	The WHSSC (Wales) Regulations 2009 Regulation 6	✓	
16	1.4.2	1.4.2	Appointment and Tenure of Joint Committee Members	<u>Vice Chair and Independent Members</u> - No amendments	The WHSSC (Wales) Regulations 2009 Regulation 7	✓	
17	1.4.4	1.4.4	Appointment and Tenure of Joint Committee Members	<u>WHSST Directors</u> - no amendments	The WHSSC (Wales) Regulations 2009 Regulation 4 (3)	✓	
17	1.4.5	1.4.5	Appointment and Tenure of Joint Committee Members	Correction of typographical error			
17	1.4.6	1.4.6	Tenure of Board Members	Refer to legislation before making amendments	The WHSSC (Wales) Regulations 2009, Regulations 6, 7, 8 & 11	✓	
17	2	2	Responsibilities and Relationships with each LHB Board and the Host LHB and Others	Refer to legislation before making amendments	The WHSSC (Wales) Directions 2009, 3		
17	2.0.1	2.0.1	Responsibilities and Relationships with each LHB Board and the Host LHB and Others	Amendment to reflect current name of Welsh Government and to improve grammar			
21	4.1 - 3.6.1	4.1, 4.1.1	Joint Sub-Committees	Numbering amended to correct previous error			
21	4.2.2	4.2.2	Joint Sub-Committees	Amended from 3 months to 6 weeks to ensure consistency with para 8.2.2			

22	5.1.2	5.1.2	Reporting Activity	Amended from 1 month to 6 weeks to ensure consistency with paras 4.2.2 and 8.2.2			
23	6.1.1	6.1.1	Putting the Citizen First	Wording amended in response to comments from WAO and new Welsh Language requirements	Section 44, Welsh Language (Wales) Measure 2011	✓	
23	6.2.1	6.2.1	Working with Community Health Councils	Amended as the responsibility rests with the LHB and not the Joint Committee – CHC members are not invited to attend Joint Committee meetings			
24	6.3.4	6.3.4	Annual Plan of Committee Business	Amended to say that plan should be published on internet and not as part of SOs			
24	6.5.3	6.5.3	Notifying and Equipping Board members	'calendar' added to clarify number of days for advance publication of papers. Regulations specify 'clear' days but Board Secretaries preferred term 'calendar'	The LHB (Constitution, Membership and Procedures) Regulations 2009, Schedule 3, 2(3)	✓	
25	6.5.4	6.5.4	Notifying and Equipping Board members	Paragraph amended to reflect need for additional impact assessments. Previously only referred to equality		✓	
25	6.5.7	6.5.7	Notifying the public and others	'calendar' added to clarify number of days for advance notice papers and ensure consistency with 6.5.3. Requirements of SO and not Regulations	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4		
26	6.6.1	6.6.1	Admission of the public, press and observers	Deleted reference to induction loop - there are a number of alternative means for improving accessibility and adding this reference does not reflect this			
26	6.6.2	6.6.2	Admission of the public, press and observers	Paragraph centred	The LHB (Constitution, Membership and Procedures) Regulations 2009, Schedule 3, 8	✓	

27	6.6.8	6.6.8	Conducting Joint Committee Meetings	Correction of typographical errors			
27	6.6.11	6.6.11	Quorum	Amendment following issuing of Ministerial Direction re ability of Chief Executive to nominate a deputy to represent them and vote on their behalf. To contribute towards quorum and exercise vote the deputy must be an Executive Director.			✓ MA-P /VG/3794/18 - 121118
28	6.6.11	6.6.12	Quorum	Due to above revision necessary to split paragraph to reflect different arrangements for Officers of WHSST			✓ MA-P /VG/3794/18 - 121118
28	6.6.12	6.6.13	Quorum	Amendment to reflect above revised arrangements and paragraph renumbered			✓ MA-P /VG/3794/18 - 121118
28 - 29	6.6.13-6.6.16	6.6.14-6.6.17	Dealing with Motions	Amendments to paragraph numbering			
29	6.6.17	6.6.18	Dealing with Motions	Correction of typographical errors			
29	6.6.18-6.6.22	6.6.19-6.6.23	Dealing with Motions	Amendments to paragraph numbering			
29	6.6.23	6.6.24	Voting	Correction of typographical errors			
30	6.6.24	6.6.25	Voting	organisations' added following comments from WAO and to ensure consistency with LHB SOs Reference to CHC representatives removed as responsibility rests with the LHB and not the Joint Committee – CHC members are also not invited			
30	6.6.25 & 6.6.26	6.6.26 & 6.6.27	Voting	Amendments to reflect above revised arrangements and paragraph renumbered			✓ MA-P /VG/3794/18 - 121118

30	6.7	6.7	Record of Proceedings	No amendments	The LHB (Constitution, Membership and Procedures) Regulations 2009, Schedule 3, 5 & 7	✓	
31	6.8.1	6.8.1	Confidentiality	WHSSC to add title of their local Standards of Behaviour Framework/Policy			
32	7.1.5	7.1.5	Register of Interests	Amended to say the register 'may' be published to ensure consistency with LHB and Trust SOs			
33	7.2.3	7.2.3	Dealing with members interests during Joint Committee meetings	Correction to ensure correct terminology for Welsh Ministers			
34	7.2.8	7.2.8	Dealing with members interests during Joint Committee meetings	Full title of regulations added for clarity	The LHB (Constitution, Membership and Procedures) Regulations 2009, Part 3, Regulation 17	✓	
34	7.5	7.5	Dealing with offers of gifts, hospitality and sponsorship	Extended to include reference to sponsorship following discussions with Board Secretaries Network			
34	7.5.1	7.5.1	Dealing with offers of gifts, hospitality and sponsorship	WHSST to add title of their local Standards of Behaviour Framework/Policy			
35	7.5.3	7.5.3	Dealing with offers of gifts and hospitality	Frequency - reference to sport removed as specifically prohibited in LHB policies			
36	n/a	7.6	Sponsorship	New section added			
36	7.6	7.7, 7.7.1 and 7.7.2	Register of Gifts, Hospitality and Sponsorship	Reference to sponsorship added			
36	7.6.3	7.7.3	Register of Gifts and Hospitality	Wording added to ensure clear paragraph refers gifts and hospitality only			



37	7.6.5	7.7.5	Register of Gifts and Hospitality	Wording added to refer to sponsorship			
38	8.2.1	8.2.1	Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups	Number 6 replaced with word 'six' as below ten			
38	8.2.3	8.2.3	Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups	Title of Welsh Government updated			
38	8.3.1	8.3.1	External Assurance	Amended to provide correct terminology for Audit General for Wales			
39	8.3.3	8.3.3	External Assurance	Amended to reflect correct titles for organisations.			
39	8.3.4	8.3.4	External Assurance	Reference to legislation removed on advice of WAO			
40	10.0.1	10.0.1	Review of Standing Orders	Added need for LHBs to "approve" and not only consider WHSSC SOs. Reference to equality removed to reflect widening of impact assessments			
42	i) & ii)	i) & ii)	Model Scheme of Reservation of Powers	Reference to Joint Committee and Advisory Groups added to reflect arrangements for WHSSC			
42	Bullet Point 2	Bullet Point 2	Model Scheme of Reservation of Powers	Amended to refer to sub-Committees and sub-Groups			
43	Bullet Point 2	Bullet Point 2	Deciding What to Retain and What to Delegate	Title of Welsh Government updated			

43	Bullet Point 7	n/a	Deciding What to Retain and What to Delegate	Sentence deleted as WHSSC is not a statutory body in its own right but a joint committee of the LHBs			
46	4	4	Schedule of Matters Reserved for the Committee	Amended arrangements for approval of SOs etc. as these are for approval by the LHBs and not WHSSC			
51	34 & 35	34 & 35	Schedule of Matters Reserved for the Committee	Title of Welsh Government updated			
52	n/a	n/a	Delegation to sub-Committees and others	Heading amended to read sub-Committees			
54	n/a	n/a	NHS Wales Framework	Amended to reflect re-introduction of Welsh Health Circulars in 2014			
55	n/a	n/a	Annex 3	Amended to refer to sub-Committees			

**Review of Emergency Ambulance Services Committee Standing Orders, Schedule 4.2, Local Health Board Model Standing Orders – September 2019**

**Table of Amendments, Cross Reference to Legislation and Confirmation of Sections which are not for variation by NHS Body**

**\*NOTE: Model SOs not previously issued by WG. Amendments reflect changes to SOs previously adapted by EASC from WHSSC SOs**

Page Number	*Previous Paragraph Reference	New Paragraph Reference	Section Heading	Reason for Amendment (if applicable)	Cross reference to legislation	Requirement of legislation – local amendment not permissible	Issued under Direction – local amendment not permissible
2	1	1	Forward	Paragraph added to reflect need to make SOs in accordance with Directions issued by Ministers - to ensure consistency with LHB/Trust SOs Change to legal citation to ensure consistent style across SOs Correction of typographical error  Note: When making SOs must also be regard to legislation	EASC (Wales) Regulations, Part 3, Regulation 10 and The LHB (Constitution, Membership and Procedures) Regulations, Regulation 14(b) and 15(5)	✓	
2	2	2	Forward	Name of host body to be inserted			
7	<b>Section A - Introduction</b>						
7	i)	i)	Statutory Framework	Legislation updated to ensure includes reference to 2016 amendments	EASC (Wales) Directions 2014, EASC (Wales) (Amendment) Directions 2016 and EASC (Wales) Regulations 2014	✓	
7	iv) & v)	iv) & v)	Statutory Framework	Amendment to ensure consistency of legal citation and reference to Ministers and not Cabinet Secretaries	NHS (Wales) Act 2006, para 4 of Schedule 2	✓	

8	viii)	viii)	Statutory Framework	Amendment to ensure consistency of legal citation and correction as Directions previously referred to when should have been Regulations.	EASC (Wales) Regulations 2014 and The LHB (Constitution, Membership and Procedures) Regulation 2009	✓	
8	x)	x)	Statutory Framework	Name of host body to be inserted			
8	xi)	xi)	NHS Framework	Amendment to reflect current name of Welsh Government and to improve grammar			
8	xiv)	xiv)	NHS Framework	Paragraph amended and reference added to the Well-being of Future Generations Act (WBFGA) Removed reference to "restructured" NHS	Well-being of Future Generations (Wales) Act 2015	✓	
8	n/a	xv)	NHS Framework	New paragraph to reflect the need to met the requirements of the WBFGA	Well-being of Future Generations (Wales) Act 2015	✓	
9	xv)	xvi)	NHS Framework	Paragraph amended to reflect change from Ministerial Letters to Welsh Health Circulars in 2014			
9	xvi)	xvii)	Joint Committee Framework	Change of name of host body			
9	xvii)	xviii)	Joint Committee Framework	Paragraph renumbered following addition of new paragraph above			
9	xviii)	xix)	Joint Committee Framework	Amended to refer to team of EASC and not Committee			
9	xix)	xx)	Applying EASC Standing Orders	Removed reference to "as per host body" as this is CTM specific and another host may choose different arrangements			
10	xx)	xxi)	Applying EASC Standing Orders	Name of host body to be inserted			
10&11	xxi)-xxv)	xxii)-xxvi)	Applying EASC Standing Orders	Paragraphs renumbered			
11	xxvi)	xxvii)	Role of Committee Secretary	Italics removed for the 'Committee Secretary' as this does not require emphasis.			

12	<b>Section B : EASC Standing Orders</b>						
12	1.1	1.1	Purpose and Delegated Functions	Refer to legislation before making amendments	EASC (Wales) Directions 2014, EASC (Wales) (Amendment) Directions 2016 and EASC (Wales) Regulations 2014	✓	
12	n/a	1.1.3	Purpose and Delegated Functions	Added new paragraph to ensure LHBs ensure Chief Executive is equipped to represent the views of the Board and has the relevant delegated authority			
12	1.1.3	1.1.4	Purpose and Delegated Functions	Paragraph renumbered following addition of new paragraph above			
13	1.1.4	1.1.5	Purpose and Delegated Functions	Amendment following issuing of Ministerial Direction re no-longer a requirement to ensure unanimous decision for funding decisions			✓ MA-P /VG/3794/18 - 121118
13	1.1.5 & 1.1.6	1.1.6 & 1.1.7	Purpose and Delegated Functions	Paragraphs renumbered due to above insertion.			
13	1.2	1.2	Membership of Joint Committee	Refer to legislation before making amendments	EASC (Wales) Directions 2014, 5(1), EASC (Wales) (Amendment) Directions 2016 and EASC (Wales) Regulations 2014, Part 2, Regulation 3	✓	
13	1.2.1	1.2.1	Membership of Joint Committee	Added reference to Chief Executive alongside Chief Officer also typographical error for Vice-Chair	EASC (Wales) Regulations 2014, Regulation 3(1)	✓	

13	1.2.2	1.2.2	Membership of Joint Committee	<u>Chief Officer or Nominated Deputy</u> - amendment to specify that nominated deputy should be an Executive Director	The EASC (Wales) Regulations 2014, Regulation 3(1)(a) and 3(4)	✓	✓ MA-P /VG/3794/18 - 121118
13	1.2.3	1.2.3	Membership of Joint Committee	Name of host body to be inserted			
13	n/a	1.2.4	Membership of Joint Committee	New paragraph added regarding arrangements if the Chief Ambulance Services Commissioner is shared to ensure consistency with LHB arrangements and equality legislation			
14	1.2.4	1.2.5	Membership of Joint Committee	<u>Associate Members</u> - Amendments to ensure consistency with wording within WHSSC SOs and paragraph renumbered due to additional paragraph above	The EASC (Wales) Regulations 2014, Regulation 3(3)	✓	
14	1.2.5	1.2.6	Membership of Joint Committee	<u>In Attendance</u> - correction of typographical error and paragraph renumbered			
14	1.3.5	1.3.5	Membership responsibilities and accountabilities	Cabinet Secretary changed to Minister for Health and Social Services	The EASC (Wales) Regulations 2014, Regulation 4(1)	✓	
15	1.3.6 & 1.3.7	1.3.6 & 1.3.7	Membership responsibilities and accountabilities	<u>Vice-Chair</u> - correction of typographical error	The EASC (Wales) Regulations 2014, Regulation 4(2)	✓	
15	1.4.1	1.4.1	Appointment and Tenure of Joint Committee Members	<u>Chair</u> - Title of Cabinet Secretary changed to Minister	The EASC (Wales) Regulations 2014, Regulation 4(1)	✓	
15	1.4.2	1.4.2	Appointment and Tenure of Joint Committee Members	<u>Vice-Chair</u> - amended to ensure consistency with Regulations	The EASC (Wales) Regulations 2014, Regulation 4(2) and 7	✓	

15	n/a	1.4.3	Appointment and Tenure of Joint Committee Members	<i>Vice-Chair</i> - paragraph added to reflect tenure of Vice-Chair due to unique position of them also being a Chief Officer.	The EASC (Wales) Regulations 2014, Regulation 7(5)	✓	
15	1.4.3	1.4.4	Appointment and Tenure of Joint Committee Members	Paragraph renumbered following addition of new paragraph above			
15	1.4.4	1.4.5	Appointment and Tenure of Joint Committee Members	Paragraph renumbered following addition of new paragraph above	The WHSSC (Wales) Regulations 2009, Regulation 5	✓	
16	2	2	Responsibilities and Relationships with each LHB Board and the Host LHB and Others	Refer to legislation before making amendments	EASC (Wales) Directions 2014, EASC (Wales) (Amendment) Directions 2016 and EASC (Wales) Regulations 2014	✓	
16	2.0.1	2.0.1	Responsibilities and Relationships with each LHB Board and the Host LHB and Others	Amendment to reflect current name of Welsh Government and to improve grammar			
17	3.1.2	3.1.2	Chairs Action on Urgent Matters	Original text was contradictory as the Lead Chief Officer is also the Vice-Chair. Amended to recognise role of Assistant Chief Ambulance Services Commissioner in these circumstances.			
17	3.2	3.2	Delegation to Joint Committee Sub-Committees and others	Amended to ensure consistency with WHSSC SOs			
17	3.2.1 & 3.2.2	3.2.1 & 3.2.2	Delegation to Joint Committee Sub-Committees and others	As above			

18	4	4	Joint Committee Sub-Committees and Sub-Groups	Amended to ensure consistency with WHSSC SOs			
18	4.0.1	4.0.1	Joint Committee Sub-Committees and Sub-Groups	Sub-committees added and paragraph numbering added			
18	n/a	4.0.2	Joint Committee Sub-Committees and Sub-Groups	Paragraph numbering added			
18	n/a	4.0.3	Joint Committee Sub-Committees and Sub-Groups	Paragraph numbering added, reference to sub-Committees and need to ensure Quality and Safety and Audit Committee			
18	n/a	4.0.4-4.0.6	Joint Committee Sub-Committees and Sub-Groups	Paragraph numbering added, reference to sub-Committees			
19	n/a	4.0.7	Joint Committee Sub-Committees and Sub-Groups	Paragraph numbering added			
19	n/a	4.0.8	Joint Committee Sub-Committees and Sub-Groups	Added categories of individuals who can be invited to join sub-Committees or sub-Groups and to ensure consistency with WHSSC SOs			
19	n/a	4.0.9	Joint Committee Sub-Committees and Sub-Groups	Paragraph added to ensure consistency with WHSSC and LHB SOs			
19	4.2.1	4.2.1	Reporting Activity to Joint Committee	Reference to sub-Committee added			
19	4.2.2	4.2.2	Reporting Activity to Joint Committee	Reference to sub-Committee added and amended from 3 months to 6 weeks to ensure consistency with WHSSC SOs. Para 5.1.2 also amended.			
20	5.1.2	5.1.2	Reporting Activity	Reference to sub-Committee added and amended from month to 6 weeks to ensure consistency with WHSSC SOs. Para 4.2.2 also amended.			
21	6.1.1	6.1.1	Putting the Citizen First	Wording amended in response to comments from WAO and new Welsh Language requirements	Section 44, Welsh Language (Wales) Measure 2011	✓	



22	6.2.3	6.2.3	Annual Plan of Committee Business	Reference to sub-Committee added			
22	6.2.4	6.2.4	Annual Plan of Committee Business	Amended to say that plan should be published on internet and not as part of SOs			
22	6.4.3	6.4.3	Notifying and Equipping Joint Committee members	10 days in accordance with Regulations. 'calendar' added to clarify number of days for advance publication of papers. Regulations specify 'clear' days but Board Secretaries preferred term 'calendar'	The LHB (Constitution, Membership and Procedures) Regulations 2009, Schedule 3, 2(3)	✓	
23	6.4.4	6.4.4	Notifying and Equipping Joint Committee members	Paragraph amended to reflect need for additional impact assessments. Previously only referred to equality			
23	6.4.7	6.4.7	Notifying the public and others	'calendar' added to clarify number of days for advance notice papers and ensure consistency with 6.4.3.	Public Bodies (Admission to meetings) Act 1960, Section 1, subparagraph 4		
24	6.6.1	6.5.1	Admission of the public, press and observers	Paragraph number corrected and deleted reference to induction loop - there are a number of alternative means for improving accessibility and adding this reference does not reflect this			
24	6.6.2	6.5.2	Admission of the public, press and observers	Paragraph number corrected and reference to representatives of the press leaving centred	The LHB (Constitution, Membership and Procedures) Regulations 2009, Schedule 3, 8	✓	
24	6.6.3 - 6.6.6	6.5.3 - 6.5.6	Admission of the public, press and observers	Paragraph numbers corrected			
25	6.6.7	6.5.7	Admission of the public, press and observers	Reference to sub-committees added			
25	6.6.8	6.5.8	Joint Committee Meetings	Correction of typographical errors			

25	6.6.9	6.5.9	Joint Committee Meetings	Paragraph number corrected			
25	6.6.10	6.5.10	Quorum	Paragraph number corrected and word "four" added as number below ten			
25	6.6.11	6.5.11	Quorum	Amendment of paragraph number and amendment following issuing of Ministerial Direction re ability of Chief Executive to nominate a deputy to represent them and vote on their behalf. To contribute towards quorum and exercise vote the deputy must be an Executive Director.			✓ MA-P /VG/3794/18 - 121118
25	6.6.11	6.5.12	Quorum	Due to above revision necessary to split paragraph to and make minor amendment to reflect different arrangements for Emergency Ambulance Services Commissioner and his staff			✓ MA-P /VG/3794/18 - 121118
26	6.6.12	6.5.13	Quorum	Amendment to reflect above revised arrangements and paragraph renumbered			✓ MA-P /VG/3794/18 - 121118
26	6.6.13	6.5.14	Dealing with Motions	Amendment to reflect above revised arrangements and paragraph renumbered			✓ MA-P /VG/3794/18 - 121118
26	6.6.14	6.5.15	Dealing with Motions	"calendar" added to ensure consistency with number of days mentioned elsewhere and paragraph renumbered			
26	6.6.15	6.5.16	Dealing with Motions	Amendments to paragraph numbering			
27	6.6.16	6.5.17	Dealing with Motions	Amendment to reflect above revised arrangements and paragraph renumbered			✓ MA-P /VG/3794/18 - 121118
27	6.6.17	6.5.18	Dealing with Motions	Correction of typographical errors and paragraph renumbered			
27	6.6.18	6.5.19	Dealing with Motions	Amendment to reflect above revised arrangements and paragraph renumbered			✓ MA-P /VG/3794/18 - 121118

27	6.6.19 - 6.6.21	6.5.20 - 6.5.22	Dealing with Motions	Paragraphs renumbered			
27	6.6.22	6.5.23	Dealing with Motions	Correction of typographical error, addition of sub-committee and paragraph renumbered			
27	6.6.23	6.5.24	Voting	Paragraph renumbered			
28	6.6.24	6.5.25	Voting	organisations' added following comments from WAO and to ensure consistency with LHB SOs			
28	6.6.25 & 6.6.26	6.5.26 & 6.5.27	Voting	Amendments to reflect above revised arrangements and paragraph renumbered			✓ MA-P /VG/3794/18 - 121118
28	6.6	6.6	Record of Proceedings	No amendments	The LHB (Constitution, Membership and Procedures) Regulations 2009, Schedule 3, 5 & 7	✓	
28	6.7.1	6.7.1	Confidentiality	Reference to sub-Committees added			
30	7.2.3	7.2.3	Dealing with members interests during Joint Committee meetings	Correction to ensure correct terminology for Welsh Ministers			
31	7.2.8	7.2.8	Dealing with members interests during Joint Committee meetings	Full title of regulations added for clarity	The LHB (Constitution, Membership and Procedures) Regulations 2009, Part 3, Regulation 17	✓	
32	7.5	7.5	Dealing with offers of gifts, hospitality and sponsorship	Extended to include reference to sponsorship following discussions with Board Secretaries Network			
32	7.5.1	7.5.1	Dealing with offers of gifts, hospitality and sponsorship	EAS Team to add title of their local Standards of Behaviour Framework/Policy			
33	7.5.3	7.5.3	Dealing with offers of gifts and hospitality	Frequency - reference to sport removed as specifically prohibited in LHB policies			
33	n/a	7.6	Sponsorship	New section added			

34	7.6, 7.6.1 & 7.6.2	7.7, 7.7.1 & 7.7.2	Register of Gifts, Hospitality and Sponsorship	Reference to sponsorship added and renumbered due to additional section above.			
34	7.6.3	7.7.3	Register of Gifts and Hospitality	Wording added to ensure clear paragraph refers gifts and hospitality only			
35	7.6.5	7.7.5	Register of Gifts and Hospitality	Wording added to refer to sponsorship			
35	8.2.1	8.2.1	Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups	Number 6 replaced with word 'six' as below ten			
36	8.2.3	8.2.3	Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups	Title of Welsh Government updated			
36	8.3.1	8.3.1	External Assurance	Amended to provide correct terminology for Audit General for Wales			
36	8.3.3	8.3.3	External Assurance	Amended to reflect correct titles for organisations.			
36	8.3.4	8.3.4	External Assurance	Reference to legislation removed on advice of WAO			
37	10.0.1	10.0.1	Review of Standing Orders	Added need for LHBs to "approve" and not only consider EASC SOs. Reference to equality removed to reflect widening of impact assessments			
39	i) & ii)	i) & ii)	Model Scheme of Reservation of Powers	Reference to Joint Committee and Advisory Groups added to reflect arrangements for EASC			

39	Bullet Point 2	Bullet Point 2	Model Scheme of Reservation of Powers	Amended to refer to sub-Committees and sub-Groups			
40	Bullet Point 2	Bullet Point 2	Deciding What to Retain and What to Delegate	Title of Welsh Government updated			
40	Bullet Point 7	n/a	Deciding What to Retain and What to Delegate	Sentence deleted as EASC is not a statutory body in its own right but a joint committee of the LHBs			
42	n/a	n/a	Quality and Safety Committee	Inserted by EASC - no comparable paragraph for WHSSC. Amended to mirror requirements for LHBs and Trusts to establish Quality and Safety Committees but determine name and role.			
44	4	4	Schedule of Matters Reserved for the Committee	Amended arrangements for approval of SOs etc. as these are for approval by the LHBs and not WHSSC			
48	n/a	34 & 35	Schedule of Matters Reserved for the Committee	Title of Welsh Government updated			
49	n/a	n/a	Delegation to sub-Committees and others	Heading amended to read sub-Committees			
51	n/a	n/a	NHS Wales Framework	Amended to reflect re-introduction of Welsh Health Circulars in 2014			
52	n/a	n/a	Annex 3	Amended to refer to sub-Committees			

**Review of NHS Wales Local Health Board Model Standing Orders Glossary of Terms – September 2019**

<b>Page Number</b>	<b>Term</b>	<b>Amendment</b>	<b>Reason for Amendment (if applicable)</b>	<b>Cross reference to legislation/Guidance</b>
2	Introductory Paragraph	Reference to EASC added	To include reference to EASC	EASC (Wales) Directions 2014, EASC (Wales) (Amendment) Directions 2016 and EASC (Wales) Regulations 2014
2	Accountable Officer	Added reference to Accountable Officer Memorandum being issued, status of Director of Shared Services	To ensure consistency with Trust Glossary of Terms	Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 Managing Welsh Public Money, January 2016
2	Additional Accounting Officer	Term "Additional" added to reflect arrangements for Director General and NHS Wales Chief Executive. Reference added to legislation and role of Permanent Secretary, Welsh Government	To reflect accountability arrangements in Wales	Managing Welsh Public Money, January 2016
3	Annual Plan of Board Business	Sentence added re need to publish on website.	To compliment Standing Orders	NHS Wales Model Standing Orders
	Assembly Government	Deleted due to change in name of body.		
3	Associate Member	EASC added	Reference to EASC	Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 The WHSSC (Wales) Regulations 2009 The EASC (Wales) Regulations 2014
3	Audit Committee	Role of Audit Committee added. EASC added	To provide information regarding the role of the Audit Committee and reference to EASC	NHS Wales Audit Committee Handbook, June 2012
3	Chair	Reference added to EASC and joint-Committee chair amended	To include reference to EASC	Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 The WHSSC (Wales) Regulations 2009 The EASC (Wales) Regulations 2014
4	Chief Executive	Reference to EASC added	To include reference to EASC	Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 The WHSSC (Wales) Regulations 2009 The EASC (Wales) Regulations 2014
4	NHS Wales Chief Executive	Title amended	Amended to ensure current title	
4	Committee	added "one which is"	Amended to ensure paragraph makes sense.	
4	Committee Members	WHSSC deleted	WHSSC removed and added to a later section	
4	Committee Secretary	EASC added	Reference to EASC	WHSSC (Wales) Regulations 2009 EASC (Wales) Regulations 2014
4	Community Health Councils	New section	Reference to Community Health Councils added to ensure consistency with Trust Glossary	Paragraph 1, Schedule 10, National Health Service (Wales) Act 2006
4	Constitution Regulations	WHSSC and EASC Regulations added	Legislation not previously included	Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 The WHSSC (Wales) Regulations 2009 The EASC (Wales) Regulations 2014

