

Cardiff and Vale Stakeholder Reference Group

Wed 25 September 2024, 13:30 - 15:00

Agenda

13:30 - 13:30 **1. Welcome and Introductions**
0 min
Lani Tucker

13:30 - 13:30 **2. Apologies for Absence**
0 min
Lani Tucker

13:30 - 13:35 **3. Declarations of Interest**
5 min
Lani Tucker

13:35 - 13:40 **4. Minutes and Matters Arising from the SRG Meeting on 10 June 2024**
5 min
Lani Tucker

 Item 4 Unconfirmed Minutes of SRG Meeting 10 June 2024.pdf (5 pages)

13:40 - 13:50 **5. Feedback from Board**
10 min
Matt Phillips

13:50 - 14:40 **6. Development of an Integrated Community Care System for Cardiff and Vale**
50 min

Cath Doman and Alex Bridgman

 Item 6 ICCS briefing SRG 25.09.24.pdf (13 pages)

14:40 - 14:50 **7. Clinical Services Plan**
10 min

Vicky Le Gry

14:50 - 15:00 **8. Partnership Work**
10 min

Sarah Tipping

Lloyd Gareth
11/09/2024 14:58:02

UNCONFIRMED MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON MONDAY 10 JUNE 2024, NANT FAWR 1, WOODLAND HOUSE, MAES Y COED ROAD, CARDIFF, CF14 4HH

Present:

Lani Tucker	Glamorgan Voluntary Services (Chair)
Frank Beamish	NHS Volunteer
Richard Cox	One Voice Wales
Paula Martyn	Independent Care Sector
Siva Sivapalan	Third Sector Older Persons
Lynda Thorne	Cardiff Council

In Attendance:

Marie Davies	Interim Executive Director of Strategy & Planning, UHB
Angela Hughes	Assistant Director of Patient Experience, UHB
Jessica Mannings	Llais
Geoff Walsh	Director of Capital, Estates and Facilities, UHB

Apologies:

Sam Austin	Llamau
Duncan Innes	Cardiff Third Sector Council
Zoe King	Diverse Cymru

SRG 24/18 WELCOME AND INTRODUCTIONS

Cllr Thorne was welcomed and introduced to the SRG.

The Chair informed the SRG that Paula Martyn had indicated that she believed the time was right to step down from the SRG having first joined the SRG 13 years ago. The Chair thanked Paula for her tremendous contribution to the Group and wished her all the best for the future.

SRG 24/19 APOLOGIES FOR ABSENCE