4	Director General, Health and Social Services	NHS Wales Chief Executive title corrected	Amended for accuracy	
5	Director of Shared Services	New section	Amended to include reference to role	
5	EASC	New section	Amended to include reference to abbreviation	EASC (Wales) Directions 2014, EASC (Wales) (Amendment) Directions 2016 and EASC (Wales) Regulations 2014
5	EASC Directions	New section	Amended to include reference to Directions	EASC (Wales) Directions 2014, EASC (Wales) (Amendment) Directions 2016
5	EASC Regulations	New section	Amended to include reference to Regulations	EASC (Wales) Regulations 2014
5	EASC SFIs	New section	Amended to include reference to EASC Standing Financial Instructions	
5	EASC SOs	New section	Amended to include reference to EASC Standing Orders	
5	EASC - Officer member employed by LHB	New section	Amended to include reference to new role due to EASC sections added	EASC (Wales) Regulations 2014
5	Functions	Reference to EASC added	Reference to EASC	Local Health Boards (Directed Functions) (Wales) Regulations 2009 (2009/1511 (W.147)) Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35 (W.35)) The Emergency Ambulance Services (Wales) Directions 2014 as amended (2014/8 (W8))
5	Host LHB	Reference to EASC and NWSSP added. Name changed for Cwm Taf Morgannwg and Velindre added	Amended to include EASC and NWSSP. Cwm Taf changed name following boundary change to Cwm Taf Morgannwg and Velindre added as host of NWSSP	EASC (Wales) Directions 2014 NWSSP (Wales) Directions 2009 Velindre NHS Trust (Establishment) (Amendment) Order 2012
6	Joint-Committee	Reference to EASC added	Amended to include reference to EASC	WHSSC (Wales) Regulations 2009 EASC (Wales) Regulations 2014
6	Joint-Committee Audit Committee	Reference to EASC added	Amended to include reference to EASC	Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35 (W.35)) The Emergency Ambulance Services (Wales) Directions (2014/8 (W8))
6	Joint-Committee Members	New section added to include membership of WHSSC and EASC.	Amended to reflect legislation and removal of WHSSC within Committee Members section	WHSSC (Wales) Regulations 2009 EASC (Wales) Regulations 2014
6	Lead Director/Officer	Reference to EASC added		WHSSC (Wales) Regulations 2009 EASC (Wales) Regulations 2014
7	National Assembly for Wales	Amended to reflect correct title and role of the Assembly	To reflect name change and to update reference to role	
7	NHS Finance (Wales) Act 2014	Citation added	Citation added to ensure consistency	NHS Finance (Wales) Act 2014
7	NWSSP	New section added	To include reference to organisation	Velindre NHS Trust (Establishment) (Amendment) Order 2012
7	Officer	Reference to EASC added	To include reference to EASC	
7	Public Services Board (PSB)	New section added	To include reference to new group	Well-being and Future Generations (Wales) Act 2015 (2015/2)
8	Regional Partnership Board (RPB)	New section added	To include reference to new group	Well-being and Social Services (Wales) Act 2014 (2014/4)
8	Shared Services Regulations	New section added	To include reference to Shared Services Regulations	The Velindre NHS Shared Services Committee (Wales) Regulations 2012

8	Shared Services Partnership Committee	New section added	To include reference to form a committee under the Shared Services Regulations	The Velindre NHS Shared Services Committee (Wales) Regulations 2012
8	Welsh Government	Change from Assembly Government to Welsh Government	Amended to reflect up to date name of Welsh Government	
8	WHSSC Regulations	Citation amended	Citation amended to ensure consistency	The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (2009/3097)



**Review of NHS Wales Trust Model Standing Orders Glossary of Terms – September 2019**  
**Table of Amendments and Cross Reference to Legislation**

<b>Page Number</b>	<b>Term</b>	<b>Amendment</b>	<b>Reason for Amendment (if applicable)</b>	<b>Cross reference to legislation/Guidance</b>
2	Accountable Officer	Added reference to Accountable Officer Memorandum being issued, status of Director of Shared Services	To ensure consistency with Trust Glossary of Terms	The National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009 as amended
2	Additional Accounting Officer	Term "Additional" added to reflect arrangements for Director General and NHS Wales Chief Executive. Reference added to legislation and role of Permanent Secretary, Welsh Government	To reflect accountability arrangements in Wales	Managing Welsh Public Money, January 2016
3	Advisory Group	Local Partnership Board added	To reflect status of Local Partnership Board as an Advisory Group	
3	Annual Plan of Board Business	Sentence added re need to publish on website.	To compliment Standing Orders	NHS Wales Model Standing Orders
3	Audit Committee	Reference to Audit Committee added	To ensure consistency with LHB Glossary of Terms	
3	Board Members	Reference to Board Members added	To ensure consistency with LHB Glossary of Terms	
3	NHS Wales Chief Executive	Title amended	Amended to ensure current title	
3	Committee	added "one which is"	Amended to ensure paragraph makes sense.	
4	Community Health Councils	Sentence regarding role added	Reference to role of Community Health Councils added	Paragraph 1, Schedule 10, National Health Service (Wales) Act 2006
4	Director General, Health and Social Services	NHS Wales Chief Executive title corrected	Amended for accuracy	

4	Director of Shared Services	New section	Amended to include reference to role	
5	National Assembly for Wales	Amended to reflect correct title and role of the Assembly	To reflect name change and to update reference to role	
5	NHS Finance (Wales) Act 2014	Citation added	Citation added to ensure consistency	NHS Finance (Wales) Act 2014
5	NWSSP	New section added	To include reference to organisation	Velindre NHS Trust (Establishment) (Amendment) Order 2012
5	Public Services Board (PSB)	New section added	To include reference to new group	Well-being and Future Generations (Wales) Act 2015 (2015/2)
6	Regional Partnership Board (RPB)	New section added	To include reference to new group	Well-being and Social Services (Wales) Act 2014 (2014/4)
6	Shared Services Regulations	New section added	To include reference to Shared Services Regulations	The Velindre NHS Shared Services Committee (Wales) Regulations 2012
6	Shared Services Partnership Committee	New section added	To include reference to form a committee under the Shared Services Regulations	The Velindre NHS Shared Services Committee (Wales) Regulations 2012
6	Welsh Government	Description amended to reflect current arrangements	Description amended to reflect current arrangements	

<b>Report Title:</b>	<b>Committees of the Board - Membership</b>						
<b>Meeting:</b>	Board				<b>Meeting Date:</b>	28.11.2019	
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	x	<b>For Information</b>
<b>Lead Executive:</b>	<b>Chair of the Board</b>						
<b>Report Author (Title):</b>	<b>Director of Corporate Governance</b>						

## SITUATION

It is important that the Committees of the Board are properly constituted to ensure the right number of Members are appointed to the Committee, that meetings are quorate and that Members with the right specialisms/ experience/interests are also on the right Committee.

WAO Structured Assessment has identified that a number of the Committees of the Board were not quorate for a couple of the meetings they observed when undertaking the assessment. This means that decisions cannot be approved. In addition to the Membership of each Committee needing to be strengthened there is currently an Independent Member vacancy and the Chair and Vice Chair positions are interim. Overall this means that the Board is currently two Independent Members short.

The Interim Chair of the Board has considered the Membership of each Committee and in discussion with the Independent Members has agreed that each Committee should broadly have four Members.

These changes will also be included within the Terms of Reference when they are updated and presented to the Board for approval at the end of the Financial Year.

## ASSESSMENT

Attached at Appendix 1 is the suggested Membership for the Committees of the Board. The Chair has agreed with individual Independent Members the changes which are detailed. In addition to this Executive Directors have also been advised where changes have taken place to the Committees they take part in or lead on as an Executive Director.

**ASSURANCE** is provided by: Discussion with the Chair of the Board, Independent Members, Governance Coordination Group and Executive Directors.

## RECOMMENDATION

The Board is asked to:

- Approve the Membership of the Committees of the Board and specifically approve the changes detailed within the last column of appendix 1 with effect from 1<sup>st</sup> January 2020.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term		Integration		Collaboration		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>	Yes / No / Not Applicable <i>If "yes" please provide copy of the assessment. This will be linked to the report when published.</i>								

Kind and caring  
 Caredig a gofalgar

Respectful  
 Dangos parch

Trust and integrity  
 Ymddiriedaeth ac uniondeb

Personal responsibility  
 Cyfrifoldeb personol

**CARING FOR PEOPLE  
KEEPING PEOPLE WELL**



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

## COMMITTEE MEMBERSHIP 2019

With effect from 1<sup>st</sup> January 2020

	Committee	Members	Chair	Vice Chair	Exec Lead	Quorum	Compliant / actions to become compliant	Actions to approve at Board
1.	Audit Committee (3 Independent Members)	John Union Dawn Ward Eileen Brandreth	John Union	Eileen Brandreth	Bob Chadwick	2 members (one must be Chair or Vice Chair)	Yes	
2.	Remuneration and Terms of Service Committee (7 Independent Members)	Charles Janczewski John Union (+) Michael Imperato (+) Susan Elsmore (+) Eileen Brandreth (+) Akmal Hanuk <i>(+) IM – Capital &amp; Estates</i>	Charles Janczewski	Michael Imperato	Len Richards	4 members (one must be Chair of Vice Chair)	Interim Chair, Vice chair and 2 new members to be approved	1. Approve Charles as Interim Chair 2. Approve Michael as Interim Vice Chair 3. Approve Susan, Eileen and Akmal as members
3.	Charitable Funds Committee (7, 4 Independent Members and 3 Executive Director Members)	Akmal Hanuk John Union Sara Mosely Fiona Jenkins Ruth Walker Martin Driscoll (+) Susan Elsmore	Akmal Hanuk	John Union	Ruth Walker	4 members (one must be Chair of Vice Chair)	One new member to be approved	1. Approve Susan as a member
4.	Finance Committee (4 Independent Members)	John Union Charles Janczewski (+) Susan Elsmore <i>(+) IM – Capital &amp; Estates</i>	<i>IM – Capital &amp; Estates</i>	John Union	Bob Chadwick	2 Members (one must be Chair or Vice Chair)	One member to be approved	1. Approve Susan as a member
5.	Mental Health and Capacity Legislation Committee	Eileen Brandreth Sara Mosely Akmal Hanuk	Sara Moseley (interim Chair)	Michael Imperato	Steve Curry	2 Members (one must be	Interim Chair and Vice Chair to be	1. Approve Sara as Interim Chair

	(4 Independent Members)	(+) Michael Imperato (-) Charles Janczewski				Chair of Vice Chair)	approved and remove one member	2. Approve Michael as Interim Vice Chair 3. Remove Charles Janczewski as member
6.	Quality, Safety and Experience Committee (4 Independent Members)	Susan Elsmore Dawn Ward Gary Baxter Michael Imperato	Susan Elsmore	Dawn Ward	Ruth Walker	2 Members (one must be Chair or Vice Chair)	Yes	
7.	Strategy and Delivery Committee (4 Independent Members)	Charles Janczewski Sara Mosely (+) Gary Baxter <i>(+) IM Capital &amp; Estates</i>	Charles Janczewski	Sara Mosely	Abigail Harris	2 Members (one must be Chair or Vice Chair)	Two members to be added	1. Approve Gary as a member
8.	Health and Safety Committee (4 Independent Members)	Michael Imperato Akmal Hanuk Dawn Ward <i>(+) IM Capital &amp; Estates</i>	Michael Imperato	Akmal Hanuk	Martin Driscoll	2 Members (one must be Chair or Vice Chair)	Yes	
9.	Digital Health Information Committee (4 Independent Members)	Eileen Brandreth Michael Imperato Charles Janczewski (+) Gary Baxter	Eileen Brandreth	Michael Imperato	Jonathan Gray	2 Members (one must be Chair or Vice Chair)	One new member to be added	1. Approve Gary as a member

## Independent Members

### Committee Membership – with effect from 1<sup>st</sup> January 2020

Independent Member	Committees
Baxter, Gary	Quality, Safety and Experience Strategy & Delivery Digital Health Information
Brandreth, Eileen	Digital Health Information (Chair) Mental Health & Capacity Legislative Audit (Vice Chair) Remuneration and Terms of Service
Elsmore, Susan	Quality & Patient Safety (Chair) Finance Charitable Funds Remuneration and Terms of Service
Hanuk, Akmal	Charitable Funds (Chair) Health & Safety (Vice Chair) Mental Health & Capacity Legislative Remuneration and Terms of Service
Imperato, Michael	Health and Safety (Chair) Quality, Safety and Experience Digital Health Information (Vice Chair) Mental Health & Capacity Legislative Remuneration and Terms of Service
Janczewski, Jan	Strategy & Delivery (Chair) Digital Health Information Finance Remuneration and Terms of Service (Interim Chair) Attend other Committees as necessary
Mosely, Sara	Mental Health & Capacity Legislative (Vice and Interim Chair) Strategy & Delivery (Vice Chair) Charitable Funds
Union, John	Audit (Chair) Charitable Funds (Vice Chair) Finance (Vice Chair) Remuneration and Terms of Service
Ward, Dawn	Quality, Safety and Experience (Vice Chair) Audit Health and Safety
<i>A. N. Other (Capital &amp; Estates)</i>	<i>Finance (Chair) Strategy &amp; Delivery Health &amp; Safety Remuneration and Terms of Service</i>

**CONFIRMED MINUTES OF FINANCE COMMITTEE  
HELD ON 25<sup>th</sup> SEPTEMBER 2019  
LARGE MEETING ROOM, HQ, UHW**

**Present:**

John Antoniazzi	JA	Chair, Independent Member – Estates
Charles Janczewski	CJ	Vice Chair (Board)
Andrew Gough	AG	Assistant Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Len Richards	LR	Chief Executive
Martin Driscoll	MD	Executive Director of Workforce and Organisational Development
Ruth Walker	RW	Executive Nurse Director
Steve Curry	SC	Chief Operating Officer

**In Attendance:**

Mark Jones	MJ	Welsh Audit Office
------------	----	--------------------

**Secretariat:**

Paul Emmerson	PE	Finance Manager
---------------	----	-----------------

**Apologies:**

Abigail Harris	AH	Executive Director of Planning
John Union	JU	Independent Member – Finance
Nicola Foreman	NF	Director of Corporate Governance
Robert Chadwick	RC	Executive Director of Finance

<b>FC 19/093</b>	<b>WELCOME AND INTRODUCTIONS</b>  The Chair welcomed everyone to the meeting.	<b>ACTION</b>
<b>FC 19/094</b>	<b>APOLOGIES FOR ABSENCE</b>  Apologies for absence were noted.	
<b>FC 19/095</b>	<b>DECLARATIONS OF INTEREST</b>  The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
<b>FC 19/096</b>	<b>MINUTES OF THE FINANCE COMMITTEE MEETING HELD ON 31<sup>st</sup> JULY 2019</b>  The minutes of the meeting held on 31 <sup>st</sup> July 2019 were reviewed for accuracy. Subject to an amendment to the meeting date reference the minutes of the meeting were agreed as a true and accurate record.  <b>Resolved – that:</b>	



	The minutes of the meeting held on 31 <sup>st</sup> July 2019 were approved by the Committee as an accurate record.	
<b>FC 19/097</b>	<p><b>ACTION LOG FOLLOWING THE LAST MEETING</b></p> <p><b>FC19/085</b> – A summary of the key remedial actions planned to move towards Financial Balance alongside a comparison of actual Clinical Board performance against forecast performance would be reported to the next Finance Committee.</p> <p>A presentation on Plans to Deliver a Break Even Position is to be considered as part of the agenda of the Finance Committee held on the 25<sup>th</sup> September 2019.</p> <p><b>Action Complete.</b></p> <p><b>Resolved – that:</b></p> <p>The Finance Committee <b>received</b> the Action Log and <b>noted</b> the completed action.</p>	
<b>FC 19/098</b>	<p><b>CHAIRS ACTION SINCE THE LAST MEETING</b></p> <p>There had been no Chairs action taken since the last meeting.</p>	
<b>FC 19/099</b>	<p><b>FINANCE REPORT AS AT MONTH 5</b></p> <p>The Deputy Director of Finance presented the UHB's financial performance to month 5 and highlighted that the UHB had reported a deficit of £2.817m which included an in month overspend of circa £0.410m. The cumulative overspend was within the expected profile of spend at this point of the year and the Deputy Director of Finance confirmed that the UHB plans to reach a balanced year end position would be outlined in further detail in the presentation to follow.</p> <p>The UHB Vice Chair (CJ) indicated that in view of the continuing overspend that the Committee required assurance that the UHB's plans to reach a balanced year end position were robust and deliverable. In addition the UHB vice chair (CJ) asked for the Finance Committee to be informed of performance against the projected recovery profile on a monthly basis moving forwards. Picking up on the requests the Deputy Director of Finance indicated that the plan to break even would be outlined in the presentation to follow on the agenda and added that it was intended that a comparison of actual performance against the forecast recovery profile would be incorporated within the Monthly Finance Report which was a standing item on the agenda of future Finance Committee meetings.</p> <p>Four measures remained RAG rated Red on the Finance Dashboard namely: remaining within revenue resource limits; the reduction in the underlying deficit to £4m; the delivery of the recurrent £16.345m 2% devolved target; the delivery of the £12.8m recurrent/non</p>	Executive Director of Finance

	<p>recurrent corporate target. It was indicated that greater assurance of delivery against the 4 red rated measures was expected to be gained as the UHB moved into the second half of the year.</p> <p>Performance against Income targets including LTA performance was again broadly break even.</p> <p>The pay position was underspent in month and cumulatively underspent by £1.2m. In response to a query from the Finance Committee Chair (AC) the Deputy Director of Finance indicated that the underspend was relatively small and was a result of both fortuitous and managed vacancies. The Executive Director of Workforce and Organisational Development confirmed that the vacancy panel considered whether a vacancy needed to be filled immediately when considering requests.</p> <p>It was noted that the trend in nursing overspends had improved in month and that this was in part a result of further funding which had been secured by the Women and Children's Clinical Board to support nursing posts in the Children's Hospital which had a retrospective impact on the reported position.</p> <p>The Executive Nurse Director provided an update on the nursing position and reminded the Committee of the progress that the UHB had already made, namely: eradicating the use of off contract agency and Healthcare support worker agency; implementing a new model for assessing specialising requirements in the Medicine Board which is now to be rolled out to other Clinical Boards; and trialling a tool in the Medicine Clinical Board to enable ward sisters to visualize the financial impact of filling each shift with either agency, bank or overtime before roll out to other Clinical Boards.</p> <p>The UHB was now focussing on areas of high spend and in this context the UHB was about to trial an initiative to tackle the significant level of agency cost which on average was incurred every Sunday. The Committee was informed that a switch to permanent staff would enhance patient safety and it was noted that a Sunday agency shift was 85% more expensive than a comparable bank shift. The initiative aimed to use the UHBs resources more effectively by switching off all Sunday agency shifts. Some wards would continue to be able to access agency shifts on a Sunday subject to an evaluation of the risks and benefits during the trial period. During the trial period requests to use agency staff would be scrutinized through the Nursing hierarchy.</p> <p>On a related issue, it was also noted that other initiatives in respect of bank and rostering were being progressed nationally.</p> <p>Referring to patient safety the Chief Executive indicated to the Committee that the UHB had fully established and funded rosters which were compliant with the Nurse Staffing Act.</p>	
--	---	--

	<p>In this context the Executive Nurse Director indicated that the UHB was unable to fill all shifts due to vacancies and the unavailability of temporary staff. However the number of substantive nursing staff employed by the UHB was increasing with the number of nurses employed by the UHB being circa 255 more than the previous year with 154 new graduates currently moving through preceptorship. In addition the UHB was recruiting nurses from overseas to progress through the NMC adaptation programme.</p> <p>The UHB Vice Chair (CJ) noted that the progress on recruitment was encouraging and enquired whether the attrition rate offered similar assurance. The Executive Director of Workforce and Organisational Development indicated that the attrition rate across the UHB was approximately 11% which was towards the middle of the 8-15% range reported by most cities. It was noted that some movement was expected due to grading and the age profile of nursing staff.</p> <p>The Finance Committee Chair (JA) asked how the UHB could ensure that it was attractive to staff currently working in other areas and in response the Executive Nurse Director indicated that the UHB was able to promote itself as a centre of excellence in a number of services e.g. midwifery and the children's hospital. The availability of modern buildings and facilities in a number of areas alongside the UHB's rotation programme was also an appeal to potential recruits.</p> <p>Moving on, the Deputy Director of Finance indicated that non pay was continuing to overspend with significant pressures in continuing healthcare, prescribing and premises and fixed plant. It was noted that an overspend had emerged in month against commissioned services.</p> <p>Clinical Boards (including Capital Estates and Facilities) had reported a cumulative overspend of £5.5m for the year to date.</p> <p>It was highlighted that the overspends of £1.5m in PCIC and £2.2m in Medicine were the largest Clinical Board Variances. The UHB Vice Chair (CJ) indicated that the report suggested that in percentage terms that the overspend in Medicine at 4% was more significant than in PCIC where the overspend was 1%. The Chief Operating Officer informed the Committee that pay pressures particularly in nursing were the main focus in the Medicine CB and that there were signs that performance in this area was improving. The pressures in PCIC were largely a consequence of category M drug costs, NICE approved drugs and an increase in continuing healthcare clients. Members of the UHBs executive team had recently met with PCIC to consider the overspend that had emerged in year. It was noted that the UHB's prescribing spend compared relatively well with the rest of Wales and that the in year pressure was a consequence of an increase in category M drug tariffs and the implementation of NICE approved drugs. The pressure in continuing healthcare had arisen as the number of new clients entering the system in year was 40% higher than the number of clients currently exiting services. In respect of continuing healthcare the Chief Operating Officer indicated</p>	
--	--	--

	<p>that the UHB intended to reconsider the way that complex packages are managed.</p> <p>The Deputy Director of Finance informed the Committee that all Clinical Boards had been tasked to reach the best financial position that they could by year end.</p> <p>The UHB vice chair (CJ) asked what was driving the additional security costs being reported against capital and estates. The Chief Executive explained that a number of sites had remained opened longer than expected and that this had led to the requirement for additional security. The security provided at Whitchurch was partly in response to concerns from the local community after a number of incidents on the site. It was also noted that the 24 hour security presence at Woodland House was a pressure against budgets.</p> <p>The UHB had a fully identified savings plan and there was a big push to move the amber schemes to a green rating as soon as possible.</p> <p>It was noted that the UHB's PSPP performance continued to exceed the 95% target; cash plans were currently on target with the UHB not expecting to request additional cash support in 2019/20 and that there was some slippage against capital expenditure profiles at month 5 which was expected to be recovered by year-end.</p> <p>In conclusion the Deputy Director of Finance highlighted that the key risks to the Plan was the management of budgets to deliver a balanced financial position by year end and this risk was assessed as being up to £4m.</p> <p><b>ASSURANCE</b> was provided by:</p> <ul style="list-style-type: none"> <li>• The scrutiny of financial performance undertaken by the Finance Committee and the UHBs intention to recover the year to date deficit and deliver a break even position by the year end as planned.</li> </ul> <p><b>Resolved – that:</b></p> <p>The Finance Committee <b>noted</b> that the UHB has an approved IMTP which includes a balanced Financial Plan for 2019/20;</p> <p>The Finance Committee <b>noted</b> the £2.817m deficit at month 5;</p> <p>The Finance Committee <b>noted</b> the key concerns and actions being taken to manage risks</p>	
<b>FC 19/100</b>	<p><b>PLANS TO DELIVER A BREAK EVEN POSITION (presentation)</b></p> <p>The Deputy Director of Finance presented the Plans To Deliver A Break Even Position.</p>	

	<p>The Committee was reminded that the UHB brought forward an underlying financial deficit of £36.3m into 2019/20. The Deputy Director of Finance then described how the UHB had developed a balanced financial plan for 2019/20 founded on the application of additional funding provided by Welsh Government; the management of cost pressures and investments; and the delivery of a savings programme of c£30m.</p> <p>The UHB had reported an in month deficit of £0.407m and a cumulative deficit of £2.817m against its balanced financial plan at month 5. The Committee was informed that the main element of the cumulative deficit was a £5.468m overspend by delegated budget holders which was in part mitigated by a £2.651m underspend on central budgets. At month 5 the UHB was still forecasting a balanced year end position on the assumption that the year to date deficit would be recovered.</p> <p>The Deputy Director of Finance then described the process that the UHB had followed to develop and maintain its financial forecast.</p> <p>The main elements of the process were: the production of Clinical Board financial forecasts at month 2 which were subsequently challenged at Executive Performance Reviews and escalation meetings; the identification of corporate opportunities and unavoidable corporate risks; the development of a risk adjusted forecast to identify the risks requiring management and the scale of risk in the forecast; and discussion and agreement of the Financial Forecast at management executive at month 4 with an update at month 5.</p> <p>The initial forecast had indicated a forecast year end overspend of c £4m. This initial forecast was then refined to reflect visible risks and opportunities leading to a risk adjusted year end forecast overspend of c £0.950m. In the context of the UHB's overall budget this forecast was considered to represent a broadly balance financial position.</p> <p>The Committee was informed that on the basis of its risk adjusted financial forecast the UHB had signalled to Welsh Government that it intended to recover the £2.817m year to date deficit at month 5 and deliver a year end break even position. The UHB had acknowledged that the delivery of break-even required concerted management attention and was not without risk of delivery which the UHB assessed to be up to £4m. In addition Welsh Government was informed that the forecast year end break even position assumed full delivery of the savings plan and excluded risks relating to the Welsh Risk Pool.</p> <p>The Deputy Director of Finance then moved on to describe the monthly forecast profile that had previously been provided to Welsh Government which showed that the UHB's overspend was expected to increase in month 6 before a gradual recovery of the overspend in the last 6 months of the year. It was noted that at month 5 UHB performance was marginally better than the forecast profile. On the basis of the updated forecast and plan, the Deputy Director of Finance noted that this profile would need to be revised for month 6. The Chief Executive confirmed that at this stage the UHB was in a position to</p>	<p>Executive Director of Finance</p>
--	--	--

	<p>recover the position without recourse to contentious decisions if it grasped and delivered opportunities which it had already identified.</p> <p>In a similar vein, the Deputy Director of Finance described the monthly forecast profile for Clinical Boards which showed that the Clinical Board overspend was expected to increase up until month 11 before a partial recovery in the final month of the year. It was noted that at month 5 Clinical Boards aggregate performance was £0.370m worse than the forecast profile.</p> <p>The Finance Committee Chair (JA) asked how Clinical Boards were incentivised to manage operational pressures and the Chief Executive indicated that the established performance review process was the primary means of ensuring that Clinical Board operations aligned with corporate objectives. In addition personal reputation and the establishment of a sustainable service which could be further developed were motivations for Clinical Boards.</p> <p>The main risks to the forecast position were described as: the requirement to manage the risk adjusted position across a number of areas; the progression of amber savings schemes to green; maintenance of expenditure restraints; Winter funding; the absence of a contingency reserve to cover unexpected pressures; Closing down the residual £1m risk; and Clinical Board improvement plans.</p> <p>The Deputy Director of Finance then concluded by advising that financial performance would be managed by: monitoring the monthly position against profile; managing Clinical Board Performance via the monthly Executive Performance Reviews; managing the overall position via Management Executive; 'banking' opportunities as they become available; determining if and when expenditure restraints need to be enhanced; and providing assurance to the Finance Committee.</p> <p>The Finance Committee Chair (JA) requested that an update forecast be brought back to all future Finance Committee meetings for the remainder of the Financial Year so that assurance could be provided on delivery of a break even position.</p> <p><b>Resolved – that:</b></p> <p>The Finance Committee <b>noted</b> the plans and actions required to deliver a break even position in 2019/20.</p>	Executive Director of Finance
FC19/101	<p><b>CLINICAL BOARDS IN ESCALATION</b></p> <p>The Chief Operating Officer confirmed that the number of Clinical Boards in escalation remained at 3. There were concerns around the financial performance of the Medicine, PCIC and Surgery Clinical Boards.</p> <p>It was noted that the financial performance of Surgery had improved in month 5.</p>	

	<p><b>Resolved – that:</b></p> <p>The Finance Committee noted the actions being taken to manage financial performance</p>	
<b>FC19/102</b>	<p><b>COST REDUCTION PROGRAMME AND CROSS CUTTING THEME</b></p> <p>The Assistant Director of Finance asked the Finance Committee to note the 2019/20 Cost Reduction Report which included the following key points:</p> <ul style="list-style-type: none"> <li>• At 31<sup>st</sup> August 2019 £15.943m of schemes had been identified as Green or Amber against the devolved 2% savings target of £16.345m, leaving a gap of £0.402m. £13.650m of the identified schemes were recurrent.</li> <li>• Schemes totalling £13.202m had been identified as Green or Amber against the corporate savings target of £12.800m target as at 31<sup>st</sup> August 2019 leaving a surplus of £0.402m which covered the gap in delegated schemes. The recurrent effect of the identified schemes in 2020/21 was £11.500m.</li> </ul> <p>The Committee was informed the main concerns were the shortfall against the 2% devolved CRP target of £0.402m which needed to be addressed as soon as possible and the level of recurrent schemes which needed to improve to ensure that the UHB started 2020/21 in the best possible position.</p> <p><b>Resolved – that:</b></p> <p>The Finance Committee <b>noted</b> the progress against the £29.145m UHB savings requirement for 2019/20.</p>	
<b>FC19/103</b>	<p><b>RISK REGISTER</b></p> <p>The Assistant Director of Finance confirmed that one additional risk had been added to the 2019/20 Risk Register in month 5, namely a risk of up to £0.5m in respect of the UHB's share of the estimated year end overspend by the Welsh Risk Pool.</p> <p>Three (3) risks remained categorized as extreme risks (Red) on the 2019/20 Risk Register as follows:</p> <ul style="list-style-type: none"> <li>• Reduction in the £36.3m underlying deficit b/f to 2019/20 to the IMTP planned £4m c/f underlying deficit in 2020/21;</li> <li>• Management of Budget pressures;</li> <li>• Management of Nursing overspend - £1.363m month 5.</li> </ul> <p><b>Resolved – that:</b></p> <p>The Finance Committee <b>noted</b> the risks highlighted within the 2019/20 risk register.</p>	

<b>FC 19/104</b>	<b>MONTH 5 FINANCIAL MONITORING RETURNS</b>  These were noted for information.	
<b>FC 19/105</b>	<b>ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES</b>  That the Finance Committee had received and considered a plan to del a break even position with risks of £4m that needed to be managed.	
<b>FC 19/106</b>	<b>DATE OF THE NEXT MEETING OF THE BOARD</b>  <b>Wednesday</b> 30 <sup>th</sup> October; <b>2.00pm</b> ; Cefn Mably, Meeting Room, Ground Floor , HQ, Woodland House	



**Unconfirmed Minutes of the Strategy & Delivery Committee**  
**Tuesday 3<sup>rd</sup> September – 9:00am – 12:00pm**  
**Nant Fawr 2 & 3, Woodland House**

**Chair:**

Charles Janczewski                      CJ              UHB Interim Chair & Committee Chair

**Members:**

Sara Moseley                              SM              Committee Vice Chair & Independent Member

**In Attendance:**

Robert Chadwick	RC	Executive Director of Finance
Steve Curry	SC	Chief Operating Officer
Martin Driscoll	MD	Executive Director of Workforce & Organisational Development
Lisa Dunsford	LD	Director of Operations
Nicola Foreman	NF	Director of Corporate Governance
Abigail Harris	AH	Executive Director of Strategic Planning
Jason Roberts	JR	Deputy Nurse Director
Keithley Wilkinson	KW	Equality Manager

**Secretariat:**

Laura Tolley                              LT              Corporate Governance Officer

**Observers:**

Anne Beegan                              AB              Wales Audit Office

**Apologies:**

John Antoniazzi	JA	Independent Member
Fiona Kinghorn	FK	Executive Director of Public Health
Ruth Walker	RW	Executive Nurse Director

<b>S&amp;D 19/09/001</b>	<b>Welcome &amp; Introductions</b> <p>The Committee Chair (CC) welcomed everyone to the public meeting verbally in English and Welsh.</p> <p>The CC extended a special welcome to Anne Beegan from Wales Audit Office who observed the meeting and to Jason Roberts, Deputy Nurse Director, who attended in the absence of Ruth Walker, Executive Nurse Director.</p>	<b>Action</b>
<b>S&amp;D 19/09/002</b>	<b>Quorum</b> <p>The CC confirmed the meeting was quorate.</p>	
<b>S&amp;D 19/09/003</b>	<b>Apologies for Absence</b> <p>Apologies for absence were noted.</p>	
<b>S&amp;D 19/09/004</b>	<b>Declarations of Interest</b>	

	The CC advised the Committee that he was no longer involved with WHSSC.	
<b>S&amp;D 19/09/005</b>	<p><b>Minutes of the Committee Meeting held on 25<sup>th</sup> June 2019</b></p> <p>The Director of Corporate Governance (DCG) confirmed that Christopher Dawson-Morris – Corporate Strategic Planning Lead needed to be included on the attendance list.</p> <p>The Committee Vice Chair (CVC) provided an update regarding the Annual Equality Plan and advised that conversations had been held with the Equality Manager and Assistant Director of Organisational Development defining the role of Equality Champions and how Equality would be woven into the Amplify vision.</p> <p>The CC shared with the Committee that the Equality Manager (EM) had been tasked to produce a paper which detailed how this would be structured and the paper would be brought to the Committee for further discussion at a later date.</p> <p><b>Resolved – that:</b></p> <p>(a) Subject to the above amendment the Committee approved the minutes of the meeting held on 25<sup>th</sup> June 2019</p>	<p><b>LT</b></p> <p><b>KW</b></p>
<b>S&amp;D 19/09/006</b>	<p><b>Action Log following the Meeting held on 25<sup>th</sup> June 2019</b></p> <p><b>Resolved – that:</b></p> <p>(a) The Committee reviewed the action log following meeting held on 25<sup>th</sup> June 2019</p>	
<b>S&amp;D 19/09/007</b>	<p><b>Chairs Action taken since last meeting</b></p> <p>There had been no Chairs actions taken since the last meeting.</p>	
<b>S&amp;D 19/09/008</b>	<p><b>Having an unplanned care system that provides the right care, in the right place first time</b></p> <p>The Chief Operating Officer (COO) introduced the presentation and explained it looked at the last 12 months, preparations for the forthcoming year and the direction of travel going forward.</p> <p>The COO confirmed the demand for services had increased.</p> <p><b>2019/20 (year to date):</b></p> <ul style="list-style-type: none"> <li>• EU attendances up 3%</li> <li>• Of which Majors up 5%</li> <li>• Ambulance conveyances down 3%</li> <li>• Medicine admissions up 13%</li> <li>• Surgical emergency admissions down 6%</li> </ul>	

An additional 450 patients attending EU per month – 2/3rds of which were majors.

The COO explained that the detailed information and data pulled from Lightfoot was very helpful and gave the Operations Team an insight to improve the delivery of services.

The COO summarised the Unscheduled Care/Winter Initiatives as:

- Keep Me Home
- Right place, right time
- Every Day Counts
- Get Me Home

The operations team had supported care homes in the community and actively intervened to keep patients in the care home when they became unwell.

Work had been undertaken in Primary Care Sustainability, particularly in MSK and Mental Health areas. Alongside this Cluster Pilots were being developed to extend GP Practice hours. Work had been undertaken which looked at the frail older person liaison services in particular at weekends and rapid flu testing work had been carried out in hospitals.

A 'Safety Huddle' approach had been implemented at the front end of hospital which concentrated on keeping patients safe and focused on patient flow. Processes in the hospital had concentrated on improvement around managing patients through the system and avoiding delays.

Further work had taken place across the system with discharge pathways particularly at St Davids Hospital but more on a domiciliary basis where through the Transformation Fund a bid has been submitted for a Get Me Home + Model.

The COO provided an example of the 'SAFER' model and explained that it required discipline to be implemented at ward level. However, this would ensure that patients continued to flow through hospitals as it focused on what needed to happen next for the patient, why there was a delay and how it could be improved. He explained that the Model had been implemented in Llandough Hospital and there had been a significant gain from its use.

The COO described the impact on bed occupancy and confirmed how this correlated with performance on 4 and 12 hour performance. He explained that when winter on winter 4 hour performance was compared, a marked change could be seen compared to last year. Whilst the team could not confirm what had caused the improvement, the actions that had been taken with bed occupancy had improved the situation. For example EU Performance had averaged 82.7% in Quarter 1 2019 which was an improvement of 5.2% compared to the same Quarter the previous year.

The COO discussed the Reflections on Winter 2018/19 and explained that the external factors were less pronounced this year than previous ones –

	<p>with lower incidences of flu, warmer temperatures and no disruption due to adverse weather. Despite this, demand was the same or higher across most parts of the system, in particular EU attendances and Medicine admissions. However, even with higher demand performance improved in almost all areas.</p> <p>The CVC commended the presentation and asked if the transformation money that has gone into rebalancing primary and community care was having an impact and making a difference? In response, the COO confirmed that there was early evidence in relation to Get Me Home +. He added that data had been looked at for patients who had gone through Get Me Home + against patients who had not and confirmed and that up to 28 days had been taken off pathways. The COO explained that it was not 100% reliable, however, with that data along with the significant decrease in 14 day length of stay, Delayed Transfers of Care (DTC) reductions and bed occupancy reduction it suggested that the system was working. The evaluation was currently being tested with the transformation team.</p> <p>The COO confirmed that 2 years of transformation funding had been received, therefore the plan was to test and evaluate during this period before looking to incorporate into the everyday business should it be successful.</p> <p>The CC thanked the COO for the presentation and confirmed it provided the committee with good assurance.</p> <p>The CC requested the presentation be uploaded to iBabs.</p> <p>The Executive Director of Strategic Planning (EDSP) felt it would be helpful to take the presentation to the Executive meeting with the Local Authorities.</p> <p><b>Resolved – that:</b></p> <ul style="list-style-type: none"> <li>(a) The Committee Members noted the presentation</li> <li>(b) The presentation be added to the HSMB agenda</li> <li>(c) The presentation be taken to the Regional Partnership Board</li> </ul>	<p>LT</p> <p>AH</p> <p>LT</p> <p>AH</p>
<b>S&amp;D 19/09/009</b>	<p><b>Strategic Clinical Plan – Update</b></p> <p>The EDSP introduced the paper and it was noted that the clinical plan provided an overview of how clinical services would develop over the next decade. It was also noted that in some areas work was ongoing to develop the detailed service model, for example, the South West Cluster had received transformation funding to enable them to fully develop their cluster service model and this would inform the further development of the clinical services plan.</p> <p>The EDSP confirmed that there was an increasing separation in the roles of UHL and UHW emerging and there were business cases going through for increasing theatre capacity at UHL.</p>	

	<p>A key point in the document was being clear about the UHB Tertiary Services Plan. Ian Langfield, Corporate Planning Manager had undertaken a very detailed piece of work alongside Swansea to help the UHB understand, from a needs and sustainability basis, what the configuration of tertiary services across UHW, Swansea and into England should look like for the population of Cardiff and Vale and what that meant for the business case that was being developed for UHW.</p> <p>The EDSP explained she would like the 80 Amplify attendees to go out and engage with their teams regarding the Clinical Plan as part of the engagement process.</p> <p>The CC thanked the EDSP for the Clinical Plan and urged the EDSP to speak with Michael Imperato, Independent Member regarding the strategic consultation, as he had a lot of experience and expertise in this area.</p> <p>The CVC commented that the language should be changed if it went out to the general public, as it was not easily understood. In response, the EDSP confirmed that this would be built into the engagement plan.</p> <p><b>Resolved – that:</b></p> <ul style="list-style-type: none"> <li>(a) The Committee noted the progress to date in the development of the UHB's strategic Clinical Services Plan and the emerging clinical models for UHW and UHL.</li> <li>(b) The Committee would send any further comments they had on the draft Clinical Services Plan (by Friday 6<sup>th</sup> September 2019) to <a href="mailto:Anne.Wei@wales.nhs.uk">Anne.Wei@wales.nhs.uk</a>.</li> <li>(c) The Committee would comment on the draft engagement plan, particularly in relation to the engagement questions and whether the right issues are being tested during engagement (by Friday 6<sup>th</sup> September 2019) to <a href="mailto:Anne.Wei@wales.nhs.uk">Anne.Wei@wales.nhs.uk</a>.</li> </ul>	<p><b>AH</b></p> <p><b>AH</b></p> <p><b>ALL</b></p> <p><b>ALL</b></p>
<b>S&amp;D 19/09/010</b>	<p><b>Scrutiny of the Capital Plan</b></p> <p>The EDSP introduced the paper and confirmed that the UHB had received a Discretionary Capital funding allocation for 2019/20 of £14.428m, which was allocated to projects identified in the respective Clinical and Service Boards IMTPs, Estates, IM&amp;T &amp; Medical Equipment backlog maintenance and Statutory Compliance works. The programme was funded from the discretionary capital budget and prioritised balancing the needs to address problems with the existing estate, and invest in developments required to deliver the IMTP priorities.</p> <p>The draft discretionary capital programme was agreed by the Capital Management Group and issued for approval to the UHB Management Executive and the Board at the beginning of each financial year.</p> <p>In addition to the discretionary funding received from Welsh Government (WG), the UHB also received all Wales capital funding for schemes that</p>	

	<p>had been approved by Welsh Government or were progressing through the business case process.</p> <p>She explained that the UHB currently had 5 Business Cases submitted to WG for consideration including:</p> <ul style="list-style-type: none"> <li>• Strategic Outline Case for CRI Sexual Health Referral Centre</li> <li>• Strategic Outline Case for UHW Academic Avenue development (Theatres/Haematology Ward and Day Unit/Polytrauma Unit)</li> <li>• Outline Business Case for Maelfa Wellbeing Hub</li> <li>• Outline Business Case for Penarth Wellbeing Hub</li> <li>• Business Justification Unit for Cystic Fibrosis Unit at UHL</li> </ul> <p>The CMG report which was attached at the appendix was of the Major Capital Projects and it highlighted a number of key issues relating to several of the schemes including:</p> <ul style="list-style-type: none"> <li>• Neonatal Unit</li> <li>• Rookwood relocation</li> <li>• UHW Haematology Day Unit</li> <li>• UHW Major Trauma &amp; Vascular Hybrid Theatre</li> <li>• Penarth Wellbeing Hub</li> </ul> <p>The CVC asked if there was any support required from the Committee. In response, the EDSP explained that business cases could not be changed once agreed and that timescales for business cases needed to be realistic as when business cases go to Welsh Government it takes time to get all responses from different sources.</p> <p>The CC requested assurance as in the plan the Medical Equipment budget was only £1M however, based on previous spending he was aware that the need was £4-5M. He also asked for confirmation that patient safety was utmost in those considerations. The EDSP confirmed that a log of medical equipment had been developed and was improving with the help of procurement and clinical boards. The EDSP explained that the team are not in a position to proactively replace equipment that is needed as current funding does not allow for it, therefore it is prioritised.</p> <p>The Executive Director of Finance (EDF) confirmed that Clive Morgan was managing the medical equipment and although there was only £1M in that programme at the end of the year, traditionally, Welsh Government conducted a stock take of all big schemes and would make available extra money which would need to be spent before the year end and Clive had a list of medical equipment that he could purchase should those circumstances arise.</p> <p>The EDF confirmed that the medical equipment figures could be shared with the Committee for assurance going forward.</p> <p>The EDSP advised the Committee of an update to the plan and confirmed that the Poly Trauma Ward would move from A3 link to A4 Ward.</p> <p><b>Resolved – that:</b></p>	RC
--	--	----



	<p>(a) The Committee noted the paper</p> <p>(b) The Committee were assured that the Capital Programme was being closely monitored to ensure the UHB met their statutory and mandatory obligations referred to within the report</p>	
<b>S&amp;D 19/09/011</b>	<p><b>Summary on the Integrated Care Fund</b></p> <p>The EDSP confirmed that the paper outlined the quarterly return, the annual report and the new programme lead. The EDSP explained the reports had gone back to the Regional Partnership Board and provided the Committee with an overview of the Intermediate Care Fund and Transformation Fund.</p> <p>The COO commented that the summary linked heavily with unscheduled care and felt it more important that the rigour of measurement was applied by schemes to enable understanding of which schemes were working and which schemes may not be.</p> <p>The EDSP confirmed that a modest transformation bid had been submitted and although formal feedback was not yet received they were aware the bid had not been approved, therefore, a new bid had been submitted with certain items taken out. The EDSP explained it was thought the Minister would make an announcement on transformation funding before the summer recess however this had not been forthcoming therefore this required discussion with Welsh Government colleagues.</p> <p>The CVC asked if money was being held back due to the unknown impact of Brexit. In response, the EDSP explained that money was not being specifically held back however due to the uncertainty, Welsh Government would hold some reserves because of unknown Brexit consequences.</p> <p>The CC shared with the Committee that the Integrated Care Fund was closely monitored by the Regional Partnership Board to ensure funds were used effectively.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee noted the Q4 Performance Report of the Integrated Care Fund (ICF) and the Transformation Fund in 2018-19.</p>	
<b>S&amp;D 19/09/012</b>	<p><b>Amplify 2025</b></p> <p>The Executive Director of Workforce &amp; Organisational Development (EDWOD) introduced the paper and confirmed Cardiff and Vale University Health Board (CAVUHB) had signed a learning alliance with Canterbury Health Board (CHB) from New Zealand. CHB had made significant cultural and system improvements during the past ten years which had positively impacted on how patients move through their ‘joined up’ services, consequently improving outcomes. These changes had benefitted staff moral and improved the culture within CHB to a high trusting environment, with a person centred approach.</p>	

	<p>CAVUHB had designed a similar program of work to develop their own health system for the benefit of patients and staff. The recent 'Amplify2025' engagement event was the first step in this process. 'Amplify 2025' enabled 80 of the highly engaged leaders at CAVUHB to think differently about delivering healthcare, ensuring CVUHB put "Wyn" at the heart of decision making. Amplify 2025 was designed to complement the current ten year strategy and strategic clinical service plan.</p> <p>The EDWOD explained that the next stage of Amplify was to increase the number of staff exposed to the new thinking by inviting them to take part in the design of health services for the future. The Health Board was in the process of establishing a 'Showcase' experience at which up to five thousand staff, partners in the community, patients, families, suppliers and other visitors would be invited to attend.</p> <p>The EDWOD explained that during the first Amplify event a number of leaders sponsored a table of 9-10 people, those leaders were now expected to engage and encourage their table in preparation for the showcase event.</p> <p>The EDWOD confirmed changes had already been seen and "Wyn" was placed at the heart of decision making.</p> <p>The CC complimented the team ambition for changing staff culture and improving development.</p> <p>The CVC asked how interests and ambitions of staff were being captured. In response, the EDWOD stated that after the showcase event all attendees would be asked how they would like to make change and all staff had been encouraged to put themselves forward for Amplify.</p> <p>The CC commented that the 'assurance by' section on the paper required strengthening going forward.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee Members agreed to support and promote the Culture and leadership enabler and champion the ambition of Amplify 2025.</p>	MD
S&D 19/09/013	<p><b>Infrastructure / Estates Update</b></p> <p>The EDSP introduced the paper and confirmed that it was an ongoing review of the estates function. The Estates Team had engaged widely however they had faced some challenges with the proposed changes.</p> <p>The EDSP explained the Estates team were currently understaffed by approximately 30 members, however with support from Workforce and Organisational Development new team members were starting to come through. The EDSP advised the team had performed extremely well with the resource they had and more workforce would enhance the service greatly.</p>	



	<p>The CVC supported the changes outlined as she felt they coincided well with the feedback which had been received from patient safety visits, the CVC encouraged the EDSP to keep monitoring the outstanding issues in the system.</p> <p>The EDSP explained there were some differences with opinions relating to prioritisation of estates issues, therefore a system was being developed to enable staff visibility of outstanding estates and maintenance issues.</p> <p>The Equality Manager (EM) commented the phrase 'Handyman' was found in the paper and requested this term be avoided in future and re-worded.</p> <p>The CC confirmed that he felt assured by the update provided and welcomed modernisation in the Estates Department.</p> <p><b>Resolved – that:</b></p> <ul style="list-style-type: none"> <li>(a) The Committee Members noted the contents of the report</li> <li>(b) The Committee Members supported the work being undertaken by the estates team to manage an ageing estate and infrastructure within the limited resource available</li> <li>(c) The Committee Members supported the modernisation proposals in relation to the structure and the introduction of technology to ensure that the department was fit to meet its on-going challenges</li> </ul>	<b>AH</b>
<b>S&amp;D 19/09/014</b>	<p><b>Research &amp; Development Update</b></p> <p>The Medical Director (MD) advised the Committee that the research function had the best year in the last 5 years with over 6,500 patients recruited into research studies. The delivery of the research activity was going very well despite the challenges outlined in the paper.</p> <p>The MD confirmed that overall, the research performance had been very strong. There had been a particularly strong performance in Cancer studies, Womens &amp; Childrens studies and work had just started on primary pharmacological studies in children which was a big step.</p> <p>The MD confirmed that the paper focussed on two areas which were Funding Arrangements and the Joint Research Office and went on to explain that due to changes in internal funding processes, the UHB had converted to the Welsh Government recommended funding process. There was a new value based funding model going online in April 2020 which would be a positive step as it would benefit the UHB by addressing the current imbalances which exist in the current funding process.</p> <p>The MD explained that the Joint Funding Office was an important strategic development which would improve CVUHB ongoing relationship with Cardiff University. The MD explained that the relationship had struggled over past years, but was now a key component into developing Lakeside into a Joint Research Office.</p>	

	<p>The CC queried why it had been stated, within the paper, that the research position was strong, however, the research &amp; development budget had dropped significantly over 5 years. In response, the MD confirmed that this was correct and despite the restricted funding, Cardiff &amp; Vale were the only Health Board in Wales who had increased research functionalities. The MD explained that the value based funding plan for next year hoped to address that issue.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee Members would promote, at all opportunities, the need for WG/HCRW to have a “Value Based Healthcare” R&amp;D funding model to support CVUHB’s R&amp;D activities through more appropriate funding for the sort of complex and tertiary type studies that CVUHB undertakes.</p> <p>(b) The Committee Members noted the R&amp;D and its aims of moving the WG TUPE’d staff from the Clinical Research Facility to the vacated office space which would become available on the 2<sup>nd</sup> floor of UHW when the R&amp;D Office moves from there to Lakeside in April 2020.</p>	
<p><b>S&amp;D 19/09/015</b></p>	<p><b>Update on the Independent Review of the CAMH Service and Delivery Unit Report</b></p> <p>The COO provided the verbal update and confirmed a number of reviews had taken place in the CAMH Service and specialist care CAMHs had been brought back from Cwm Taf at the start of 2019.</p> <p>The COO confirmed there had been exceptional increases in the demand for primary care CAMHs during April and May 2019 with 100% increase year on year for referrals in. As a result of this increase the services in tier 1 measures had deteriorated remarkably due to the back log in the service, mainly around 28 day assessments and time to treatment. The COO advised the Committee that as a result of this a comprehensive report would be taken to Board in September 2019 to advise where the service was at and what it was doing to improve the situation.</p> <p>The COO confirmed that 2 pieces of work had been undertaken to help improve the situation. This included a piece of work being undertaken by the Delivery Unit which was focussing on the Primary Care Side and a further piece of work which had been commissioned by ourselves when the services were taken back in.</p> <p>The recommendations from the Delivery Unit report included the following:</p> <ul style="list-style-type: none"> <li>• Describing thresholds for assessment</li> <li>• Measures to improve the part one measure</li> <li>• Better awareness of general practice and how to access primary care CAMHs</li> <li>• Integration of both primary and secondary CAMHs services</li> </ul>	

	<ul style="list-style-type: none"> <li>Ensuring that work was carried out to deal with the Therapeutic Interventions back log</li> </ul> <p>The independently commissioned report recommendations included:</p> <ul style="list-style-type: none"> <li>Service capacity - including working upstream with highest referrers GP's and Schools</li> <li>Patient Flow - establishing a clinical single point of access</li> <li>Service Delivery - introduce group sessions and group therapy</li> <li>De-professionalising the service – services working to the user needs</li> </ul> <p>The COO explained that both reports had been brought together into one plan and a marked improvement was expected to be seen from September through to November 2019.</p> <p>The CC explained that he felt the proposals put forward were exciting and would be sustainable going forward.</p> <p>The CVC asked if there would be communication around the re-structure as this could be a distressing change for some service users. In response, the COO confirmed both reports outlined the need for better communication with Primary Care, therefore there were specific proposals in the report which looked at how to communicate better with GP's and this would include one key message which would be how the message could be simplified for service users.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee Members noted the verbal update on the Independent Review of the CAMH Service and Delivery Unit Report</p>	
<b>S&amp;D 19/09/016</b>	<p><b>Key Organisational Performance Indicators</b></p> <p>The COO introduced the paper which was taken as read and then opened it up for comments or questions from Committee Members</p> <p>The CC thanked the COO for the helpful report and asked in relation to pension and tax issues, if there were any timescales when these would be resolved. The COO confirmed unfortunately not. The EDWOD explained that they were waiting for an update from Welsh Government but due to the current issues Welsh Government were facing they were not sure when a plan to resolve this would be provided. The CC expressed his disappointment that there were no current timescales to resolve the issues.</p> <p>The CC explained that in relation to follow up patients, the position remained static and asked when the Committee would see a positive change in position in this area. In response, the COO explained that there were significant system processing issues identified from a Public Accounts Review, it was unique to CVUHB due to the scale of CVUHB compared to other Health Boards. The COO confirmed the team were ensuring that the position was being validated and processes needed to</p>	

	<p>be clinically led as patients could not be taken off waiting lists without clinicians sign off. Once the process had been signed off by clinicians, it would be implemented and then a significant reduction would be seen.</p> <p>The CC asked what opportunities were available to stabilise the ambulance handover service. In response, the COO explained that the service was erratic, this was occasionally driven by performance, patient flow and also by the number of ambulances received. The COO confirmed there were options to reduce this, by reduction of flow and work was currently being undertaken directly relating to this issue. The COO advised the Committee a full discussion had taken place regarding the Assessment Unit in UHW following the recent HIW report and explained the pressures in the unscheduled care system could appear at any point therefore, the team had refreshed the handover protocol and there had also been a direct release protocol brought in by WAST.</p> <p>The CC commented that the Committee had previously requested the CAMHS figures be separated in the report however they had not been on this occasion, therefore requested this be done for the next meeting.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee Members noted the year to date performance for 2019-20 against key operational Welsh Government performance targets and delivery profiles as set out in the Health Board's Integrated Medium Term Plan (IMTP)</p>	SC
S&D 19/09/017	<p><b>Primary Care Out of Hours Service – Peer Review and Public Accounts Committee Report</b></p> <p>The COO introduced the paper and confirmed it provided an update on the national peer review of Urgent Primary Care/Out of Hours (OOH) and the actions that were taken forward within the Health Board. The COO explained it also provided a brief overview of the inquiry undertaken by the Public Accounts Committee.</p> <p>The COO confirmed the intentions of the reviews were to review the resilience of the OOH service, to understand the way forward, provide national recommendations and to recognise good practice .</p> <p>The COO explained the peer review noted a number of areas where CVUHB were doing well which included:</p> <ul style="list-style-type: none"> <li>• Workforce planning and the MDT model as best practice across Wales (this had been cascaded to others).</li> <li>• The development of the remote working protocol as best practice in Wales and the protocol on death certification (again these have been shared with the All Wales OOH forum).</li> <li>• The work undertaken on demand capacity analysis which is also being used as a model for implementation in other Health Boards.</li> <li>• The escalation protocols and arrangements for on call and out of hours which will be suggested to other Health Boards as good practice.</li> </ul>	

	<ul style="list-style-type: none"> <li>• The “good culture and excellent support management and leadership” within the Health Board.</li> </ul> <p>The COO advised the Committee there was also a number of actions following the peer review which were reflected in the appendices.</p> <p>The COO explained that there had been a good discussion at the Public Accounts Committee with CVUHB and Hwyl Dda Health Board contributing and attending the Committee. The COO confirmed a number of areas noted as complimentary for CVUHB and in the report almost all actions were at Welsh Government Level.</p> <p>The COO confirmed an additional peer review in OOH would be conducted in November which would be shared with the Committee.</p> <p>The CC asked the COO and Director of Operations (DO) if the OOH service was still being provided out of UHW as the peer review suggested it was not the best place for the service. In response, the DO confirmed that CVUHB provided 3 OOHs, however the service at UHW was not open at all times. The DO explained that views had changed around operating an OOH service at UHW and there was no longer a need to have the service open in UHW, therefore it would be formally proposed to Management Executives in October 2019 to close the service.</p> <p>The CVC asked what were the greatest challenges the service faced. In response, the DO confirmed the inevitable challenge was the unpredictability of the service.</p> <p>The DO advised the Committee that a challenge from the peer review was to be more ambitious and to look at a regional dental service, training hubs as it was felt CVUHB were in a good position to take proposals forward. The DO confirmed a meeting was being held with 111 to discuss initial proposals and business cases.</p> <p>The CC asked if there was a timeframe for going on board with the 111 service. In response the DO explained it was 2021, however there could be potential to bring the date forward.</p> <p><b>Resolved – that:</b></p> <ul style="list-style-type: none"> <li>(a) The Committee noted the feedback from the National Peer Review and Public Accounts Committee.</li> <li>(b) The Committee considered the request from the Chief Executive of Aneurin Bevan University Health Board (who is the Strategic Lead for Out of Hours Services) for the Peer Review report and action plan to be considered by appropriate Board Committee.</li> <li>(c) The Committee noted the action plan in response to the national peer review and the monitoring through PCIC Clinical Board and the Executive Performance Reviews</li> </ul>	SC
S&D 19/09/018	Workforce Key Performance Indicators	

	<p>The EDWOD introduced the report and confirmed that workforce data would not change that much with 15,000 staff month by month. CVUHB's pay bill was underspent which matched other Health Boards. The EDWOD explained there were some challenges within medicine and surgery, particularly around nursing, therefore the team had been very active in recruiting over past months which had been successful. The EDWOD confirmed that we were now recruiting internationally and despite this been a risk early signs indicated it had gone very well with 40 international nurses been employed for the Medicine and Surgical Clinical Boards.</p> <p>The EDWOD confirmed that it had been difficult to get job plans for the medical staff at the level required therefore he had engaged with the MD who had previous experience in this area and a different system solution was being considered.</p> <p>The EDWOD advised the Committee of a small absence increase in June 2019 which was surprising. May 2019 had been good at just 4.6% however it had now moved closer to 5%. The EDWOD confirmed the aim was to remain at 4.5% but as the winter months approached this would bring some challenges.</p> <p>The CC requested the EDWOD to monitor the flu immunisation data closely which was at 58%. In September 2018 it was over 60%. The EDWOD confirmed the flu immunisation process would start in September 2019, therefore it would start with new data, starting at 0% and it would Increase as the months went by.</p> <p>The CC welcomed the report as it gave the Committee the opportunity to challenge what they felt was appropriate.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee noted the Workforce Key Performance Indicators.</p>	<b>MD</b>
<b>S&amp;D 19/09/019</b>	<p><b>Welsh Language Scheme</b></p> <p>The EDWOD introduced the report and confirmed the Welsh Language (Wales) Measure 2011 replaced the Welsh Language Act 1993 and as part of the new legislation. He advised that in Wales the Welsh language had equal legal status with English and must not be treated any less favourably. Public bodies no longer needed to develop and implement Welsh Language Schemes but had to comply with a set of national Welsh Language Standards instead.</p> <p>The EM explained that the biggest challenge CVUHB faced was that out of 121 standards, CVUHB chose to challenge 30 of the standards that it felt it could not comply with. The EM confirmed a response to the challenges was expected from the Welsh Language Commissioner by 12<sup>th</sup> September 2019.</p> <p>The EM explained from an assurance perspective that CVUHB needed to move on with Welsh Language Standards, there had previously been lack</p>	



	<p>of ownership and support from Clinical Boards. The EM confirmed the proposal was to get a steering group together to help CVUHB move forward with the Welsh Language Standards which would enable compliance.</p> <p>The EDWOD confirmed better senior involvement was required therefore a paper would be taken to Management Executive to gain support and strengthen impact.</p> <p>The Director of Corporate Governance (DCG) asked how CVUHB compared to other Health Boards with how many challenges they had made to the Commissioner and if any had been accepted. In response, the EM confirmed there were issues with the geography but North Wales had challenged 3/4 standards and Cwm Taf had challenged 7. The EM explained 5 of the 7 challenges Cwm Taf had made, CVUHB were already complying with.</p> <p>The CC confirmed the need for CVUHB to embrace the Welsh Language as part of the UHB culture.</p> <p><b>Resolved – that:</b></p> <ul style="list-style-type: none"> <li>(a) The Committee Members noted the content of the report</li> <li>(b) The Committee Members supported the actions to assist the organisation in complying with the standards</li> </ul>	
<b>S&amp;D 19/09/020</b>	<p><b>Appraisal Rates – Deep Dive</b></p> <p>The EDWOD confirmed the paper aimed to provide assurance to the Committee that workforce had developed value based appraisals and were now being rolled out across the organisation.</p> <p>The EDWOD confirmed the new value based appraisals looked at how staff perform duties, career planning, identified talents, and so on. The new process had been tested widely throughout the organisation with a number of groups who had gone through with results been mapped on a 9 box grid, which looked at performance and potential.</p> <p>The EDWOD confirmed the process had taken longer to implement than what was hoped for however he commended the team who had developed and implemented it as they had worked extremely hard with the whole organisation to get this implemented.</p> <p>The EDWOD explained that people stay with an organisation because they believe they have a future and that is what CVUHB should be helping staff to achieve.</p> <p>The CC confirmed he welcomed the approach and confirmed it would be of great benefit to the organisation and its staff.</p> <p><b>Resolved – that:</b></p>	

	(a) The Committee Members supported and promoted the revised Values Based Appraisal process.	
<b>S&amp;D 19/09/021</b>	<p><b>Board Assurance Framework – Capital Assets</b></p> <p>The DCG introduced the paper and confirmed the Committee had 4 risks set out in the Board Assurance Framework that the Committee were responsible for. The Committee had already discussed the following risks on the BAF:</p> <ol style="list-style-type: none"> <li>1. Workforce</li> <li>2. Sustainable Primary and Community Care</li> <li>3. Sustainable Culture Change</li> </ol> <p>Therefore, the report looked at Capital Assets and was presented to the Committee for challenging in order to provide extra assurance to the Board when the Board Assurance Framework would be reviewed in its entirety at the end of September 2019.</p> <p>The CC confirmed the paper was an accurate reflection of the Capital Assets.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee Members noted the risk in relation to Capital Assets and provided further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.</p>	
<b>S&amp;D 19/09/022</b>	<p><b>Employment Policies</b></p> <p>(a) NHS Wales Special Leave Policy (b) Maternity Policy</p> <p>The EDWOD introduced the paper and confirmed the minor amendments to both policies.</p> <p>The CC requested the Committee have full sight of the policies with the changes included. In response, the EDWOD confirmed the policies would be circulated to the Committee.</p> <p><b>Resolved – that:</b></p> <p>(a) The Committee Members adopted the revised NHS Wales Special Leave Policy (b) The Committee Members approved the revised Maternity, Adoption, Paternity and Shared Parental Leave Policy (c) The Committee approved the full publication of these documents in accordance with the UHB Publication Scheme</p>	<b>MD</b>
<b>S&amp;D 19/09/023</b>	<p><b>Any Other Business</b></p> <p><b>Resolved – that:</b></p>	



	(a) There was no other business to discuss.	
<b>S&amp;D 19/09/024</b>	<b>Items to bring to the attention of the Board</b>  <b>Resolved – that:</b>  (a) There were no items to bring to the attention of the Board	
<b>S&amp;D 19/09/025</b>	<b>Date &amp; Time of next Meeting</b>  29th October 2019, Nant Fawr 1 & 2, Ground Floor, Woodland House	

**CONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD ON 9<sup>TH</sup> JULY  
NANT FAWR 2, GROUND FLOOR, WOODLANDS HOUSE, MAES-Y-COED**

**Present:**

Michael Imperato	MI	Independent Member – Legal (Chair)
Akmal Hanuk	AH	Independent Member – Community
Dawn Ward	DW	Independent Member – Trade Union

**In attendance:**

Janice Aspinall	JA	Staff Safety Representative
Charles Dalton	CD	Head of Health and Safety
Martin Driscoll	MD	Director of Workforce and OD
Geoff Walsh	GW	Director of Capital, Estates and Facilities

**Secretariat:**

Rachael Daniel	RD	Health and Safety Adviser
----------------	----	---------------------------

**Apologies:**

Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Fiona Kinghorn	FK	Director of Public Health

**Observer:**

Laurie Higgs	LH	Swansea Bay University Health Board
--------------	----	-------------------------------------

<b>HSC: 19/07/001</b>	<b>WELCOME AND INTRODUCTIONS</b>  The Chair welcomed everyone to the meeting.	<b>ACTION</b>
<b>HSC: 19/07/002</b>	<b>APOLOGIES FOR ABSENCE</b>  Apologies for absence were noted.	
<b>HSC: 19/07/003</b>	<b>DECLARATIONS OF INTEREST</b>  The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.	
<b>HSC: 19/07/004</b>	<b>MINUTES OF PREVIOUS MEETING</b>  The minutes of the Health and Safety Committee held on the 9 April 2019 were reviewed.  <b>The Committee resolved – that:</b>  The Committee approved the minutes of the meeting held on 9 April 2019.	
<b>HSC: 19/07/005</b>	<b>COMMITTEE ACTION LOG</b>  The Committee reviewed the action log from the meeting held on the 9 <sup>th</sup> April 2019.	

HSC: 19/036 – Enforcement Agencies Correspondence Report: The Head of Health and Safety advised the contractor fall legal case would be heard in Court on the 15<sup>th</sup> - 16<sup>th</sup> July 2019.

**The Committee resolved – that:**

The outcome of the case would be brought to the October meeting.

CD

**HSC:  
19/07/006**

**PRESENTATION – STRUCTURE AND PROCESS FOR STAFF HEALTH AND SAFETY TRAINING**

The Director of Workforce and OD informed the Committee the presentation would be deferred to the October meeting.

**HSC:  
19/07/007**

**HEALTH AND SAFETY ANNUAL REPORT**

The Head of Health and Safety presented the Annual Report to the Committee and highlighted the following key issues:

- A notable reduction in the number of lost time (RIDDOR) incidents, down from 118 to 99.
- An 8% reduction in the number of all staff reported events.
- Staff reported incidents show that violence and aggression accounts for 59% of all events and shows a small rise of 3% from 2018/19.
- A positive trend in the reduction of manual handling incidents with the overall number for 2018/19 16% lower than the previous year. Equally data shows that the 5 year average for all manual handling incidents represent a significant improvement of being 38% lower than the previous 5 years and lost time events being 26% lower.
- The reporting of sharps injuries is the lowest recorded to date at 255 being 8% lower than 2017/18. Furthermore since the introduction of the safer sharps initiative 5 years ago, data demonstrates an average reduction of 29% over the pre safer sharps period.
- Mandatory training of health and safety has significantly improved with 4 clinical boards achieving the 85% target and a further 3 being above 80%.
- Tutor led training compliance for both manual handling and violence and aggression is well below requirement and a review is being progressed with an aim to enhance competence.
- The number of prosecutions for assaults on staff significantly increased during the year from 52 to 81. This effectively equates to a successful conviction every four and a half days of the year and the ten year average is still significantly greater than one successful conviction per year.
- The lone worker devices continued to be highly valued by staff with average usage being at 70% and devices in great demand.
- Control of Substances Hazardous to Health (COSHH) compliance increased from 62% in 2017/18 to 82% in 2018/19.
- Corporate recruitment of an Adviser to enhance contractor control for non-estate activities.

- High degree of contractor control maintained throughout 2018/19, reduction in the number of non-compliance issues identified with the new advisory category introduced.
- Notably consistently high Environmental Health star ratings of food preparation areas and restaurants was achieved during the period.

The Chair thanked Mr Dalton for his presentation.

**The Committee resolved that:**

The Annual Report be noted.

**PEDESTRAIN ACCESS STRATEGY**

The Director of Capital, Estates and Facilities provided the Committee with an update following the last meeting. As previously reported there are three high risk areas and in order to prioritise these a Task and Finish Group was being established. The key aims of this group will be to identify the cause of the risk and develop tangible cost effective solutions to mitigate the risk to an agreed practical level. Mr Walsh also advised a programme of works had been developed for the group.

The Independent Member – Trade Union queried whether there would be any engagement with the public. Mr Walsh advised the aim is to move traffic off site but at present there is an abuse of parking by staff and students and a behavioural change is required. The Independent Member – Community queried whether there had been any campaigns to raise awareness with these groups. Mr Walsh stated the Chief Executive is very active in promoting the Park and Ride Facilities but their needs to be a change in staff attitudes to parking on site.

The Chair offered his congratulations to Mr Walsh and his team for moving this issue forward.

**The Committee resolved that:**

- (a) the report be noted.
- (b) an update of the Task and Finish Group Programme of Works be provided to the October meeting.

**PROACT AUDIT SURVEY PROGRESS**

The Head of Health and Safety informed the Committee the Operational Health and Safety Group will review the status of the survey results and the action plan would then be brought to the Committee for assurance.

**The Committee resolved that:**

- (a) the report be noted.
- (b) the action plan be brought to a future meeting.

**HSC:  
19/07/008**

**HSC:  
19/07/009**

**GW**

**HSC:  
19/07/010**

## **HSE INSPECTION OF VIOLENCE AND AGGRESSION AND MUSCULOSKELETAL DISORDERS IN HEALTHCARE 2018-19**

The Head of Health and Safety informed the Committee as previously reported the inspection was anticipated during the third financial quarter. Mr Dalton also informed the Committee Hywel Da Health Board had also been inspected during the first week of July and the inspection had been undertaken by 4 Inspectors over 4 days, and had now been expanded to include Asbestos Management. A meeting was taking place with Hywel Da at the end of the month to learn from their experience.

Mr Dalton stated he was concerned the Risk Management Policy and Procedure were currently out of date and this had been raised with the Director of Corporate Governance. He proposed that a Health and Safety Risk Assessment Procedure be developed and presented to the September meeting of the Operational Health and Safety Group for approval, this was endorsed by the Committee.

**CD**

The Chair welcomed Mr Laurie Higgs, Head of Health and Safety for Swansea Bay University Health Board to the meeting and invited his observations from the inspection undertaken at Swansea Bay. Mr Higgs advised in addition to the general ward areas and accident and emergency they also visited the mortuary and operating theatres. He informed the Committee the Health Board had received 4 Improvement Notices relating to the management of manual handling risks to staff within the operating theatres, accident and emergency department and porters, 4 related to violence and aggression management in the accident and emergency department and porters and 1 related to inadequate arrangements to report and investigate incidents to ensure lessons learnt.

The Independent Member – Community thanked Mr Higgs for attending as it was good to share experiences.

Mr Imperato requested a progress report for the next meeting, Mr Dalton added a table top assessment against the knowns would also be undertaken.

**CD**

### **The Committee resolved that:**

- (a) the report be noted.
- (b) a progress report be presented to the October meeting.
- (c) a table top assessment be undertaken prior to the next meeting.

**HSC:  
19/07/011**

## **ENFORCEMENT AGENCIES REPORT**

The Head of Health and Safety informed the Committee of one new item in relation to a needle stick injury from a known BBV+ source which had been reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations whereby the HSE had requested further information. This information had been provided to the HSE and based off this no further action was to be taken.

Mr Dalton also advised the Committee the case in relation to the Contractor Fall would be heard in Court on the 14/15<sup>th</sup> July 2019.

**The Committee resolved that:**

- (a) the report be noted.
- (b) the outcome of the Contractor Fall case be brought to the October meeting.
- (c) agreed that appropriate actions were being pursued to address the issues raised.

**HSC:  
19/07/012**

**FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE  
REPORT**

The Director of Capital, Estates and Facilities informed the Committee unwanted fire alarms had reduced in University Hospital of Wales (UHW) by 22% and training compliance had increased to 70%.

Mr Walsh also highlighted the 2 significant fires which had occurred since the last meeting.

The first was at Lansdowne Hospital which had been a deliberate act. The second was on Ward C5 whereby a patient set themselves on fire lighting a match whilst on oxygen, this incident could have been a lot worse were it not for the actions of the staff on duty at the time and in particular the security staff, the staff have been commended for their actions on the day. A full debrief of this incident was being co-ordinated by Huw Williams, Emergency Preparedness Manager.

The Independent Member - Community advised there was increased assurances since the last meeting, he queried whether there would be an investigation in to the C5 incident. Mr Walsh advised there was an on-going criminal investigation and also as mentioned the internal debrief. The debrief included all staff who were involved in the incident on the day and the findings of the debrief would be presented to the Board, he also added there were some lessons to be learnt from the incident.

Mr Hanuk added he would like these types of incidents to be part of the training course.

Mr Walsh also raised his concerns in relation to the fire at Lansdowne Hospital as potentially the ducts in the building could have been accessed, as a result enhanced security was being put in place. He added Whitchurch Hospital was also a concern as there were too many access points, again the security had been enhanced with 3 dog handlers on a 24/7 basis at a cost of approximately £35k per month.

The Independent Member – Trade Union commended the Work undertaken by Mr Walsh with the Fire Service.

**The Committee resolved that:**

- (a) the report be noted.

**HSC:  
19/07/013**

**HEALTH AND SAFETY ASSURANCE SCHEDULE AND PRIORITY  
IMPROVEMENT PLAN 2019/20**

The Head of Health and Safety informed the Committee a lot of the actions were operational in nature and would be monitored through the Operational Health and Safety Group.

Mr Dalton brought one item to the attention of the Committee, he advised evacuation chair training was currently being reviewed and looking at whether a response team would be more appropriate as opposed to training a vast number of nursing and clinical staff.

**The Committee resolved that:**

- (a) the report be noted.
- (b) agreed that appropriate actions are being taken to address the issues raised.

**HSC:  
19/07/014**

**ENVIRONMENTAL HEALTH INSPECTION OF ALL AROMA  
COFFEE OUTLETS, UNIVERSITY HOSPITAL OF WALES (UHW)  
ON 25<sup>TH</sup> APRIL 2019**

The Director of Capital, Estates and Facilities informed the Committee whilst a score of 3 is generally satisfactory as a Service Board the standard has been set at 4 and above. He was concerned at the type of mistakes identified in the inspection and he requires internal assurances. The inspections were becoming onerous and he was seeking to take on a qualified individual to manage food hygiene across the Health Board.

On a positive note Mr Walsh advised that the outlets in UHL had scored 5 since the UHW inspection.

**The Committee resolved that:**

- (a) the report be noted and the remedial actions taken.

**HSC:  
19/07/015**

**UPDATED HEALTH AND SAFETY RELATED POLICIES  
SCHEDULE**

The Health and Safety Adviser informed the Committee the Department was looking to reduce the overall number of policies to have a small suite of policies with procedures feeding from these.

The Independent Member – Trade Union requested staff representatives be involved in the process.

**The Committee resolved that:**

- (a) the updated schedule be noted.

**HSC:  
19/07/016**

**CONTRACTOR CONTROL POLICY**

The Health and Safety Adviser informed the Committee the Policy approval was being deferred until after the outcome of the court case

	<p>in July so that any actions could be incorporated into the Policy. The Policy would then be presented to the October meeting.</p> <p>The Director of Capital, Estates and Facilities informed the Committee Internal Audit would be undertaking a review of contractor control.</p> <p><b>The Committee resolved that:</b></p> <p>(a) the Policy would be deferred to the October meeting so that the outcome of the court case could be incorporated as appropriate.</p>	<b>GW</b>
<b>HSC: 19/07/017</b>	<p><b>WORK PROGRAMME 2019/20</b></p> <p>The Executive Director of Workforce and OD informed the Committee the Work plan had been updated.</p> <p><b>The Committee resolved that:</b></p> <p>(a) the Work Plan for 2019/20 be approved.</p>	
<b>HSC: 19/07/018</b>	<p><b>OPERATIONAL HEALTH AND SAFETY GROUP</b></p> <p><b>The Committee resolved that:</b></p> <p>(a) the minutes of the Operational Health and Safety Group held in February 2019 be RATIFIED.</p>	
<b>HSC: 19/07/019</b>	<p><b>FIRE SAFETY GROUP</b></p> <p><b>The Committee resolved that:</b></p> <p>(a) the minutes of the Fire Safety Group held in March 2019 be RATIFIED.</p>	
<b>HSC: 19/07/020</b>	<p><b>HEALTH AND SAFETY PRIORTY IMPROVEMENT PLAN – DETAILED</b></p> <p><b>The Committee resolved that:</b></p> <p>(a) the plan be NOTED.</p>	
<b>HSC: 19/07/021</b>	<p><b>ENVIRONMENTAL HEALTH INSPECTION OF CENTRAL FOOD PRODUCTION UNIT, UNIVERSITY HOSPTITAL OF WALES ON 25<sup>TH</sup> MARCH 2019</b></p> <p><b>The Committee resolved that:</b></p> <p>(a) the report be NOTED.</p>	
<b>HSC: 19/07/022</b>	<p><b>DATE OF THE NEXT MEETING OF THE COMMITTEE</b></p> <p>Tuesday 8<sup>th</sup> October at 9.00am, Woodlands House, Heath, Cardiff, CF14 4TT</p>	



**Minutes from the Local Partnership Forum Meeting held on 7 August 2019 at  
10am in Nant Fawr Room 1, Woodland House**

**PRESENT:**

Martin Driscoll	Exec Director of Workforce and OD (co-Chair)
Mike Jones	Chair of Staff Representatives / UNISON (co-Chair)
Len Richards	Chief Executive
Pauline Williams	RCN
Mathew Thomas	UNISON
Fiona Kinghorn	Executive Director of Public Health
Dorothy Debrah	BDA
Peter Hewin	BAOT/UNISON
Rhian Wright	RCN
Stuart Egan	UNISON
Joanne Brandon	Director of Communication and Engagement
Robert Chadwick	Executive Director of Finance
Dean Morris	RCN
Steve Gaucci	UNISON
Joe Monks	UNISON
Caroline Bird	Deputy COO
Rachel Gidman	Assistant Director of OD
Nicola Foreman	Director of Corporate Governance
Stuart Walker	Medical Director
Ruth Walker	Executive Director of Nursing
Andrew Crook	Head of Workforce Governance
Abigail Harris	Executive Director of Strategy and Planning

**IN ATTENDANCE:**

Alun Tomkinson	Clinical Board Director, Surgical Services (part of meeting)
David Allison	General Manager, Integrated Medicine (part of meeting)
Keithley Wilkinson	Equality Manager (part of meeting)

**APOLOGIES:**

Julie Cassley	Deputy Director of WOD
Peter Welsh	Senior Hospital Manager, UHL
Bill Salter	UNISON
Fiona Salter	RCN
Ffion Matthews	SOC
Dawn Ward	Independent Member – Trade Union
Ceri Dolan	RCN
Janice Aspinall	RCN

**SECRETARIAT:**

Rachel Pressley	Workforce Governance Manager
-----------------	------------------------------

**LPF 19/045 WELCOME AND INTRODUCTIONS**

Mr Driscoll welcomed everyone to the meeting and introductions were made. Mr Walker was welcomed to his first meeting since starting as Medical Director.

**LPF 19/046 APOLOGIES FOR ABSENCE**

Apologies for absence were noted.

**LPF 19/047 DECLARATIONS OF INTEREST**

There were no declarations of interest in respect of agenda items.

## **LPF 19/048 MINUTES OF THE PREVIOUS MEETING**

The minutes from the meeting held on 5 June 2019 were agreed to be an accurate record of the meeting.

## **LPF 19/049 ACTION LOG**

The Local Partnership Forum noted the action log.

## **LPF 19/050 PROPOSAL TO INCREASE THE RANGE OF SURGICAL TREATMENTS IN UHL**

The Forum received a presentation from Mr Tomkinson on a proposal to increase the range of non-complex surgical treatments in UHL.

This proposal is aligned with the UHB strategy *Shaping Our Future Wellbeing* and has been developed in the context of the need to replace UHW in the next 10 or so years. The vision is for the range of non complex surgical treatment for adults in UHL to be increased, and for complex surgery to continue and be expanded in UHW with the Major Trauma Centre and single cancer pathway.

Mr Tomkinson described the clinical rationale i.e. predictive and planned treatment with shorter waiting times, better patient outcomes and home earlier. He did acknowledge that for some people it may mean they need to travel further.

The next stage is an 8 week engagement with patients, the public and other stakeholders.

The Forum discussed the presentation and the following points were noted:

- Mr Jones asked if additional theatres and wards would be required. Mr Tomkinson advised ENT had taken possession of the old endoscopy theatre, and there was a plan to increase the number of orthopaedic theatres as part of the estates plan. With relation to beds, he explained that the proposal wouldn't necessarily mean additional beds were needed as long as the schedule was carefully designed so that patients who did not require admission were brought in earlier in the day.
- Mr Jones suggested that there would be an impact in terms of sustainable travel on the UHL site. Mr Tomkinson said that this would actually mean there was less travel between sites because staff would be based in one site for a day or even a week at a time. He emphasised that theatre staff were being asked which site they would prefer to work on and were not being forced to move.
- Mr Hewin flagged the importance of engaging with Allied Health Professionals early on in the process so that they could be involved in the change rather than having to react to it. Mr Tomkinson agreed, emphasising that this is not a model for doctors but for the entire community.
- It was noted that a EHIA has been completed and that real efforts were being made to be visible and engaging

*(Mrs Harris joined the meeting)*

- Mr Richards noted that non-complex surgical cases tend to be the ones that get cancelled because of emergencies, winter pressures etc. This would not happen at UHL.
- Mrs Kinghorn referred to the links between this model and prehabilitation and the better outcomes achieved when patients are fitter and healthier. Mrs

Walker supported this, noting that patients tend to deteriorate when they are on a waiting list.

- Mr Hewin asked when / if a formal OCP process would begin. Mr Driscoll advised that this was the start of an engagement process and the timescales around any formal organisational change had not yet been determined.

*(Mr Tomkinson left the meeting)*

## **LPF 19/051 PROPOSALS TO IMPROVE CARE FOR FRAIL OLDER PEOPLE IN THE VALE OF GLAMORGAN**

The Forum received a presentation from Mr Allison on proposals to improve care for frail older people in the Vale of Glamorgan. It was noted that these proposals were still at an informal stage and that this had been brought to the Forum as part of a 'pre-engagement' exercise to test them and receive feedback on them.

Mr Allison talked about the challenges faced on the care of frail older people and the improvements that needed to be made, especially around length of stay and the implications of delayed discharge. He reminded the forum that there had been significant investment in primary and community services over the past four years, and explained that these proposals are specifically around hospital services.

In the Vale of Glamorgan these services are currently delivered in UHL and Barry, but an audit had demonstrated that by transferring patients to Sam Davies Ward in Barry Hospital their length of stay tended to increase. The proposal was to introduce a pathway of care which supported earlier intervention and rehabilitation, and reduced delays, through 3 main strands delivered at UHL:

- Preventing hospital admission
- Acute frailty assessment
- Discharge to assess (D2A)

It was therefore proposed to close the beds in Sam Davies Ward and re-purpose it.

Mr Allison acknowledged that there would be challenges for patients, relatives and staff and emphasised that work was taking place to address these e.g. transport, flexible visiting, and using existing staff elsewhere to retain their skills and experience.

The next step would be an 8 week engagement exercise once the timescales were agreed with the CHC.

The Forum discussed the presentation and the following points were noted:

- A D2A pilot in St David's Hospital had been very successful – there was 3 months' worth of data which demonstrated an increase in the number of patients discharged back to their homes. The Forum expressed an interest in finding out more about these results.
- Mr Hewin noted that Mr Allison had referred to an 'enhanced physio role' and asked exactly what this meant. Mr Allison advised that it was more about enhancing their presence than the role. He said that it was clear that patients needed to be nursed differently – this was partly about a skills mix, but there was also a need for a change in behaviours e.g. getting patients to move more.
- Mr Egan expressed concern about the proposal to close beds given the context of an aging population. Mr Allison argued that by introducing a D2A model in UHL gerontology wards, and enabling the timely discharge of

medically fit patients, beds would be freed up and it would have a profound positive effect on patient flow

- Mrs Wright asked if the required resources existed in the community. Mr Allison stated that they were working to improve this, but that by stopping over-prescribing care, capacity in the community would actually be freed up.
- Mrs Debrah said that both presentations had demonstrated the importance of therapies but we still have the old model of working. She reiterated the importance of including therapists from the outset not after the changes were agreed.

*(Mr Allison left the meeting)*

#### **LPF 19/052 STRATEGIC EQUALITY PLAN 2020-2024**

Mr Wilkinson reminded the Forum of our legal obligation to produce and deliver a 4 year Strategic Equality Plan. The current plan ends on 31 March 2020.

The report described the intent and process to be followed (including timescales), and highlighted the alignment with Shaping Our Future Wellbeing, the Future Generations Act and other legislation.

*(Mr Wilkinson left the meeting)*

#### **LPF 19/053 STANDARDS OF BEHAVIOUR FRAMEWORK POLICY**

Mrs Foreman presented the draft Policy for comment and input from the Forum. It was agreed that as there were a significant number of comments this would be referred to the Employment Policy Sub Group for follow up.

**ACTION: Dr Pressley/Mr Hewin**

#### **LPF 19/054 CHIEF EXECUTIVES REPORT**

Mr Richards updated the Forum on 3 areas:

##### **1. Amplify 2025**

Mr Richards advised that 80 people had been invited to attend Amplify on the basis that they had already made changes in their area. The work signaled that there was a real intent to increase the pace of change across the organisation. The Executive team had each sponsored a table, and would be working with their teams to help drive the changes forward. Mrs Gidman added that the next step was a huge showcase for the rest of the organisation in October 2019. She invited LPF members to view the Amplify outcomes at the end of the meeting.

##### **2. Board members**

Mr Richards welcomed Dr Walker who had started as Medical Director 4 weeks previously. He also thanked Miss Battle who had left as UHB Chair and gone to Hywel Dda. He was sorry to see her go, but was glad that she remained in NHS Wales and that we had a good friend in Hywel Dda UHB. She was being replaced by Charles (Jan) Janczewski as Acting Chair until a Ministerial appointment was made. Mr Richards gave assurances that the legacy Miss Battle had started through the Safety Valve would continue.

Dr Hopkins is currently acting as Interim Chief Executive at Cwm Taf UHB. This was initially for a period of 4 weeks and Mr Richards would advise the LPF if that was formally extended. Mr Jones suggested that if this became a medium or long term arrangement he would like to send a letter as joint Chairs thanking her for her contribution and support to LPF over the years.

### 3. JET Meeting

The annual JET (Joint Executive Team) meeting with Welsh Government had gone well. It was a positive reflection of the UHB's performance over the last year, including the move from Targeted Intervention to Enhanced Monitoring. A copy of the outcome letter from the meeting would be shared with LPF members.

**ACTION: Dr Pressley**

### LPF 19/055 CLINICAL SERVICES PLAN

Mrs Harris advised that a Clinical Services Plan for the next 10 years was being developed to enable us to articulate clearly how services will adapt and change, especially in Primary Care, and to engage further with our Communities. Key areas include:

- Technology
- How we use beds
- Specialist services
- Primary care including hubs and wellbeing centres

Workshops are being held in the locality and a more detailed paper would be brought to the next LPF meeting.

**ACTION: Mrs Harris**

Mr Hewin raised concern about health and safety issues in some CMHTs, and stated that he did not believe Global Link fitted the model. Mrs Harris acknowledged his concerns. She would be attending a meeting to discuss these issues the following day and would report back to the LPF.

**ACTION: Mrs Harris**

Mr Egan said that there were issues with lots of community services and buildings and suggested that the poor infrastructure would send the wrong message to patients and would not give them confidence in our services.

### LPF 19/056 SUSTAINABLE TRAVEL

Mrs Harris reminded the Forum that a commitment to sustainable travel is a requirement of the Future Generations Act and that the UHB had signed up to this along with Cardiff Council through the Public Services Board.

The Health Charity had supported a new Park and Ride Service from Cardiff (Toys R Us) to UHL, but staff were also encouraged to park away from the main sites and walk part of their journey as part of a healthy commute.

Discussions were taking place with Cardiff Council about the option to develop an interchange at UHW. This would require significant investment and needed to be considered in the context of the re-build and other changes to infrastructure needed, include new theatres.

Mr Jones re-iterated the point made at previous meetings about the need for a Park and Ride service from the Vale to UHL.

Mr Egan suggested that all patients should be made aware of the Park and Ride services in their appointment letters. Mr Richards advised that this had been discussed and was in progress.

#### **LPF 19/057 FINANCE REPORT**

The Local Partnership Forum received and noted the Finance Report for the period ending 31 May 2019. Mr Chadwick advised that the figures for month 3 (June) were now available and were concerning as we were £1.8m away from where we wanted to be at this point. If this continued we would be £7m overspend at the end of the year and would lose the approved status of our IMTP.

#### **LPF 19/058 WORKFORCE KPI REPORT**

The Local Partnership Forum received and noted the new format Workforce Report for the period ending 31 May 2019.

PADR levels were concerning, but improvements had been made in sickness with a cumulative rate of 4.69%. This was close to target, but was better than most of Wales and the discussion around unsocial hours payments was dependent on an All-Wales target being reached.

Mrs Gidman stated that there were actually more than 1000 apprentices (including existing staff), not 270 as recorded on the dashboard.

#### **LPF 19/059 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT**

The Local Partnership Forum received and noted the Patient Safety, Quality and Experience Report.

Mrs Walker noted that the arrangements for reporting pressure damage to Welsh Government had been changed and that this had had an impact on the number of serious incidents reported.

There was an increase in the number of concerns, but no trends had been identified.

#### **LPF 19/060 ITEMS FOR BOARD**

There were no specific items which the LPF wanted to be brought to the attention of the Board.

#### **LPF 19/061 ANY OTHER BUSINESS**

There was no other business to be raised.

#### **LPF 19/062 FUTURE MEETING ARRANGEMENTS**

The next meeting will be held on Wednesday 2 October at 10.00am with a staff representatives pre-meeting at 9 am in Room Nant Fawr 1, Woodland House.

## Minutes of the Meeting of the Welsh Health Specialised Services Committee

held on 14 May 2019 at 09:30

at National Imaging Academy Wales, Pencoed Business Park,  
Bridgend, CF35 5HY

### Members Present:

Vivienne Harpwood	(VH)	Chair
Carole Bell	(CB)	Director of Nursing and Quality Assurance, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB (by VC)
Paul Griffiths	(PG)	Independent Member/Audit Committee Representative
Charles Janczewski	(CJ)	Independent Member/Chair of the WHSSC Quality and Patient Safety Committee
Sian Lewis	(SL)	Managing Director, WHSSC
Tracy Myhill	(TM)	Chief Executive, Swansea Bay UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Jennifer Thomas	(JT)	Medical Director, WHSSC
Allison Williams	(AW)	Chief Executive, Cwm Taf Morgannwg UHB

### Deputies Representing Members:

Peter Durning (for LR)	(PD)	Clinical Director, Cardiff & Vale UHB
------------------------	------	---------------------------------------

### Apologies:

Kieron Donovan	(KD)	Associate Members / Chair of the Welsh Clinical Renal Network
Ian Phillips	(IP)	Independent Member
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB

### In Attendance:

Karen Preece	(KP)	Director of Planning, WHSSC
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC

### Observers:

Simon Dean	Welsh Government
Chris Markall	Head of Finance, CVUHB
Reza Rahman	Mallinckrodt Pharmaceuticals

### Minutes:

Michaela Henderson	(MH)	Corporate Governance Officer, WHSSC
--------------------	------	-------------------------------------

The meeting opened at 09:30





JC19/001	<p><b>Welcome, Introductions and Apologies</b></p> <p>The Chair formally opened the meeting and welcomed members.</p> <p>Apologies were noted as above.</p>
JC19/002	<p><b>Declarations of Interest</b></p> <p>The Joint Committee noted the standing declarations. There were no additional declarations to note.</p> <p>VH reminded the Independent Members of their obligation under the Standing Order 1.3.2 to act in a balanced manner, ensuring any opinion expressed is impartial and based on the best interests of the health service across Wales.</p> <p>VH reminded all Members of their obligation under Standing Order 7.3.1 that individual board members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides specialised and tertiary services.</p> <p>VH also reminded Members of Standing Order 7.3.3 whereby any Health Board Chief Executive who feels conflicted about the matter under discussion, in the event of a vote, they must abstain from voting.</p>
JC19/003	<p><b>Minutes of the meeting held 22 January 2019 and 26 March 2019</b></p> <p>Members noted that the Joint Committee had supported the minutes of the meeting held on 22 January 2019 at the meeting on 26 March 2019 and that, as that meeting had not been quorate, the minutes would be referred to the next meeting for formal approval.</p> <p>The Joint Committee <b>approved</b> the minutes of the meetings held on 22 January 2019 and 26 March 2019 as true and accurate records.</p>
JC19/004	<p><b>Action Log and Matters Arising</b></p> <p><b>JC18016 – Reports from the Joint Sub-Committees</b></p> <p>VH reported that the letter to Gail Williams offering congratulations on behalf of the Joint Committee on her award (Renal Nurse of the Year) had been drafted and would be sent shortly. <b>Action closed</b></p> <p>There were no matters arising not dealt with elsewhere on the agenda.</p>



JC19/005	<p><b>Report from the Chair</b></p> <p>The Joint Committee <b>received</b> the report from the Chair that reminded Members of the various appointments to the Joint Committee, Welsh Renal Clinical Network and the Quality &amp; Patient Safety Sub-Committee discussed at the last meeting and approved by Chairs action on 28 March 2019.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"> <li>• <b>Note</b> the content of the Report; and</li> <li>• <b>Ratify</b> the Chair's Action.</li> </ul>
JC19/006	<p><b>Report from the Managing Director</b></p> <p>The Joint Committee <b>received</b> the report from the Managing Director. SL drew attention to the following items within the report which the Members discussed further:</p> <p><b><i>Mother and Baby Unit</i></b></p> <p>SL reported that Management Group had requested more work be done around the staffing model and revenue costs, and a contracting framework be agreed by the Finance Sub-Group, before a full paper is presented to Joint Committee at the September meeting.</p> <p>Members noted SD was liaising with Welsh Government regarding funding for the Mother and Baby Unit.</p> <p><b><i>Potential Data Sharing Issue</i></b></p> <p>SL reported the potential data sharing issues had been resolved although there was still an underlying legislative issue to be resolved by Welsh Government.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"> <li>• <b>Note</b> the content of the Report.</li> </ul>
JC19/007	<p><b>Thoracic Surgery Update</b></p> <p>The Joint Committee <b>received</b> the report the purpose of which was to</p> <ul style="list-style-type: none"> <li>• Outline the latest information regarding the thoracic surgery cover arrangements for the Major Trauma Centre ('MTC'), including the workforce arrangements suggested by the medical directors of Swansea Bay UHB (SBUHB) and Cardiff and Vale UHB (CVUHB), and provide a commissioning assessment of those arrangements;</li> <li>• Provide assurance on the arrangements for addressing the further issues raised by the affected health boards as part of their conditional approval of the recommendation for a single adult thoracic surgery centre based in Morriston Hospital, Swansea;</li> <li>• Highlight the key lessons learned from the review of the conduct of the engagement exercise and public consultation;</li> </ul>



- Note the development of the thoracic surgery commissioning plan;
- Note the implementation project has been established by SBUHB; and
- Seek support from Joint Committee for the recommendations to go forward to the six affected health boards and that they be asked to confirm their unconditional approval for a single adult thoracic surgery centre based in Morriston Hospital, Swansea.

Members discussed a number of matters relating to the number of thoracic surgeons required to provide safe cover for the MTC and the pros and cons of delaying a decision on the workforce model until the publication of new guidelines by the Society of Cardiothoracic Surgeons of the UK and Ireland.

It was reported that the chair of CVUHB had expressed concerns particularly relating to delays and patient safety.

**ACTION: It was agreed that the Chair of WHSSC would discuss this with the chair of CVUHB to gain a better understanding of those concerns.**

After careful consideration, Members:

- Requested Dr Sian Lewis (and the WHSS Team) bring a WHSSC commissioning proposal back to the Joint Committee by the end of June 2019 that would take into consideration a number of matters and some uncertainties raised in the paper and during the meeting, related to workforce arrangements that had been developed to provide thoracic surgical cover from Morriston Hospital, Swansea, for the MTC in UHW, Cardiff;
- Noted and received assurance that arrangements are in place to address the further issues raised by the affected health boards in November 2018;
- Supported the recommendations arising from the assessment of lessons learned from the engagement exercise and public consultation;
- Noted the development of the thoracic surgery commissioning plan; and
- Noted the implementation project led by SBUHB has commenced with project board and stakeholder meetings already held.

Consideration of the final recommendation set out in the paper was postponed to the June meeting.

The indicative scope of work for the WHSS Team included:

1. Detail regarding the anticipated demand for thoracic surgery in south Wales, this would include out-patient and surgical activity and allow for the planned 20% increase in activity;



	<ol style="list-style-type: none"><li>2. Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills;</li><li>3. Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants;</li><li>4. Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants;</li><li>5. Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (e.g. telephone advice or on site input); and</li><li>6. Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons).</li></ol>
JC19/008	<p><b>South Wales Blood and Marrow Transplant Programme – Review of Investment: Review of Investment – Haematology Pathways</b></p> <p>The Joint Committee <b>received</b> the paper the purpose of which was to:</p> <ul style="list-style-type: none"><li>• Outline the investment made in the south Wales BMT programme between 2014/15 and 2016/17, and outline the purpose of this investment;</li><li>• Set out what has been achieved with the additional investment with regard to meeting patient need and delivering on quality standards to meet the service specification and JACIE accreditation requirements;</li><li>• Describe the clinical outcomes achieved by the south Wales BMT service;</li><li>• Note current risks in the service and the plans to address these risks; and</li><li>• Note future service developments.</li></ul> <p>Members noted the service had excellent clinical outcomes but poor infrastructure and that CVUHB was undertaking work to improve the infrastructure.</p> <p>Members noted:</p> <ul style="list-style-type: none"><li>• The investment made in the south Wales BMT programme;</li><li>• The confirmation that the investment has been implemented.</li><li>• The increase in capacity to meet patient need and the achievement of the quality standards in the service specification and JACIE accreditation requirements;</li><li>• The excellent clinical outcomes achieved by the service and published by the British Society for BMT;</li><li>• The current risks and the plans to address these risks; and</li><li>• The future service developments.</li></ul>



JC19/009	<p><b>Welsh Renal Clinical Network – Terms of Reference</b></p> <p>The Joint Committee <b>received</b> the paper that proposed revised Terms of Reference for the Welsh Renal Clinical Network ('WRCN') Board.</p> <p>Members noted that, in accordance with the WHSSC Governance and Accountability Framework, the WRCN, as a sub-committee of WHSSC, was required to review the WRCN Board Terms of Reference annually. Members noted the review process had been completed and the WRCN Board approved, on 10 April 2019, all amendments as highlighted in the appended document.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"><li>• <b>Approve</b> the revised WRCN Board Terms of Reference.</li></ul>
JC19/010	<p><b>Review of Governance and Accountability Framework</b></p> <p>The Joint Committee <b>received</b> a paper that presented proposed amendments to the WHSSC Governance and Accountability Framework.</p> <p>Members noted the WHSS team was looking at whether the Mental Health and Learning Disabilities Collaborative Commissioning Group was still fit for purpose given it hadn't met in the previous financial year and would bring their evaluation back to a future meeting.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"><li>• <b>Note</b> the contents of this paper;</li><li>• <b>Approve</b> the proposed amendments to the WHSSC Governance and Accountability Framework; and</li><li>• <b>Support</b> the amended WHSSC Governance and Accountability Framework being taken forward for ratification by local health boards.</li></ul>
JC19/011	<p><b>Joint Committee Annual Business Cycle 2019-20</b></p> <p>The Joint Committee <b>received</b> the paper the purpose of which was to provide Members with the Draft Joint Committee Annual Business Cycle 2019-20.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"><li>• <b>Note</b> and <b>support</b> the content of the report, including the schedule of meetings for 2019-20.</li></ul>
JC19/012	<p><b>Corporate Risk Assurance Framework</b></p> <p>The Joint Committee <b>received</b> the paper the purpose of which was to provide Members with an update on the WHSSC risk management framework as at 31 March 2019.</p>



	<p>Members noted the large number of risks shown in the report and KP reported that work was underway to remove provider risks from the corporate risk register. KP further noted that the CRAF should be read in conjunction with the Integrated Performance Report and that a detailed risk discussion was planned for a future Management Group meeting.</p> <p>Members noted the escalation process was being reviewed and as a result clarity would be provided around the de-escalation process.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"><li>• <b>Note</b> the update provided within the report; and</li><li>• <b>Receive assurance</b> that risks were being appropriately assessed and managed.</li></ul>
JC19/013	<p><b>Integrated Performance Report</b></p> <p>The Joint Committee <b>received</b> the report the purpose of which was to provide members with a summary of the performance of services commissioned by WHSSC for February 2019 and details the action being undertaken to address areas of non-compliance.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"><li>• <b>Note</b> February performance and the actions undertaken to address areas of non-compliance.</li></ul>
JC19/014	<p><b>Finance Report Month 12 2018-19</b></p> <p>The Joint Committee <b>received</b> the report the purpose of which was to set out the financial position for WHSSC for the 12th month of 2018-19.</p> <p>Members noted the financial position reported at Month 12 for WHSSC was an under spend of £2,589k and for EASC an under spend of £603k giving a total under spend of £3,192k.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"><li>• <b>Note</b> the current financial position and year-end position.</li></ul>
JC19/015	<p><b>Reports from the Joint Sub-Committees</b></p> <p><b>Management Group Briefings</b></p> <p>The Joint Committee <b>received</b> the Management Group Briefings from the meetings held on 28 March 2019 and 25 April 2019.</p> <p><b>All Wales Individual Patient Funding Request Panel</b></p> <p>The Joint Committee <b>received</b> the report.</p> <p><b>Integrated Governance Committee</b></p> <p>The Joint Committee <b>received</b> the report.</p>



	<b>Quality and Patient Safety Committee</b> The Joint Committee <b>received</b> the report.  <b>Welsh Renal Clinical Network</b> The Joint Committee <b>received</b> the report.
JC19/016	<b>Date and Time of Next Meeting</b>  The Joint Committee noted an extraordinary meeting would be organised for the end of June 2019 and Members notified of the date, time and location.

The meeting closed at 12:20

**Chair's Signature:** .....

**Date:** .....



## **WELSH HEALTH SPECIALISED SERVICES COMMITTEE JOINT COMMITTEE MEETING – SEPTEMBER 2019**

The Welsh Health Specialised Services Committee held its latest public meeting on 16 September 2019. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

<http://www.whssc.wales.nhs.uk/2019-20-whssc-joint-committee>

### **Action log & matters arising**

Members noted the action log.

### **Managing Director's Report**

The Joint Committee noted the content of the Managing Director's report and, in particular, updates on:

- ***Soft Tissue Sarcoma in South Wales***: There had been positive progress in addressing the previously reported issues.
- ***Perinatal Mental Health – Mother and Baby Unit***: Management Group (MG) had reviewed the business case for the south Wales MBU and significant progress had been made in addressing the remaining issues.
- ***CAR-T***: The business case had been signed off, enabling CVUHB to proceed with the service.
- ***Veterans' Trauma Network (VTN)***: Approval was given for WHSSC to directly commission the VTN from CVUHB until it could be hosted by the MTN. The service was expected to be cost neutral or better.
- ***WHSSC Office relocation***: The impending move to Treforest Industrial Estate, Pontypridd was noted.

### **Chair's Report**

The Joint Committee received an oral report from the Chair. The Chair explained that Charles (Jan) Janczewski has stepped down as an Independent Member of the Joint Committee and as chair of the WHSSC Quality & Patient Safety Committee following his appointment as Interim

Chair of CVUHB and that a replacement was being sought. The Chair recorded her thanks to CJ for his contribution.

### **Major Trauma Network for South Wales – Tranche 2 Recruitment**

Members received a paper that had been circulated prior to receipt of key items, including CVUHB Business Case and output from the latest Gateway Review. The paper identified Tranche 2 Recruitment items (1) that were in accord with recommendations derived as a result of the Peer Review (2) that didn't accord with recommendations from Peer Review. Tranche 1 Recruitment had been agreed by JC on 30 August.

A Professional Peer Review had been undertaken during August. An Executive Steering Group (ESG) Report included recommendations from the ESG derived as a result of the Peer Review. CVUHB did not agree with all of the recommendations in the Report. The Report had been approved by the ESG earlier in the day, subject to comments received back within 48 hours. Peer Reviewers had also seen and confirmed support for the ESG Report and recommendations.

The result of the latest Gateway Review was now known to be Amber/Red with good progress on many issues but four significant outstanding issues.

The SBUHB ODN Business Case had been reviewed on 11 September. The CVUHB Business Case had now received preliminary review and it was noted that there were three main areas of discord (1) 24/7 consultant rota, (2) proposal for 14 (rather than 10) beds in Poly Trauma Unit, and (3) additional (fourth) plastic surgery consultant. It had been agreed at the ESG meeting earlier in the day that WHSSC would review these issues with CVUHB and take them to the MG meeting on 26 September for scrutiny.

Welsh Government was optimistic about funding start-up costs incurred during 2019-20 with some recognition that further top-up funding might be required for future years. The overall financial picture was noted as being around £15m p.a.

The Finance Working Group is waiting for (1) finance and manpower baselines, (2) activity and income flows for non-elective cases, and (3) the business case for the CVUHB Trauma Unit (distinct from MTC).

The key requirements for an April 2020 go live are (1) physical and staff infrastructure, (2) governance structure for ODN, and (3) Welsh Government capital approval. EMERTS was scheduled for an April 2020 'go live' but needed to be asked to confirm that protocols can be varied and/or patient risks managed for a later go live of the MTC and ODN if necessary.



The WHSS Team will develop commissioning advice to JC.

The Project Business Case (PBC) would be available in October 2019. A PBC briefing for all parties being was being arranged for 23 October. The 12 Nov JC meeting will receive feedback on the PBC. Health boards will formally consider the PBC at their late November board meetings. It was agreed that health boards would hold short meetings at end of October 2019 to ascertain likely level of support from boards prior to formal consideration of the PBC at their boards in November, this will inform the 'go live' date and potentially provide cover for incurring Tranche 2 costs. It was agreed that the Tranche 2 recruitment process can begin ahead of late October support from boards (subject to MG scrutiny on 26 September) with interviews scheduled for late October but without confirming appointments until November. This reflects the need to manage the risks associated with moving too quickly or not quickly enough.

### **Major Trauma – Commissioner's Risk Register**

The Joint Committee received the first draft of the Commissioner's Risk Register for the Major Trauma Centre and Operational Delivery Network. It was noted that the Register would now, and continuously, be updated for the latest developments.

### **Integrated Commissioning Plan – Revised Timeline**

Members received a paper explaining that Welsh Government has relaxed the submission date for IMTPs to 31 January 2020. It was noted that the WHSSC ICP needs to include MTC and ODN on approval of the Project Business Case. It was agreed that the WHSS Team would continue to work toward submitting the ICP to JC on 12 November 2019.

### **Radio Frequency Ablation for Barrett's Oesophagus**

Members received a paper that (1) provided an update on the work led by WHSSC to develop the commissioning framework for a south Wales based Radiofrequency Ablation service for patients with Barrett's Oesophagus, and (2) confirmed the future commissioning arrangements for Radiofrequency Ablation for patients with Barrett's Oesophagus. Approval of the proposal was delegated to MG.

### **Other reports**

The Joint Committee received the Integrated Performance Report and the Financial Performance Report.

The Joint Committee also noted the update reports from the following joint sub committees and advisory groups:

- Management Group; and
- Quality & Patient Safety Committee.



GIG  
CYMRU  
NHS  
WALES

Tim Gwasanaethau Iechyd  
Arbenigol Cymru  
Welsh Health Specialised  
Services Team



PARCH  
-  
RESPECT



PARTNERIAETH  
-  
PARTNERSHIP



GWELLA AC  
ARLOESI  
-  
IMPROVEMENT  
& INNOVATION

## **WELSH HEALTH SPECIALISED SERVICES COMMITTEE JOINT COMMITTEE MEETING – NOVEMBER 2019**

The Welsh Health Specialised Services Committee held its latest public meeting on 12 November 2019. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

<http://www.whssc.wales.nhs.uk/2019-20-whssc-joint-committee>

### **Action log & matters arising**

Members noted the action log.

### **Chair's Report**

The Chair reported that Mr Emrys Elias, Vice-Chair of ABUHB, had been nominated as an Independent Member of the Joint Committee and Chair of the WHSSC Quality & Patient Safety Sub-committee, and had signified his willingness to act. He would be appointed shortly by Chair's Action.

### **Managing Director's Report**

The Joint Committee noted the content of the Managing Director's report and, in particular, updates on:

- **Perinatal Mental Health – Mother and Baby Unit:** Discussions have commenced regarding options for an interim solution and the business case for the substantive model has been progressed. A paper will go to Management Group on 28 November for consideration.
- **Vulnerable Groups Portfolio:** Welsh Government has formally requested that WHSSC take forward the commissioning of an All Wales Traumatic Stress Service and supports the further development of the Gender Service, Forensic Adolescent Consultation and Treatment Service as well as refugee resettlement. To facilitate this they have agreed two years' funding for a Senior Planner and Associate Medical Director.

## **Risk Register for Thoracic Surgery Implementation**

Members received a paper that shared the south Wales thoracic surgery services centre risk register. Members noted the information provided and asked for the nature of the risks to be clarified. It was further noted that good progress was being made on the project.

## **WHSSC Governance and Accountability Framework**

Members received a paper that explained proposed changes to be made to the WHSSC Governance and Accountability Framework, including the WHSSC Standing Orders and Associated Documents.

Members:

- Noted the content of the paper;
- Approved the amended WHSSC Standing Orders and Associated Documents; and
- Supported the amended WHSSC Standing Orders being taken forward for approval by the seven Welsh Local Health Boards.

## **Integrated Governance Committee Terms of Reference**

Members received a paper that presented revised Terms of Reference for the Integrated Governance Committee for approval.

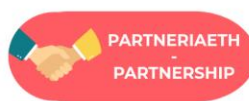
Members approved the revised Integrated Governance Committee Terms of Reference.

## **Other reports**

The Joint Committee received the Integrated Performance Report for August 2019 and the Financial Performance Report for Month 6 of 2019-20.

The Joint Committee also received the update reports from the following joint sub committees and advisory groups:

- Management Group;
- Integrated Governance Committee;
- Quality & Patient Safety Committee;
- All Wales Individual Patient Funding Request Panel;
- Welsh Renal Clinical Network; and
- NHS Wales Gender Identity Partnership Group.



**EMERGENCY AMBULANCE SERVICES  
JOINT COMMITTEE MEETING**

**'CONFIRMED' MINUTES OF THE MEETING HELD ON 23  
JULY 2019 AT THE EDUCATION CENTRE LLANDOUGH  
HOSPITAL CARDIFF**

**PRESENT**

<b>Members</b>	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Gary Doherty	Chief Executive, Betsi Cadwaladr UHB
Len Richards	Chief Executive, Cardiff & Vale UHB
Sian Harrop-Griffiths	Swansea Bay UHB
Karen Miles	Hywel Dda UHB (Via VC)
Carol Shillabeer	Chief Executive, Powys THB
Glyn Jones	Director of Finance/Deputy CEO, Aneurin Bevan UHB
<b>In Attendance:</b>	
Jason Killens	Chief Executive Welsh Ambulance Services NHS Trust
Anthony Hayward	Corporate Director, National Collaborative Commissioning Unit
James Rodaway	Head of Commissioning, EASC
Jamie Kaijaks	Finance Graduate Trainee, Swansea Bay UHB
Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Shane Mills	Director Quality and Patient Experience, National Collaborative Commissioning Unit
Stuart Davies	Director of Finance, WHSSC and EASC Joint Committees
Chris Polden	Managing Director ORH (for one item)
Gwenan Roberts	Head of Corporate Services, Cwm Taf Morgannwg UHB (Secretariat)

<b>Part 1. PRELIMINARY MATTERS</b>		<b>ACTION</b>
EASC 19/48	<p><b>WELCOME AND INTRODUCTIONS</b></p> <p>Chris Turner (Chair), welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves.</p> <p>The Chair advised that the main business would be followed by a development session involving a presentation from James Rodaway on Risk Management.</p>	



	<p><b>EASC 19/08 &amp; EASC 19/21 &amp; EASC 19/23</b>  <b>Emergency Medical Retrieval and Transfer Service (EMRTS)</b>  Members <b>NOTED</b> that information was awaited in relation to the Gateway Review, a meeting was scheduled to take place in early August and an update would be provided at the November meeting.</p> <p><b>Ambulance Quality Indicators (AQI)</b>  Members <b>NOTED</b> the work to link the AQIs with the performance dashboard.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the action log.</li> </ul>	CASC
EASC 19/53	<p><b>MATTERS ARISING</b></p> <p>There was none.</p>	CASC
EASC 19/54	<p><b>CHAIR'S REPORT</b></p> <p>The Chairs report was <b>received</b> by Members. In presenting the report Chris Turner highlighted his key meetings which had taken place since the last meeting of the Committee.</p> <p>Members <b>NOTED</b> that during the appraisal with the Minister, the emphasis had been on driving change across the system and ensuring that the EAS Committee was operating corporately. Other issues discussed included Amber implementation and the Red performance.</p> <p>Members also <b>NOTED</b> that a request has been received from the Deputy Chief Executive at NHS Wales for a discussion to take place at EASC on the regional escalation processes.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Chair's Report.</li> </ul>	Chair
EASC 19/55	<p><b>CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT</b></p> <p>The Chief Ambulance Services Commissioners (CASC) report was <b>received</b> by the Committee.</p> <ul style="list-style-type: none"> <li>• <b>Update on Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway Review</b></li> </ul> <p>Members <b>NOTED</b> that the CASC was due to meet with colleagues from Swansea University at the beginning of August to receive the first draft of the Gateway Review.</p>	CASC





	<p>Members <b>NOTED</b> that the Mental Health Access review was due to report in the new year which would give a better understanding of demand from people with mental health distress for urgent care services. Carol Shillabeer explained that the term 'mental health' was being used in its widest form. Jason Killens also supported that there was a need for a better service but suggested a 'Once for Wales' approach was needed.</p> <p>Shane Mills and Carol Shillabeer agreed to develop further information for Committee Members to capture all of the work to date (<b>Added to the Action Log</b>).</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the update and the actions agreed.</li> </ul>	<p>Carol Shillabeer /Shane Mills</p>
<p>EASC 19/56</p>	<p><b>DEMAND AND CAPACITY REVIEW</b></p> <p>Jason Killens provided an overview of the work on the Demand and Capacity Review at the Welsh Ambulance Services NHS Trust (WAST) to date and invited Chris Polden from ORH to give a short presentation. Members <b>NOTED</b> the intention to provide a final report to the Committee at the November meeting.</p> <p>Chris Polden gave an overview of the work of the ORH Management Consultancy set up in 1986 who were working globally with emergency services. Members <b>NOTED</b> the work across the UK with ambulance services who were identifying similar themes to those identified by WAST. Other issues such as the ageing population, long waits for patients in Amber category and seasonal variation were also considered as part of the review.</p> <p>The Review aims were clarified as:</p> <ul style="list-style-type: none"> <li>• Forecast incident demand over the next 5 years</li> <li>• Agree the required level of quality and time performance for each type of patient</li> <li>• Model the resources needed to achieve these levels of time and quality assuming current operations</li> <li>• Identify WAST efficiencies and the impact these will have on the staffing required</li> <li>• Identify unscheduled care system efficiencies and the impact these will have on the staffing required</li> <li>• Model the impact of planned service changes and their impact on patient flows</li> <li>• Model the resources required for call handling clinical staff and dispatch in the clinical contact centres.</li> </ul>	<p>Jason Killens</p>



- **RED Performance**

Members **NOTED** that in the main Hywel Dda and Powys health board areas were dipping below the 65% target; recovery plans were in place and further actions had been added although it was recognised that there was more work to do to improve response times.

Members **NOTED** the current improvement focus areas had been identified and were being actioned including:

- Continuing to develop and utilise information on demand, capacity and efficiency to inform action planning. This includes the use of sophisticated performance analysis and modelling software (QlikSense and Optima Predict) to support Operations
- Overproducing on RRV unit hours at times when red performance is poor (twilight shifts)
- Increasing the number of Community First Responders
- Working with Trade Union Partners to understand post production hours lost and to identify actions to reduce them
- Continuing work to reduce abstraction rates, with sickness levels now on a downward trend
- Reviewing deployment points, moving them where possible to reduce response times.

The expansion of the Advanced Paramedic Practitioner (APP) was discussed and Members **NOTED** the plans for the condensed APP MSc programme.

Members **NOTED** that WAST had also been working to reduce hours lost from handover to clear. As part of this work to cleanse and refine the data, a dual pin system for handover was being rolled out in each Emergency Department and the work would be completed by the end of August.

Jason Killens explained that the service changes and the Major Trauma Network work would have an impact and WAST felt that a co-ordinating desk would be required for 16 hours. Members **NOTED** that the WAST bid covered training and how much in the current allocation or getting the ambulance teams for the major trauma centre, call handling requirements would also need to be considered.

Members **RESOLVED** to

- **NOTE** the report.





	<p>Members <b>NOTED</b> that the Annual Governance Statement had been finalised and received at the Audit Committee on 30 May 2019.</p> <p>Members <b>RECEIVED</b> and <b>NOTED</b> the Internal Audit Report on Handover of Care at Emergency Departments Follow-up Health Board Related Recommendations which was received by the Host Body's Audit Committee on 9 July 2019. Members <b>NOTED</b> that the report received a 'Reasonable' assurance rating and four medium priority recommendations had been made. The actions required would be factored into the forward work plan for the Committee with the majority to be delivered by the next meeting.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>ENDORSE</b> the Annual Governance Statement</li> <li>• <b>NOTE</b> the report.</li> </ul>	
EASC 19/64	<p><b>CLINICAL RISK REVIEW – CLOSURE REPORT</b></p> <p>The closure report for the Clinical Risk Review was <b>received</b>. In presenting the report, Ross Whitehead confirmed that 24 actions had been identified and most had now been completed or now informed the work of the Management Group.</p> <p>Member <b>NOTED</b> the importance of the clinical records within the Ambulance service; additional clinical audits would also be carried out and access to policies and guidelines would take place.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the report</li> <li>• <b>ENDORSE</b> the closure report.</li> </ul>	Ross Whitehead
EASC 19/65	<p><b>FORWARD PLAN OF BUSINESS</b></p> <p>Members <b>received</b> the forward plan of business.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Forward Plan</li> <li>• <b>AGREE</b> that the Chair and the Chief Ambulance Services Commissioner review the Forward Plan for future</li> </ul>	ALL

<b>ANY OTHER BUSINESS</b>		
EASC 19/66	There was none.	
<b>DATE AND TIME OF NEXT MEETING</b>		
EASC 19/67	A meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 10 September 2019 at the National Collaborative Commissioning Unit, Treforest Industrial Estate.	Committee Secretary

Signed .....  
**Christopher Turner (Chair)**

Date:.....

**EMERGENCY AMBULANCE SERVICES  
JOINT COMMITTEE MEETING**

**'CONFIRMED' MINUTES OF THE MEETING HELD ON  
10 SEPTEMBER 2019 AT THE NATIONAL COLLABORATIVE  
COMMISSIONING UNIT, TREFOREST INDUSTRIAL ESTATE**

**PRESENT**

<b>Members</b>	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Gary Doherty (Via VC)	Chief Executive, Betsi Cadwaladr BCUHB
Len Richards	Chief Executive, Cardiff & Vale CVUHB
Tracy Myhill	Chief Executive, Swansea Bay SBUHB
Steve Moore (Via VC)	Chief Executive, Hywel Dda HDdUHB
Carol Shillabeer	Chief Executive, Powys PTHB
Sharon Hopkins	Chief Executive, Cwm Taf Morgannwg CTMUHB
<b>In Attendance:</b>	
Simon Dean (in part)	Deputy Chief Executive NHS Wales
Nicola Prygodzicz	Director of Planning, Aneurin Bevan ABUHB
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust
James Rodaway	Head of Commissioning & Performance Management, EASC
Julian Baker	Director, Collaborative Commissioning
Ross Whitehead	Assistant Director of Quality and Patient Experience
Jo Mower	Clinical Director National Programme Unscheduled Care
Rachel Marsh	Interim Director of Planning, Welsh Ambulance Services NHS Trust
Lee Brooks (in part)	Director of Operations, Welsh Ambulance Services NHS Trust
Stuart Davies	Director of Finance, WHSSC and EASC Joint Committees
Gwenan Roberts	Head of Corporate Services, Cwm Taf Morgannwg UHB (Secretariat)
Maxine Power (in part)	Executive Director of Quality, Innovation and Improvement, North West Ambulance Service



<b>Part 1. PRELIMINARY MATTERS</b>		<b>ACTION</b>
EASC 19/68	<p><b>WELCOME AND INTRODUCTIONS</b></p> <p>Chris Turner (Chair), welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves.</p>	
EASC 19/69	<p><b>PRESENTATION</b></p> <p>Maxine Power, Executive Director of Quality, Innovation and Improvement from the North West Ambulance Service was welcomed to the meeting and gave a presentation entitled 'Tackling the Challenge of Handover Delays'.</p> <p>Members <b>NOTED:</b></p> <ul style="list-style-type: none"> <li>• Population 7.9m; 31 hospital sites, large numbers of Clinical Commissioning Groups to work with; large population health footprint; 4 strategic transformation partnerships which provided an area of great challenges but great opportunities</li> <li>• Winter of 2017-8 particularly challenging including increase of serious incidents from 2-3 per month to 20; key issue crews waiting at A&amp;E</li> <li>• The overview of the 10 years of initiatives in NHS England</li> <li>• Worked with the 'super six' organisations as the most willing</li> <li>• Chief Executives asked to take a personal interest in the lost hours</li> <li>• Used patient stories to help understanding</li> <li>• Used 15 different actions to get different responses – the exchange visits to different organisations most powerful as well as having executive and board sponsorship</li> <li>• Locally on the ground things felt 'chaotic'</li> <li>• Sites chose what actions they felt were appropriate</li> <li>• A strong set of diagnostics and measures were identified</li> <li>• Tracker on an hourly basis and worked closely with the regulator.</li> </ul> <p>Members discussed the implications and ideas for NHS Wales and identified that other agencies would also be willing to assist such as 1,000 Lives Plus. The notion of having a competitive element was also recognised as a useful driver. In terms of patient safety the use of a safety checklist was known and Members felt it was helpful to learn from the experience of others although a lot of the actions identified were already available in NHS Wales.</p>	Jo Mower

	<p>The value of front line staff working together and learning between sites was felt to be key. Both Jo Mower and Julian Baker shared the specific initiatives being led or co-ordinated by the National Programme for Unscheduled Care in Wales and Members felt that actions were already been taken. Members felt it would be helpful to have an update in the future on the actions taken which impacted specifically on handover delays.</p> <p>It was agreed that the Clinical Director for the National Programme for Unscheduled Care (Dr Jo Mower) should present the Emergency Department Quality and Delivery Framework to the next EASC meeting ensure that that the pace of progress was being maintained (<b>Added to Action Log</b>).</p>	
EASC 19/70	<p><b>APOLOGIES FOR ABSENCE</b></p> <p>Apologies for absence were received from Judith Paget, Glyn Jones, Georgina Galletly, Steve Ham, Anthony Hayward, Shane Mills and Tracey Cooper.</p>	
EASC 19/71	<p><b>DECLARATIONS OF INTERESTS</b></p> <p>There were no additional interests to those already declared.</p>	
EASC 19/72	<p><b>MINUTES OF THE MEETING HELD ON 23 JULY 2019</b></p> <p>The minutes were <b>confirmed</b> as an accurate record of the meeting held on 23 July 2019.</p>	
EASC 19/73	<p><b>ACTION LOG</b></p> <p>Members <b>RECEIVED</b> the action log and <b>NOTED</b> progress as follows:</p> <p><b>EASC 18/06 &amp; 18/65 &amp; 19/21</b>  <b>Integrated Performance Dashboard</b>  Members <b>NOTED</b> that work was continuing on the development of the Dashboard which was linking data across the system. A further update would be provided at the next meeting.</p> <p><b>EASC 19/08 &amp; 19/21</b>  <b>Mental Health Staff Clinical Desk</b>  Members <b>NOTED</b> that work was continuing with the Welsh Government in terms of developing a national approach. A further update would be provided to the Committee in November (<b>Added to the Forward Look</b>).</p> <p>Members <b>NOTED</b> that Carol Shillabeer had discussed with the</p>	<p>CASC</p> <p>Director of Quality and Experience</p>

	<p>lead Chief Constable (Dyfed Powys Police) and the work would inform the 'Once for Wales' option. It was anticipated that the work would be completed early in 2020.</p> <p><b>EASC 19/08 &amp; EASC 19/21 &amp; EASC 19/23</b>  <b>Emergency Medical Retrieval and Transfer Service (EMRTS)</b>  Members <b>NOTED</b> that information was awaited in relation to the Gateway Review, a meeting was scheduled to take place in early August; an update would be provided at the November meeting.</p> <p>Members <b>RESOLVED</b> to: <b>NOTE</b> the action log.</p>	CASC
EASC 19/74	<p><b>MATTERS ARISING</b></p> <p>There was none.</p>	CASC
EASC 19/75	<p><b>CHAIR'S REPORT</b></p> <p>The Chairs report was <b>received</b> by Members. In presenting the report, Chris Turner highlighted his key meetings which had taken place since the last meeting of the Committee.</p> <p>Members <b>NOTED</b> the:</p> <ul style="list-style-type: none"> <li>• Feedback on the Annual Appraisal from the Minister and the importance of maintaining momentum of the Amber Review</li> <li>• Chair's involvement in Chairing the Evaluation Panel for the allocation of the 'A Healthier Wales' funding</li> <li>• Impact on EASC of the NHS Executive and that further discussion would be required when more information was available</li> <li>• Intention of the Chair and the Chief Ambulance Services Committee (CASC) to visit all health boards to update Boards on the work of the Joint Committee and asked for the support of Members to arrange as soon as possible (<b>Added to Action Log</b>).</li> </ul> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Chair's Report.</li> </ul>	<p>Chair</p> <p>Members</p>
EASC 19/76	<p><b>CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT</b></p> <p>The Chief Ambulance Services Commissioners (CASC) report was <b>received</b> by the Committee.</p> <p>• <b>Amber Review Implementation Programme</b></p>	<p>CASC</p> <p>CASC</p>

	<p>Members <b>NOTED</b> the work to date and that the Minister was planning to make a statement in November. Progress was being made against the 9 recommendations as a detailed report would be provided for the Committee at the November meeting (<b>Added to Forward Look</b>).</p> <p>Members also <b>NOTED</b> that there were no specific risks to be reported although all were aware of the continuing challenges to ambulance responsiveness and lost hours in relation to handover delays.</p> <ul style="list-style-type: none"> <li>• <b>Update on Management Group</b> Members <b>NOTED</b> that the representation from all areas was good and subject to reviewing the membership, including adding WAST to the Group, <b>APPROVED</b> the terms of reference. It was <b>AGREED</b> that a forward work plan would be produced by the Management Group and shared at the next meeting (<b>Added to the Forward Look</b>).</li> <li>• <b>Risk Register</b> Members <b>NOTED</b> that further discussion would need to be held at the next meeting including agreement how the risk management framework would be used (<b>Added to the Forward Look</b>).</li> <li>• <b>Stroke Services</b> Members <b>NOTED</b> the Minister's expectations and new measure for ambulance services. Further information would be provided in due course (<b>Added to the Forward Look</b>).</li> <li>• <b>Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review</b> Members <b>NOTED</b> that the Delivery and Assurance Group was due to meet in September and an update would be provided at the November meeting (<b>Added to the Action Log</b>).</li> <li>• <b>Non-Emergency Patient Transport Service (NEPTS)</b> Members <b>NOTED</b> that good progress was being made. The Chief Ambulance Services Commissioner thanked the health boards for their support and thanked the Welsh Ambulance Services NHS Trust for their work to date. Further updates would be provided at the meeting in January (<b>Added to the Forward Look</b>).</li> <li>• <b>RED performance</b></li> </ul>	<p>CASC</p> <p>CASC</p> <p>CASC</p> <p>CASC</p>
--	---	---

Members **NOTED** that this would be discussed in detail in the provider update report.

• **Handover position**

Members **NOTED** that during the last weekend, performance was not at the level expected with 650 hours lost across Wales.

**Members NOTED** ongoing work in the following areas:

- Aneurin Bevan, Cardiff & Vale and Betsi Cadwaladr as pilot sites for the EDQDF
- The Swansea Bay improvement plan was considered good but needed pace to implement
- The Delivery Unit were planning to work at the Princess of Wales Hospital site to assist with the drifting performance
- Aneurin Bevan had visited Preston to view progress being made.

Members discussed what additional actions should be taken, how they could learn from others and how they could work more closely together at times of heightened escalation. It was felt that it was important to build on work already underway and to concentrate on a small number of initiatives that would have the greatest impact.

Members discussed the need to do further work and to address the current position which was much worse than last year.

Members **NOTED** that at the National EDQDF Summit held in July 2019, a significant amount of good initiatives which were showing signs of success had been identified. Members specifically discussed the use of the checklist and having the emergency department consultant at the front door in terms of triage but this did not have the anticipated impact due to the whole system issue of patient flow throughout the hospital sites. Members **NOTED** the good progress that was being made with the EDQDF programme.

A discussion took place on the current escalation plans and processes. It was agreed that the plans needed to be reviewed and the daily conference calls should be hosted by WAST. A national event would be organised as a matter of urgency to finalise this.

A discussion took place on the use of alternative pathways and the important role that they can play in managing demand into

	<p>Emergency departments and reducing the number of ambulance conveyances.</p> <p>It was agreed that each Health Board would make available to WAST an additional three pathways in time for this winter.</p> <p>Simon Dean challenged the leadership and ownership of the Members and felt that it was important to make more progress on the journey which was a clear Ministerial priority. The Deputy Chief Executive of NHS Wales asked about priorities of organisations and the role of the whole executive in ensuring the pace.</p> <p>Simon Dean also challenged the Members regarding whether the local systems were completely understood and the impact on the lack of consistency across Wales; he felt that there were areas that organisations could just make the changes required. The challenge was to ensure that changes could be made at pace - these changes needed to be clarified organisation by organisation. The importance of the work required by WAST was also discussed including the importance of increasing the staffing levels as well as clarifying how community risks are captured and managed effectively.</p> <p>Members discussed resetting thresholds such as for corridor waits which are normalised thresholds in some organisations. Members agreed that the goal zero tolerance although this would depend on the starting point for each health board (HB).</p> <p>Discussion took place in relation to the immediate release arrangements for RED category requirements and agreed the need to comply with the current policy to avoid what was seen as a potentially growing risk to patients waiting longer for an ambulance response in the community. Members also agreed to use the next Management Group to identify areas for further pace and for in-depth discussion prior to any Committee meeting.</p> <p>Following discussion Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the report and the agreed actions</li> <li>• <b>APPROVE</b> the Terms of Reference for the Management Group (subject to the review of the membership).</li> </ul>	CASC
EASC 19/77	<b>WELSH AMBULANCE SERVICES NHS TRUST (WAST) PROVIDER UPDATE</b>	Jason Killens



	<p>Jason Killens also asked Members for support in their organisations with GoodSAM which integrates with the computer aided dispatch.</p> <p>Jason Killens agreed to send additional information following the meeting to Members (<b>Added to the Action Log</b>).</p> <p>Members also received the ORH slide deck for information. The steering group was meeting regularly to track progress and it was anticipated would finish in September and the final report would be received at the November meeting (<b>Added to the Forward Look</b>).</p> <p>Following discussion Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the work being undertaken and the priorities agreed for winter resilience.</li> <li>• <b>Receive</b> the RED Improvement plan.</li> </ul>	<p>Jason Killens</p> <p>Jason Killens</p>
EASC 19/78	<p><b>WELSH AMBULANCE SERVICES NHS TRUST (WAST) RELIEF GAP EMERGENCY AMBULANCE SERVICES REFERENCE DOCUMENT</b></p> <p>Members received the Reference Document, Stephen Harrhy presented the document.</p> <p>Members <b>NOTED</b> that following the WAST Joint Executive Team meeting with Welsh Government officials Members <b>NOTED</b> that the Reference Document had been developed as a response to the information directly provided to the Welsh Government from WAST on the stated relief gap within the provision for emergency ambulance services.</p> <p>Members <b>NOTED</b>:</p> <ul style="list-style-type: none"> <li>• The timescales for the information</li> <li>• IMTP and commissioning intentions</li> <li>• CASC Review of WAST spend on front line staff compared to the overall increased allocation since 2013-2014</li> </ul> <p>Jason Killens informed the Committee that discussions had taken place with the Chair of WAST in relation to the proportion of spend on frontline staff and confirmed the commitment to return to 2013/14 levels; he also explained that the organisation was 'paramedic rich' although in the report to the Welsh Government had identifying a requirement for an additional 40 paramedics. Members felt it would be helpful to have confirmation in terms of where resources had been allocated to better understand the current position, generally Members felt that spending on</p>	



	<p>frontline staff was not as they expected.</p> <p>Following discussion Members <b>RESOLVED</b> to: <b>AGREE</b> to the following:</p> <ul style="list-style-type: none"> <li>• Receive a plan from WAST outlining how they would return to 2013/14% levels of spending on frontline staff recurrently</li> <li>• Use WAST contingency and 1% 'A Healthier Wales' funding slippage as non-recurrent allocation for use by EASC; money to be allocated on spend and with agreement on impact on performance</li> <li>• Receive a review what has happened to the funding provided to date since 2013/14 (CASC to undertake on behalf of EASC)</li> <li>• Tapering funding to be discussed as part of the IMTP process and linked to outcome of Demand and Capacity Review</li> <li>• Handover improvement plan to be agreed by EASC</li> <li>• Detailed discussion to take place at the Management Group meeting on 23 September 2019</li> <li>• No delay in any immediate actions to be undertaken.</li> </ul>	<p>Jason Killens</p> <p>CASC</p> <p>CASC</p> <p>EASC</p> <p>WAST CASC</p> <p>WAST</p>
<p>EASC 19/79</p>	<p><b>WELSH AMBULANCE SERVICES NHS TRUST (WAST) SERVICE TRANSFORMATION</b></p> <p>Members received the WAST Service Transformation Report. In providing an overview of the background to the report, Jason Killens gave a summary of the work to date.</p> <p>Rachel Marsh provided the detail in relation to the schemes that WAST were asking for support.</p> <ul style="list-style-type: none"> <li>• Falls Service – strong evidence of the positive impact of the service</li> <li>• Advanced paramedic practitioners: funding received during the last winter; further 25 undertaking training starting in September; working in primary care; rapid response vehicle and the clinical control centre.</li> <li>• GPs and others closely aligned with control centres to work with the categories of green and amber 2 calls for alternative pathways.</li> </ul> <p>Stephen Harrhy supported the report in terms of explaining that the patients who would be mostly dealt with would be seen in a more timely way. Julian Baker asked about the net impact of the appointments and the need for a strong evaluation process. Members <b>NOTED</b> that the evaluation for the falls bid showed clearly the positive impact on the patient experience. Members also <b>NOTED</b> that there was a lot of work required to ensure the right information was available for inclusion in the IMTP for the next year.</p>	

	<p>Chris Turner supported the report reiterating the need to sharpen the impact and capture the outcome. Following discussion Members <b>NOTED</b> that there were around 94 pathways in use within WAST. Clinical colleagues had met and developed a proposal to work internally to develop standardised pathways and particularly high volume codes to ensure consistency in the services across Wales would be developed. It was agreed that each Health Board would make available to WAST access to three pathways in time for this winter</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>AGREE</b> make available to WAST access to three pathways in time for this winter</li> <li>• Support the development of Level 1 Falls Response across Wales</li> <li>• Support the expansion of Advanced Paramedic Practitioners using a rotational model (subject to the Demand and Capacity review)</li> <li>• <b>AGREE</b> to support WAST as the handler of choice subject to pilot schemes being developed into a viable pan Wales model.</li> </ul>	
EASC 19/80	<p><b>FINANCE REPORT</b></p> <p>Members <b>received</b> the Finance Report which was presented by Stuart Davies. Members <b>NOTED</b> the current financial position and the ongoing work to allocate the 1% 'A Healthier Wales' allocation.</p> <p>Members <b>RESOLVED</b> to: <b>NOTE</b> the report.</p>	Stuart Davies
EASC 19/81	<p><b>AMBULANCE QUALITY INDICATORS</b></p> <p>The Committee received the report on Ambulance Quality Indicators (AQIs). In presenting the report, Stephen Harrhy gave an overview of the key issues which had also been discussed earlier in the meeting including handover delays.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the overview of the last quarter's AQIs.</li> </ul>	Ross Whitehead
EASC 19/82	<p><b>REGIONAL ESCALATION</b></p> <p>Members received the report on Regional Escalation.</p>	Stephen Harrhy



	<p>call based on the Exercise Wales Gold course, with a specific focus on managing health services during periods of escalation.</p> <ul style="list-style-type: none"> <li>• Agree that the revised process to be live by the 1 December 2019.</li> </ul>	ALL
EASC 19/83	<p><b>1% 'A HEALTHIER WALES' COMMISSIONING ALLOCATION 2019/2020</b></p> <p>Members received the report which provided the Committee with an update on progress on the proposals agreed through the Healthier Wales Awarding &amp; Evaluation Panel (HWAEP) on the EASC 1% 'A Healthier Wales' Commissioning Allocation 2019/20 and ongoing evaluation.</p> <p>Following discussion Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>ENDORSE:</b> the Chairs action on the advice of the Healthier Wales Awarding Evaluation Panel (HWAEP) for the Green and rejected submissions.</li> <li>• <b>NOTE</b> the next steps of the Amber + &amp; - submissions to progress the potential Chair's actions contained within Appendix 1 &amp; 2 in light of the emerging financial and service delivery risks around Emergency Ambulance Services. (WAST Relief Gap Paper &amp; EASC: Reference Document circulated to EASC Members in August 19.)</li> </ul>	Julian Baker
EASC 19/84	<p><b>ESTABLISHMENT OF THE SOUTH, MID AND WEST WALES TRAUMA NETWORK – WELSH AMBULANCE SERVICES NHS TRUST BUSINESS CASE</b></p> <p>The Report to Establish the South, Mid and West Wales Trauma Network and the WAST business case was received by the Committee. In presenting the Report, Stephen Harray gave an overview of the content and development process of the WAST element of the Major Trauma Network (MTN) business case. This included the development of the options, the process of peer review and the commissioner oversight of the review and refinement of the costings.</p> <p>It was recognised that the costs had fluctuated through this process due to the options and the decisions that had been made. EASC had supported the WAST business case being put forward to the South Wales MTN board.</p> <p>EASC were asked to agree to support the non-recurrent in year</p>	

	<p>costs (£57k) to develop the trauma desk, IT and staff training. EASC supported funding this proposal.</p> <p>Following discussion on the funding arrangements for implementation Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>ENDORSE</b> the Welsh Ambulance Service NHS Trust element of the Major Trauma Programme Business Case.</li> </ul>	
EASC 19/85	<p><b>FORWARD PLAN OF BUSINESS</b></p> <p>Members <b>received</b> the forward plan of business.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Forward Plan</li> <li>• <b>AGREE</b> that the Chair and the Chief Ambulance Services Commissioner review the Forward Plan for future meeting.</li> </ul>	ALL

ANY OTHER BUSINESS		
EASC 19/86	There was none.	
DATE AND TIME OF NEXT MEETING		
EASC 19/87	A meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 12 November 2019 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL.	Committee Secretary

Signed .....

**Christopher Turner (Chair)**

Date .....

Well-being of Future Generations Act: progress in implementing in the UHB	Date	29 Oct 2019	Overall assessment	Green										
<b>Background</b> <p>The Well-being of Future Generations (WFG) Act is ground-breaking legislation in Wales requiring specific statutory bodies in Wales to consider the needs of future generations when making decisions and setting their strategic approach. Cardiff and Vale UHB is a named statutory body under the Act and is also a statutory member of the statutory Public Services Boards in Cardiff and the Vale, working in partnership to implement agreed Well-being Plans for each area.</p> <p>A Cardiff and Vale UHB WFG Steering Group has been set up which is overseeing the implementation of the Act, and the work required to enable the culture change required by the Act, to embrace the ways of working. The group meets every 2-3 months and maintains an annual work programme action plan to assess progress. The group is chaired by the Executive Director of Public Health and membership includes the Board Champion for Future Generations, the Vice Chair. A schedule of reports on WFG (both statutory, and to raise awareness of the Act within the UHB) is maintained by the group.</p>														
<b>Highlights since last report on 30 Apr 2019</b> <ul style="list-style-type: none"><li>• We have recently published a bilingual <a href="#">‘demonstrator directory’</a> on our website listing over 35 projects and programmes the UHB is leading which exemplify the WFG Act in action, showing a huge breadth of issues being tackled.</li><li>• The Health Board has recently received feedback from the Office of the Future Generations Commissioner on a self-reflection audit on our progress in implementing the WFG Act which we were asked to complete in December 2018. There are many positives in the feedback, and relevant recommendations will be progressed by means of an action plan overseen by the Steering Group.</li><li>• The Steering Group Terms of Reference have been updated, with an intention to invite members of Clinical Board staff who have received ‘Acting today for a better tomorrow’ awards in their Clinical Board, onto the Steering Group.</li><li>• A draft report has recently been received from the Wales Audit Office following an inspection into the UHB’s implementation of the WFG Act</li></ul>														
<b>Key actions for 19/20</b> <p>The following objectives and progress status are taken from the WFG Steering Group action plan for 19/20. The full updated action plan is attached for information. Progress on actions is within proposed timeframes.</p> <table><tr><th>Objective</th><th>Status</th></tr><tr><td><b>Objective 1:</b> Provide advice to support the UHB’s statutory annual review of its well-being objectives, and review actions in place to meet the UHB and partnership well-being objectives</td><td>G</td></tr><tr><td><b>Objective 2:</b> Identify and support UHB-led WFG ‘demonstrator’ projects, which show action being taken to meet the well-being objectives of the UHB and/or the two partnerships</td><td>A</td></tr><tr><td><b>Objective 3:</b> Agree, implement and regularly review a communications plan</td><td>G</td></tr><tr><td><b>Objective 4:</b> Ensure robust governance processes in place to provide assurance and leadership on WFG within the UHB and externally as required</td><td>G</td></tr></table>					Objective	Status	<b>Objective 1:</b> Provide advice to support the UHB’s statutory annual review of its well-being objectives, and review actions in place to meet the UHB and partnership well-being objectives	G	<b>Objective 2:</b> Identify and support UHB-led WFG ‘demonstrator’ projects, which show action being taken to meet the well-being objectives of the UHB and/or the two partnerships	A	<b>Objective 3:</b> Agree, implement and regularly review a communications plan	G	<b>Objective 4:</b> Ensure robust governance processes in place to provide assurance and leadership on WFG within the UHB and externally as required	G
Objective	Status													
<b>Objective 1:</b> Provide advice to support the UHB’s statutory annual review of its well-being objectives, and review actions in place to meet the UHB and partnership well-being objectives	G													
<b>Objective 2:</b> Identify and support UHB-led WFG ‘demonstrator’ projects, which show action being taken to meet the well-being objectives of the UHB and/or the two partnerships	A													
<b>Objective 3:</b> Agree, implement and regularly review a communications plan	G													
<b>Objective 4:</b> Ensure robust governance processes in place to provide assurance and leadership on WFG within the UHB and externally as required	G													
<b>Identified issues or risks</b> <table><tr><th>Issue or risk to delivery</th><th>Commentary incl. mitigation</th><th>Status</th></tr><tr><td>No issues or risks currently identified</td><td></td><td></td></tr></table>					Issue or risk to delivery	Commentary incl. mitigation	Status	No issues or risks currently identified						
Issue or risk to delivery	Commentary incl. mitigation	Status												
No issues or risks currently identified														
Author		Dr Tom Porter, Consultant in Public Health Medicine												

<b>Report Title:</b>	Implementation of Well-being of Future Generations (Wales) Act in Cardiff and Vale UHB: Update						
<b>Meeting:</b>	Board				<b>Meeting Date:</b>	28 Nov 2019	
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>		<b>For Information</b> X
<b>Lead Executive:</b>	Executive Director of Public Health						
<b>Report Author (Title):</b>	Consultant in Public Health Medicine						

## SITUATION

The attached Flash Report provides assurance that the UHB is taking steps to embed and deliver the Well-being of Future Generations (WFG) Act. The Flash Report is provided as a regular update to the Strategy and Delivery Committee and is brought today to the Board for information.

## REPORT

### BACKGROUND

The Well-being of Future Generations (WFG) Act introduced a number of new statutory duties for the UHB. An internal Steering Group meets regularly to oversee the actions required to fully embed the Act in the UHB and ensure the organisation is meeting its statutory duties under the Act. The attached Flash Report provides regular assurance in this regard, with an update every 6 months submitted to the Strategy and Delivery Committee. This Report was taken to the 29 Oct 2019 Committee.

### ASSESSMENT

The WFG Act introduced new statutory responsibilities for the UHB, both as an individual organisation, and in partnership as part of the two Public Services Boards (PSBs) in Cardiff and the Vale.

Within the UHB, the Shaping our Future Well-being Strategy objectives are the organisations' Well-being objectives under the WFG Act; so reviewing and demonstrating progress against our Well-being objectives requires regular review and implementation of the SOFW Strategy. In the partnership arena, we contribute to the statutory Well-being Plans (one for Cardiff; one for the Vale) through our participation in the PSBs and delivery of key actions in the Plans, individually and together with partner organisations.

A Cardiff and Vale UHB WFG Steering Group, chaired by the Executive Director of Public Health, meets regularly to determine and implement the actions required to embed the requirements into the UHB, both from a process and governance perspective, as well as the culture change required for the UHB to implement routinely the sustainable development (SD) principle. The SD principle requires the organisation to routinely follow the five ways of working from the Act (prevention, long-term, collaboration, integration, involvement), and contribute to the seven national well-being goals.

The attached Flash report summarises progress by the Steering Group against the action plan for 2019/20. This report provides regular assurance for Strategy and Delivery Committee that the UHB is undertaking the actions required to meet its statutory requirements under the Act.

### ASSURANCE is provided by:

Internal Well-being of Future Generations Steering Group, chaired by the Executive Director of Public Health, monitoring progress against an annual internal WFG action plan. 6 monthly updates for assurance to Strategy and Delivery Committee.

## RECOMMENDATION

The Board is asked to:

- **NOTE** the attached Flash Report provides regular assurance to the Strategy and Delivery Committee of progress against the Steering Group's action plan, to undertake actions required for the UHB to meet its statutory duties under the Act
- **NOTE** that a 20/21 action plan will be prepared before the end of this financial year

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
<b>Equality and Health Impact Assessment Completed:</b>		Not Applicable							





<b>Report Title:</b>	<b>Estates Maintenance Priorisation and Performance</b>					
<b>Meeting:</b>	<b>Board Meeting</b>			<b>Meeting Date:</b>	<b>28/11/19</b>	
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	
					<b>For Information</b>	<b>X</b>
<b>Lead Executive:</b>	<b>Executive Director of Finance</b>					
<b>Report Author (Title):</b>	<b>Estates Manager</b>					

## SITUATION

The Board requested information on how estates maintenance requests are prioritised and how well the service is performing following issues raised during Patient Safety Walkrounds.

## BACKGROUND

It is recognised that the Estates Department provides a critically important service that impacts directly on the delivery of safe and effective patient care.

Cardiff and Vale University Health Board's Estates Department is currently two years into the implementation of a the five year "Estates Maintenance Strategy" aimed at reviewing and implementing new aims and goals for the department. This delivery of the strategy aims to bring the Estates Teams in line with a modern practices resulting in an improved serviced delivery model with modern ways of working efficiently. The change process is also supporting a development in the culture of the department.

The strategy and modernisation programme supporting its implementation has been developed through a number of stages involving senior staff within the Estates Department and staff from all of the estates disciplines. It is anticipated that the proposed changes and structure development will achieve the following benefits to the UHB:

- Increased flexibility across the department by staff being able to work at multiple sites.
- A more planned approach to maintenance, helping to lesson any risk and minimise service disruption.
- Embrace technology to allow more efficient and improved performance.
- Ensure prioritisation and clarity to the user on every task. (Maintenance Request)

All planned and reactive maintenance is currently achieved through an ageing maintenance software called Backtraq. This software is no longer fit for purpose and under the workshops for Modernisation identified as a key issue for change to ensure the estates department is run and monitored robustly.

Backtraq logs basic detail of a request by a user and then forms a default priority to the estate teams for completion. The user due to poor setup and location identification logs the task inconsistently and often locations are confused. Users also currently have the option to ring a helpdesk based at Barry. This method also records inaccuracies in data - location and task.

The tasks default to a priority 3 with no user input or real knowledge to the estate teams to

change accordingly. The management teams then work through the lists and assign to the relevant discipline. (I.e. Carpentry / Building / Mechanical / Plumbing or Electrical). The task then remain live until it is assigned and then the assignee (the team member) completes the job and signs it off on Backtraq. The system is old, cumbersome and lacks detail. No user updates are available during work design, order for information.

Since the launch of the Estates Strategy in 2017 a significant amount of work has been undertake and successfully completed, allowing improvement of the estate performance and this can be demonstrated in the section below.

## Assessment

The Estate Modernisation Programme has allowed us to recruit key new management positions such a lift and risk engineer, and a new maintenance manager which then allows us to monitor and track performance whilst ensuring the UHB maintenance gets completed by priority and risk. Backtraq remains our only system, however assurance can be provided that tasks are checked daily and prioritised by the supervision teams at each site whenever possible.

We are setting up and training to roll out a major update in our systems with the introduction of a new system, Micad, which will help the teams prioritise from a user and risk point of view, allows customer sign off and promotes communication. The system allows the UHB to manage the service in a timely manner allowing real data going forward for continuous Improvement. This system is industry standard and far more user and customer friendly. It allows the Estates teams to operate user friendly IPads and allows a complete professional experience by both the Estates team and the user. The new system will also allow the teams to update the user and set the job to waiting for spare, or working on system. Micad forces clear ownership and clarity and will allow greater autonomy and timely sign off of a task once requested. The new system gives for full visibility of what tasks are programmed against which resources are available and this can then be managed more effectively. The user and estates teams can change its prioritisation, enabling a more efficient estate service.

## Services Delivery:

Currently the prioritisation is as detailed below and defaults as a Priority 3.

There are several categories in the backtraq software and this is replicated in the new Estate System: MiCad.

- Priority 1 – Emergency / Very Urgent
- Priority 2 – Same Day
- Priority 3 – Three Days
- Priority 4 – 1 Week
- Priority 5 – Planned within 28 Days

The following summary shows current task performance. (E.g. left on the system outside the target delivery)

Over 90 Day	434	Tasks Remaining
Over 60 Days	810	Tasks Remaining

Over 30 Days	1507	Tasks Remaining
Jobs under 28 Days	99	Task Remaining

This is against a backdrop of the total yearly maintenance requests of over **36,000** requests each year.

Some of these outstanding requests are not maintenance requests and are requests for facility changes, new equipment or items. These can delay our performance figures as budget allows limited scope for such requests.

It should be noted that the Cardiff and Vale Estates Service is delivered at a cost of **£14.44m<sup>2</sup>** against an all Wales NHS average of **£20.89m<sup>2</sup>**.

## RECOMMENDATION

The Board is asked to:

- Note the progress being made to implement the Estates Strategy and Modernisation Programme.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click [here](#) for more information

Prevention	x	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:		Not Applicable							

Kind and caring  
Caredig a gofalgar

Respectful  
Dangos parch

Trust and integrity  
Ymddiriedaeth ac uniondeb

Personal responsibility  
Cyfrifoldeb personol

<b>Report Title:</b>	<b>Quality, Safety and Experience Committee – Chairs Report</b>					
<b>Meeting:</b>	<b>Board Meeting</b>				<b>Meeting Date:</b>	28.11.19
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	
					<b>For Information</b>	<b>X</b>
<b>Lead Executive:</b>	<b>Chair, Quality, Safety and Experience Committee</b>					
<b>Report Author (Title):</b>	<b>Corporate Governance Officer</b>					

## SITUATION

To provide the Board with a summary of key issues discussed at the Quality, Safety and Experience Committee held on 15 October 2019

## HOT TOPICS

The Assistant Director of Patient Safety and Quality (ADPSQ) informed the Members that a paper would be presented on the ophthalmology issues in December.

Health Inspectorate Wales (HIW) had carried out two unannounced visits. One at the Stroke Rehabilitation Centre and the second visit took place at Rookwood Hospital on wards 4 and 5 where a positive outcome was received in the care of patients.

The ADPSQ met with HIW who informed her that a summit would be held with all key external stakeholders including Welsh Government.

## SERIOUS INCIDENTS AND NEVER EVENTS PAPER – OCTOBER 2018-2019

The purpose of the paper was to look at whether we were learning from quality, safety and patient experience and, in particular, our Serious Incidents (SIs). Over the past year 297 SIs had been reported to Welsh Government, five of which were Never Events. Work was undertaken by the Patient Safety team to motivate people to report incidents in an open way and for those in leadership positions to respond appropriately. Reporting incidents focused mainly on ensuring that it was understood what had occurred, that we were open and transparent and were learning and endeavouring to prevent it from happening again.

Where appropriate, actions had been implemented to address arising clinical risk in response to individual incidents. Following investigation, it was recognised that continued, focused attention was required on particular areas to address the root causes and ensure shared learning across the UHB.

## TRACHEOSTOMY SIMULATION

Dr John Dunn, Consultant Anaesthetist, Programme Director and Simulation Lead provided a presentation on the training programme and shared with Members the improvements the team had put in place. Simulation was described as putting things that had been understood into action and the various aspects of the simulation suite and what it entailed were explained. Simulation is a safe learning environment with clear learning objectives and could be used to simulate isolated tasks or more complex clinical situations, which can be practised repetitively.

Patients were safer and received higher quality care when providers worked as a highly effective team. There was evidence that team training could positively impact in healthcare team processes, clinical

processes and more importantly patient outcomes.

It was stated that there was a need to provide medical staff with confidence in performing procedures and to de-brief the team following a procedure. It was emphasised that unless simulation was practiced medical staff would not understand the real thing and this was a key component of the training programme.

## **ANALYSIS OF TRENDS AND THEMES IN DEATHS OF PATIENTS WITH MENTAL ILLNESS**

Jayne Tottle, Nurse Director, Mental Health provided an overview of the trends and themes identified from Serious Incidents (SIs) and what actions had been taken to address the risks and shortfalls. The presentation also looked at the growth of the Mental Health Services which provided context to the amount of work the service undertook throughout the year.

There was robust discussion on the National Confidential Inquiry into Suicide and Homicide and the Chair said the issue was not just about health but included health inequalities, housing and poverty. This was a public sector response which was much broader than health.

It was suggested that what was learnt from the session, was that individuals who used our services were part of the population which we serve. The statistical data informed we had a suicide rate that was higher than expected and that many of those people in the data had not yet used our Mental Health Services. The data also suggested that as a community we had to do more with our local authority colleagues to have a debate and to consider a summit regarding the suicide rates in our population.

The Chair stated that the Committee had analysed trends and looked at deeper levels of assurance where hope and a way forward was described. It was acknowledged the service was very complex with interdependencies. Also highlighted was the prospect of working in partnership across the public sector on this issue.

## **MANAGEMENT OF ENDOSCOPY SURVEILLANCE PATIENTS**

Dr Jeff Turner, Consultant Gastroenterologist provided a presentation on the Management of Endoscopy Surveillance Patients. Gastrointestinal (GI) Endoscopy is used when patients are symptomatic or have diagnosed conditions and is part of the national outcome screening programme. The surveillance is important for the organisation in terms of the SIs experienced. Surveys were undertaken of patients with increased risk of cancer but part of the problem experienced was that historically, surveillance waiting times had not previously been reported to Welsh Government.

There were 24 SIs over a period of 4 years due to the surveillance backlog and this was a Wales wide issue. A presentation was made on the basis of the work undertaken and focused on how improvements had been achieved within the Health Board on a national level. The outcome was the development of a robust action plan.

An insource provider was used to clear the backlog and robust governance structures were put in place. Due to this the waiting list numbers had significantly reduced. The current situation was that the backlog had been cleared apart from patients who had postponed procedures.

In summary, the Executive Medical Director stated that the key issues discussed helped to focus on any service that was struggling, for them to be open and transparent. The key role in clinical leadership was in developing future planning and demand capacity, and for the clinical governance team to identify areas that need to be addressed. This was an exemplar of using our governance processes.

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities	6. Have a planned care system where demand and capacity are in balance
2. Deliver outcomes that matter to people	7. Be a great place to work and learn
3. All take responsibility for improving our health and wellbeing	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology
4. Offer services that deliver the population health our citizens are entitled to expect	9. Reduce harm, waste and variation sustainably making best use of the resources available to us
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives

## Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click [here](#) for more information

Prevention		Long term		Integration		Collaboration		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>		Yes / No / Not Applicable <i>If “yes” please provide copy of the assessment. This will be linked to the report when published.</i>							

<b>Report Title:</b>	<b>FINANCE COMMITTEE KEY ISSUES REPORT</b>					
<b>Meeting:</b>	Board Meeting				<b>Meeting Date:</b>	28th November 2019
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	<b>For Information</b>
<b>Lead Executive:</b>	<b>Robert Chadwick, Executive Director of Finance</b>					
<b>Report Author (Title):</b>	<b>John Union, Vice Chair of Finance Committee</b>					

## SITUATION

To provide the Board with a summary of key issues discussed at the Finance Committee held on the 31<sup>st</sup> October.

### Finance Report as at Month 6 and Updated Financial Forecast

The report updated the Committee on the UHB's financial performance to month 6.

The UHB's approved 2019/20-2021/22 Integrated Medium Term Plan (IMTP) includes a balanced financial plan for 2019/20.

The Committee was informed that the UHB had reported a cumulative overspend of £2.525m against the plan at month 6 and that this deficit was expected to be recovered by year end through the delivery of identified remedial actions.

It was emphasized that the operational overspend against delegated budgets at month 6 remained a cause for concern and in this context Clinical Boards had been tasked with improving their financial performance through the delivery of recovery measures which would be managed through the established performance management and escalation processes.

A presentation was made to the Committee on the UHB's Plans to Deliver a Break Even Position. The plans which included a risk adjusted financial forecast would be reviewed and presented to the Finance Committee on a monthly basis for the remainder of the year. The forecast was based upon Clinical Board financial forecasts; the recognition of corporate opportunities and unavoidable corporate risks; and the identification of risks requiring management.

It was noted that the aggregate Clinical Board overspend was forecast to deteriorate up until the end of February before a partial recovery in March. The delivery of a number of corporate opportunities in respect of budget underspends, released provisions and slippage on reserves was expected to offset the Clinical Board overspend leading to a gradual month on month reduction in the UHB's reported deficit before a balanced position was reached at year-end.



It was acknowledged that the delivery of break-even was not without risk of delivery. The UHB had assessed this risk to be up to £4m. This assessment assumed full delivery of the savings plan and excluded a further risk of c £1.4m which had recently emerged in respect of a potential year end overspend against the Welsh Risk Pool.

The Committee noted that the UHB's Public Sector Payment Compliance performance continued to exceed the 95% target and that cash plans were currently on target with the UHB not expecting to request additional cash support in 2019/20.

### Cost Reduction Programme and Cross Cutting Theme

The report updated the Committee about the UHB's progress against the savings requirement of £29.145m for 2019/20.

Recurrent and non recurrent schemes totaling £29.145m had been identified as Green or Amber as at 30<sup>th</sup> September 2019. The recurrent impact of schemes was forecast to be £18.103m and in this context the Committee noted a concern that further recurrent schemes need to be identified to ensure that the UHB starts 2020/21 in the best possible position.

### Risk Register

The 2019/20 Finance Risk register was presented to the Committee. It was highlighted that 3 of the risks identified on the 2019/20 Risk Register were categorized as extreme risks (Red) namely:

- Reduction in the £36.3m underlying deficit b/f to 2019/20 to the IMTP planned £4m c/f underlying deficit in 2020/21.
- Management of budget pressures including month 6 overspends of £2.590m, £1.348m and £1.168m reported respectively in the Medicine, PCIC and Surgery Clinical Boards.
- Management of nursing position which was £1.741m over budget at month 6.

### RECOMMENDATION

The Board is asked to:

- **NOTE** this report.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	
<b>Five Ways of Working (Sustainable Development Principles) considered</b> <i>Please tick as relevant, click <a href="#">here</a> for more information</i>			
Prevention		Long term	
		Integration	
		Collaboration	
		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>	Yes / No / Not Applicable <i>If "yes" please provide copy of the assessment. This will be linked to the report when published.</i>		

<b>Report Title:</b>	<b>Strategy &amp; Delivery Committee – Chairs Report</b>					
<b>Meeting:</b>	<b>Board Meeting</b>			<b>Meeting Date:</b>	<b>28.11.19</b>	
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	
					<b>For Information</b>	<b>X</b>
<b>Lead Executive:</b>	<b>Chair, Strategy &amp; Delivery Committee</b>					
<b>Report Author (Title):</b>	<b>Corporate Governance Officer</b>					

## **SITUATION**

To provide the Board with a summary of key issues discussed at the Strategy & Delivery Committee held on 29<sup>th</sup> October 2019

## **Wellbeing of Future Generations Act – WFG Flash Report**

The Committee was provided with a very detailed and positive overview of the Wellbeing of Future Generations Act Flash Report. The Committee were advised of a recent audit undertaken by Wales Audit Office where it was noted that the wellbeing objectives were aligned to the strategic objectives of the Health Board. The Chief Executive Officer informed the Committee that Cardiff & Vale aimed to show the Future Generations Commissioner that the Wellbeing of Future Generations Act was embedded in the whole approach of the UHB.

## **Ensuring that Service Provision, Quality, Finance & Workforce Elements are Aligned and Integrated**

The Committee received an informative presentation from the Assistant Director of Finance which clearly demonstrated how quality, finance and workforce elements were aligned through the work of the Business Case Approval Group.

## **Scrutiny of the Workforce Plan**

The Committee were encouraged and assured with the direction of travel within Workforce & Organisational Development. The Executive Director of Workforce & Organisational Development advised the Committee that a number of leadership sessions had taken place across the UHB which focused on developing individuals correctly. Positive feedback from the training sessions had been received and the Committee are expected to be informed of the outcomes.

## **Scrutiny of the Capital Plan**

The Committee were advised that further funding of £4.5 million had been received for imaging equipment and £2.9 million ICF funding had also been received for the Chapel Scheme in Cardiff Royal Infirmary. The Committee were informed that the Chapel in Cardiff Royal Infirmary

was being converted into an information and café area which would also provide a library service to the residents of the Roath area. It was also explained that building work was underway in the Neonatal Facility where two MRI scanner suites were being installed and completion was expected in 2020.

### **Draft IMTP**

The Committee were advised that a series of workshops had been undertaken across the UHB to ensure that the IMTP was appropriately refreshed and focused as it was developing. The Committee were encouraged by the good engagement from Clinical Boards and Corporate Teams within the UHB.

### **Digital Healthcare Strategic Outline Case**

The Director of Digital & Health Intelligence informed the Committee that a three year informatics plan was developed last year and improvements were being seen. It was explained that data repository work was being undertaken to achieve real time data and also systems were being developed to enable a digital population and workforce. The Committee were advised that Office 365 was being rolled out across the UHB and the Patient Knows Best system was in development. It was explained to the Committee that WiFi was a concern, therefore, transformation funding was being used to try and address this.

### **Developing a Performance Framework**

All Committee members shared the desire to get a performance framework in place, therefore, it was agreed that work would be completed outside of the meeting to get a framework underway. This work would enable the Committee to report to the Board effectively.

### **Key Organisational Performance Indicators**

The Committee discussed the most recent performance delivered and achieved across the main areas of service activity that are closely monitored by Welsh Government.

The Committee were advised of significantly higher admissions into Unscheduled Care and were informed of work being carried out which focused on improving patient flow in preparation for Winter. The Committee were pleased to hear the planned improvements expected within CAHMS over the coming months.

The Committee was encouraged to note the continued positive performance and year on year improvement in most areas.

## Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

## Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term		Integration		Collaboration		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>		Yes / No / Not Applicable <i>If "yes" please provide copy of the assessment. This will be linked to the report when published.</i>							

Kind and caring  
Caredig a gofalgar

Respectful  
Dangos parch

Trust and integrity  
Ymddiriedaeth ac uniondeb

Personal responsibility  
Cyfrifoldeb personol

**CARING FOR PEOPLE  
KEEPING PEOPLE WELL**



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

<b>Report Title:</b>	<b>Audit and Assurance Committee – Chairs Report</b>					
<b>Meeting:</b>	<b>Board Meeting</b>				<b>Meeting Date:</b>	28.11.19
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	
					<b>For Information</b>	<b>X</b>
<b>Lead Executive:</b>	<b>Chair, Audit and Assurance Committee</b>					
<b>Report Author (Title):</b>	<b>Corporate Governance Officer</b>					

## **SITUATION**

To provide the Board with a summary of key issues discussed at the Audit Committee held on 30 September 2019.

## **BREXIT UPDATE**

The Wales Audit Office provided an update on Brexit from the Auditor General's presentation to Welsh Government.

## **INTERNAL AUDIT PROGRESS REPORT**

The Acting Head of Internal Audit presented an overview of the progress report on the Internal Audit Plan. The following was highlighted:

- Three of the five planned audits were in draft stage with a reasonable rating. Two were a work in progress and were relatively positive.
- In providing detail of the outcomes, three reports related to the 2018/19 plan which were included in last year's opinion. No significant issues were identified.
- Seven reports had been finalised from the 2019/20 schedule. Three reports at draft stage were of substantial assurance. There were no limited assurance reports issued.
- Three reports were follow-ups from 'limited' audits last year. The Standards of Behaviour audit had made significant progress with all actions completed and achieved a substantial assurance rating. The Mental Health Clinical Board, Sickness Management and Regulatory Compliance audits had increased to reasonable assurance.

## **WALES AUDIT OFFICE PROGRESS REPORT**

In regards to the Financial Audit Update, the WAO team informed the Committee that they would be onsite to review Charitable Funds. In terms of work completed since the last Committee (the Integrated Care Fund), a regional report would come to the December Audit Committee. The Wellbeing and Future Generations draft report had been sent to the Health Board. Follow-up of Operating Theatres and Orthopaedics Services work was at fieldwork stage. The IMT follow-up would focus on governance recommendations which had been made previously. The Structured Assessment would go forward to the December meeting. The Thematic Review of Quality Governance Arrangements was an extension of the Structured Assessment work and was currently being scoped.

## **AUDIT OF FINANCIAL STATEMENTS REPORT ADDENDUM - RECOMMENDATIONS**

A report was presented that followed up on the financial work where a number of recommendations had been made. Also inspected were recommendations made in the previous year. The following was highlighted:

- WAO were pleased with the progress made by management against each of the previous year's proposals.
- In regards to the retire and return arrangements the Health Board's process was reviewed and it was considered that it should strengthen its guidance to ensure that it complied with Department of Health Guidance.
- In regard to the Annual Governance Statement, the size of the draft report had increased but this had been reduced to provide a concise document which had been accepted by WAO.
- The sensitivity around Related Party Transactions Guidance for Independent Members and Senior Officers needed to be audited for a much tighter level of materiality and to include reputational risk.

## **WALES AUDIT OFFICE REPORT - CLINICAL CODING**

An overview of the previous report was provided and the current status was also discussed. The follow up review examined progress made and concluded positively that the Health Board was producing good coding data which had been used to support service improvement but more work was needed for these proposals to be fully addressed. Since 2017, the Health Board had been consistent in achieving completeness and goals in terms of performance. Furthermore, the Health Board was well above the Wales average against the national performance. The adhoc position had significantly improved since the 2014 report but the NHS Wales Informatics Service (NWIS) had reported the Health Board accuracy rate had decreased slightly over the last 12 months. Out of the 25 recommendations previously made, seven had been fully implemented, twelve were still in progress, four were overdue and two recommendations had been superseded. One new recommendation within clinical coding had been made to resolve interim management arrangements. The follow up review across Wales would pull together key findings from the work into a short paper which would be published around December.

## **JOB PLANNING AND CLINICAL AUDIT**

Job planning was currently being re-audited in four areas of the organisation and provided the Committee with the best indication of the current status. The results of the Internal Audit Report are awaited so that a proposal can be put together and taken through a normal business cycle. A significant piece of work needed to be undertaken to develop a comprehensive local job planning process that would integrate a centralised recording system with a bespoke piece of software capable of comparing data.

In regards to Clinical Audit, there are 38 nationally mandated audits and some of these are broken down into subdivisions which brought the total to 42. The report highlighted exemplars of how national audits were being used to drive through quality improved patient safety. There had been a systematic analysis of the audits which had been taken back to the Clinical Boards highlighting the amber and red ratings.

## **POST PAYMENT VERIFICATION (PPV) REPORT**

The Post Payment Verification Manager presented the report in the new style format and informed the Committee that feedback from across the whole of Wales had asked for more comparative data and provided the detail on this. The spreadsheet had been Red/Amber/Green (RAG) rated in order to show where PPV was concerned and when to raise concerns. There would be more input into training, guidance and support measures and Scott Lavendar offered one on one training with the practices. Quarterly meetings had been reinstated with finance, counterfraud, PPV and the Primary Care Team for each discipline. The Report also looked at the schedule performance and what actions should take place. Also highlighted was that each year the average error rate for each Health Board had decreased.

## **WALES AUDIT OFFICE TRACKING REPORT**

The information provided to the Committee summarised where we were against recommendations on external audits. All of the tracking reports would be followed up on a quarterly basis. The reports would be reported to Management Executive and Health Systems Management Board to provide assurance



that this was being undertaken across the Health Board. Data from the Executives would be presented in December, which should display improved figures.

### INTERNAL AUDIT TRACKING REPORT

The table shown to the Committee was slightly different and provided detail on the assurance rates, whether they were high, low or medium recommendations over the last two financial years. This work was progressing and the expectation was it would lead to improvements. In terms of resource, it was acknowledged there was a huge amount of work to keep the trackers maintained and up to date.

### REGULATORY BODIES TRACKING REPORT

It was acknowledged there was still a lot of work to be undertaken and that centrally we needed to know what we were being inspected on. This needed to come up through the governance structure as the Board and Executives could potentially not be sighted on some significant reports. All of the Clinical Boards had advised the Corporate Governance Team of the regulatory reviews that they needed to be aware of.

To ensure that the tracking report went through due process all regulators had been written to and reports received would go into a dedicated inbox. A heat map was shown with an example of the dials highlighting the level of compliance and when an inspection was due. The aim was to complete this for the December meeting.

### DECLARATIONS OF INTEREST REPORT

Members were informed that significant progress had been made and the Health Board had achieved a rating of substantial assurance. When the audit was completed last year only a few declarations were disclosed. The tracker now showed those who had declared an interest exceeded 700 plus and this was still growing. The mechanisms were in place for communications and would be followed-up and reported regularly.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*



Prevention		Long term		Integration		Collaboration		Involvement	
<b>Equality and Health Impact Assessment Completed:</b>		Yes / No / Not Applicable <i>If “yes” please provide copy of the assessment. This will be linked to the report when published.</i>							

<b>Report Title:</b>	<b>Mental Health Capacity and Legislation Committee – Chairs Report</b>					
<b>Meeting:</b>	<b>Board Meeting</b>				<b>Meeting Date:</b>	28.11.19
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	
					<b>For Information</b>	<b>X</b>
<b>Lead Executive:</b>	<b>Chair, Mental Health, Capacity and Legislation Committee</b>					
<b>Report Author (Title):</b>	<b>Corporate Governance Officer</b>					

## SITUATION

To provide the Board with a summary of key issues discussed at the Mental Health, Capacity and Legislation Committee held on 22 October 2019.

### MENTAL CAPACITY ACT MONITORING REPORT

The Mental Capacity Act 2005 (MCA) has been in force for 12 years. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

The MCA covers people aged 16 years and over. Patients who have impaired decision-making abilities may present in any of the services that the UHB provides.

The Committee was advised that staff training figures remained disappointing especially within medical staff. The Executive Medical Director confirmed that he would take this to the Learning and Development team to look at the whole training package.

The Director of Operations for Children and Women will provide an update to HIW regarding the use of DoLS and will update the committee at the next meeting.

### INTERNAL AUDIT REPORT – DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

The EMD introduced the paper and confirmed that an improvement had been made since the last audit and DoLS had received Reasonable Assurance. In relation to Assessment of Urgent Requests the process was identified as good, however, the timeliness required work. The EMD advised the Committee that the Internal Audit Report had not reached the point of getting formal management responses on recommendations, however work on this was underway.

It was agreed that the Internal Audit report would be brought back to the next Committee meeting for discussion and assurance along with confirmation of which Executive Director was responsible for DoLS.

### MENTAL HEALTH ACT MONITORING EXCEPTION REPORT

The Head of Operations – Mental Health, introduced the report and confirmed it provided the Committee with further information relating to wider issues of the Mental Health Act. He explained he was pleased to report that there had been no breaches of the Mental Health Act since 2018 which was a credit to the department.

Regarding arrests under Section 136 of the Mental Health Act 1983. Legal advice was being sought regarding when an arrest starts and work was underway to gain clarity on this issue.

The Committee was informed that the Mental Health Department had been very proactive in providing mental health awareness and training. A mental health awareness day was held monthly and the awareness days were advertised via the intranet and social media pages. The future plan was to develop an e-module training session for all UHB staff to complete.

### **HEALTH INSPECTORATE WALES MENTAL HEALTH ACT REPORT**

HIW carried out a 3 day inspection in March 2019 within the acute admission wards of Hafan Y Coed.

The Committee was informed that the inspection and action plan was agreed at the Quality, Safety & Experience Committee and the HIW Inspectorate team were very impressed with the staff and service provided at Hafan Y Coed. The main areas of concern raised were:

- Estates
- Information for Service Users
- 'Sleeping Out'

The Health Board was recognised as providing the best system in Wales for 'Sleeping Out' and the team continued to think of ways to improve the process for patients.

The Committee was advised of a number of ongoing concerns with Estates. The Director of Corporate Governance advised that a link would be made to bring the concerns together and they would be raised at a Management Executive Meeting or the Quality, Safety & Experience Committee.

### **INDEPENDENT REVIEW OF CHILD AND ADOLESCENT MENTAL HEALTH SERVICE**

The Committee was provided with:

1. The recommendations of a Welsh Government Delivery Unit review of Primary Care CAMHS (PCAMHS) in Cardiff & Vale UHB (C&VUHB) and resulting action plan;
2. The recommendations of an external review of Secondary Care CAMHS (SCAMHS) in C&VUHB
3. A presentation on the improvement trajectories relating to CAMHS;
4. A presentation on the broader service redesign intentions of the CAMHS service which will support service improvement and sustainability.

There had been an increased demand for CAMHS and the three responses to increase capacity were:

- Appointment of locum staff, who were initially contracted until January 2020;
- Substantive appointments within the CAMHS department had been made; and
- A digital bespoke service had been implemented.

The Committee was advised that an update would be provided to the Board in November outlining the improvements to the service.

### **MENTAL HEALTH MEASURE MONITORING REPORT**

The Committee was provided with an update on the Mental Health Measure and the following was highlighted:

**Part 1a - 28 day referral to assessment compliance target of 80%** - The team had been in and out of compliance over the past 12 months, however, there had been significant investment into Primary Care which had resulted in being compliant with the target.

**Part 1b - 28 day assessment to intervention compliance target of 80%** - A more reliable reporting process had been developed and with the changes in the report it had taken the compliance achieved from 58% to 96%.

**Part 2 – Care and Treatment Planning Within Secondary Mental Health Services** - A multi-disciplinary team and new protocol had been developed to look at after care and treatment plans as the compliance target had not been met.

**Part 3 - Right to request an assessment by self –referral** - the service was compliant in August and September 2019.

**Part 4 – Advocacy – standard to have access to an IMHA within 5 working days** - This area remains 100% compliant.

## CARE AND TREATMENT PLAN UPDATE REPORT

The Committee was advised that an action plan had been created with the Delivery Unit which was broken down into separate areas that focused on how care and treatment plans were used to meet the goals of service users. There have been positive comments on the Delivery Unit having third sector involvement. There has been investment into Substance Misuse Services to investigate current issues and improve the service.

## ITEMS FOR INFORMATION AND NOTING

Items brought to the committee for information and noting were as follows:

- Hospital Managers Power of Discharge Minutes;
- Mental Health Legislation and Governance Group Minutes; and
- Annual Review of Comments Raised by members of Power of Discharge.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term		Integration		Collaboration		Involvement	
------------	--	-----------	--	-------------	--	---------------	--	-------------	--

**Equality and  
Health Impact  
Assessment  
Completed:**

Yes / No / Not Applicable

*If “yes” please provide copy of the assessment. This will be linked to the report when published.*

<b>Report Title:</b>	<b>Health and Safety Committee – Chairs Report</b>					
<b>Meeting:</b>	<b>Board Meeting</b>			<b>Meeting Date:</b>	<b>28.11.19</b>	
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	
					<b>For Information</b>	<b>X</b>
<b>Lead Executive:</b>	<b>Chair, Health and Safety Committee</b>					
<b>Report Author (Title):</b>	<b>Health and Safety Adviser</b>					

## **SITUATION**

To provide the Board with a summary of key issues discussed at the Health and Safety Committee held on 8<sup>th</sup> October 2019

### **Health and Safety Training Compliance**

The Committee received a joint presentation from the Learning Education Department (LED) and the Health and Safety Department on the new approaches taken and being pursued to improve training compliance.

### **HSE Inspection of Violence and Aggression and Musculoskeletal Disorders in Healthcare 2018/19**

The Committee were assured that work was on-going in preparation for the impending inspection. This has been communicated with the Operational Health and Safety Group and each of the Clinical/Service Board's health and safety meetings. An Adviser from the team has been allocated to co-ordinate a review of current status and develop an action plan for identified shortfalls. The Adviser has initiated a number of meetings and actions to give greater assurance of our risk with knowledge with particular emphasis on status of risk assessments, management controls and training compliance.

### **Pedestrian Access Strategy**

The Committee were advised the project programme was to be completed by January 2020.

### **Fire Safety Annual Report**

The Committee were assured that key fire safety risks were being pursued, actioned and monitored as appropriate. The Committee were advised there was a significant improvement in the number of false alarms and a significant number of fire risk assessments had been undertaken, the actions of which were being monitored by the Fire Safety Group.

### **Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20**

The Committee were assured by the prioritised approach taken within the Priority Improvement Plan.

## Lone Worker Report

The Committee were advised that overall utilisation of the devices remained high and well in excess of the previous devices with an average usage of 70%+ month on month measured against device activity and movement. This usage has been sustained over the last 3 years and justified the renewal of the contract which included replacing the existing devices with newer models.

## Environmental Health Reports

The Committee were disappointed that following EHO inspections of the Catering Department in Rookwood Hospital and Ward Based Catering In University Hospital of Wales that scores of 3 were received. The Committee requested assurances that the shortfalls identified in the inspections were being actioned, it was also suggested that the Committee plan into their work programme a presentation on Food Safety/Hygiene.

It was also noted that EHO inspections of Y Gegin, University Hospital of Wales and Aroma Plaza Outlet, University Hospital Llandough scores of 4 and 5 respectively had been received.

## Policies

The following policies were ratified/approved by the Committee:

- (i) Health and Safety Policy
- (ii) Contractor Control Policy

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention		Long term		Integration		Collaboration		Involvement	
------------	--	-----------	--	-------------	--	---------------	--	-------------	--

**Equality and  
Health Impact  
Assessment  
Completed:**

Yes / No / Not Applicable

*If “yes” please provide copy of the assessment. This will be linked to the report when published.*

Kind and caring  
Caredig a gofalgar

Respectful  
Dangos parch

Trust and integrity  
Ymddiriedaeth ac uniondeb

Personal responsibility  
Cyfrifoldeb personol

**CARING FOR PEOPLE  
KEEPING PEOPLE WELL**



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board



Report Title:	Stakeholder Reference Group Report							
Meeting:	UHB Board					Meeting Date:	28 <sup>th</sup> November 2019	
Status:	For Discussion		For Assurance		For Approval		For Information	X
Lead Executive:	Abigail Harris							
Report Author	Geoffrey Simpson, Vice Chair of Stakeholder Reference Group							

## **SITUATION**

The following report provides Board with a summary of the key issues discussed at the Stakeholder Reference Group (SRG) meeting held on 24 September 2019.

## **BACKGROUND**

This is a report provided to the Board by the Chair of the UHB SRG.

## **ASSESSMENT**

The SRG considered the following

### **Improving the Patient Pathway for Frail Older People**

The SRG noted that the formal engagement process had commenced on 2 September and would conclude on 1 November. The SRG was thanked for publicising the engagement event held in Barry the previous day attended by 53 members of the public. Whilst there had been quite a lot of support for the principles underpinning the proposals there had been very strong opposition to the model itself and the proposed closure of Sam Davies Ward at Barry Hospital. There would be an engagement mid-point review meeting with the Community Health Council the following week and it was anticipated that a public evening meeting would be arranged.

### **Thoracic Surgery**

The SRG noted that at a Special UHB Board meeting on 29 August there had been agreement on the way forward with other Health Boards and the Welsh Health Specialised Services Committee

### **Day Surgery at University Hospital Llandough**

The SRG noted that the formal engagement process had concluded. Around 30 responses had been received all of which had been broadly supportive of the proposals. A report on the outcome of the engagement process would now be produced and discussed with the CHC. If approved, it was hoped to start the process of shifting some non-complex surgery at UHL within a month or so, starting with ENT.

### **Feedback from Board**

The SRG received an update on some of the key issues discussed at the Board meeting held on 25 September 2019.

### **Integrated Medium Term Plan (IMTP)**

The SRG received a presentation from Chris Dawson-Morris on the UHB's IMTP priority setting process and the emerging priorities. The SRG heard that in developing the IMTP the process is more important than the plan. Conversations have been held with staff, patients, carers and a range of stakeholders to understand what is important to them. From these discussions a list of priorities has been developed. The emerging priorities were then shared and the SRG was asked to consider if the list sufficiently reflected the UHB's partnership agenda; and if there were additional key priorities required from a partnership perspective. The SRG suggested that specific consideration needs to be given to the support required by individuals without family. It was pleased to see the profile given to vulnerable groups. Transformation of services for vulnerable groups was welcomed. It was noted that Registered Social Landlords would have a role in supporting the UHB to deliver its priorities.

## Amplify 2025

The SRG was informed that Amplify 2025 had been launched in summer 2019 with a two day engagement event for 80 highly engaged 'leaders'. These 80 were split into groups of 10 each with an Executive 'sponsor'. They were challenged to think differently about the way the UHB delivers healthcare ensuring that 'Wyn' is at the centre of its decision making. The next stage is to establish an interactive 'Showcase' experience to which up to 5,000 staff, patients, carers and other stakeholders will be invited to attend. 'Showcase' will be a two hour experiential walk through of the system incorporating both current and future models of care. The SRG then considered some specific questions:

- What is the SRG's view on the UHB putting the patient 'Wyn' at the heart of its decision making?
- Does the SRG have any thoughts/builds on employee engagement?
- The UHB wants employees to volunteer for training or other community activities to Amplify its Vision through Showcase. Does the SRG have any suggestions in this regard?
- How would the SRG like to be involved in Showcase?

The SRG supported the principle of putting 'Wyn' at the centre of decision making. Personalising services by using 'Wyn' galvanises people to put the patient at the centre whereas focussing on performance measures has the potential to desensitise people to the needs of individuals. The aim should be to prevent 'Wyn' requiring services. The SRG commented that there is a need to consider individuals with protected characteristics and that Wyn might not be perceived as representative. Amplify should not be restricted to health services. It was agreed that the SRG would be invited to test the 'Showcase' in advance of the formal launch in spring 2020.

## RECOMMENDATION

The Board is asked to:

- **NOTE** this report.

### Shaping our Future Wellbeing Strategic Objectives

*This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

### Five Ways of Working (Sustainable Development Principles) considered

*Please tick as relevant, click [here](#) for more information*

Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓
------------	---	-----------	---	-------------	---	---------------	---	-------------	---

**Equality and Health Impact Assessment Completed:**

Not Applicable

*Amu unddwrng*

*Caredig a gofalgar*

*Respectful*

*Dangos parch*

*Trust and integrity*

*Ymddiriedaeth ac uniondeb*

*Personal responsibility*

*Cyfrifoldeb personol*



<b>Report Title:</b>	<b>Local Partnership Forum Report</b>					
<b>Meeting:</b>	UHB Board				<b>Meeting Date:</b>	28.11.19
<b>Status:</b>	<b>For Discussion</b>		<b>For Assurance</b>		<b>For Approval</b>	<b>For Information</b> x
<b>Lead Executive:</b>	Executive Director of Workforce and OD					
<b>Report Author (Title):</b>	Workforce Governance Manager					

## SITUATION

The Local Partnership Forum of the UHB held its last meeting on 2 October 2019. This report provides Board with a summary of the key issues discussed at that meeting.

## REPORT

### BACKGROUND

The UHB has statutory duty to “take account of representations made by persons who represent the interests of the community it serves”. This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of Workforce and OD. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

This report highlights for the Board the key issues discussed at the last meeting, and provide assurance regarding the business assigned to the Forum by the Board.

### ASSESSMENT

#### For Consideration:

The Forum received a presentation on the development of IMTP for 2020-23. It was noted that 2020-21 was Year 2 of the current plan, and as such was a refresh of the priorities and actions previously agreed rather than a new plan. The Forum supported the priorities and actions discussed, but expressed concern that the Clinical Board lead Staff Representatives had not been involved in the development stages.

The Forum received a paper on the importance of embedding prevention in a systematic way to ensure we deliver our mission of ‘keeping people well’. It was noted that although there is a good track record of preventative activity in the UHB, these are not always co-ordinated. The

views of the LPF were sought on the 5 actions for delivery contained in the model and individual members were asked to commit to prevention themselves through role modelling and sharing the examples of good work. LPF supported the model and the good work being done, but it was suggested that it could be more aspirational.

### For Communication:

The Deputy COO provided an update on the development of and priorities for the Winter Plan. Ms Bird gave assurances that staff representatives would be included in the debrief next year.

Sustainable travel is a standing agenda item at all LPF meetings. The new Park and Ride service from Cardiff to UHL and the shuttle bus between UHW and UHL were discussed. It was noted that Corporate Membership with Nextbikes will be launched soon, with membership for 1500 members of staff.

### For Appraisal:

LPF received the Finance Report, Workforce KPI Report and Patient Safety, Quality and Experience Report for July 2019.

**ASSURANCE** is provided by:

Ensuring alignment of Local Partnership Forum agendas with the purpose of the Forum as set out in the Terms of Reference

### RECOMMENDATION

The Board is asked to:

- **NOTE** the contents of this report

1.Reduce health inequalities		6.Have a planned care system where demand and capacity are in balance	
2.Deliver outcomes that matter to people		7.Be a great place to work and learn	x
3.All take responsibility for improving our health and wellbeing		8.Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.Offer services that deliver the population health our citizens are entitled to expect		9.Reduce harm, waste and variation sustainably making best use of the resources available to us	
5.Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.Excel at teaching, research, innovation and improvement and provide an environment where	

				innovation thrives					
Five Ways of Working (Sustainable Development Principles) considered Please tick as relevant, click <a href="#">here</a> for more information									
Prevention		Long term		Integration		Collaboration	x	Involvement	x
Equality and Health Impact Assessment Completed:		Not Applicable							

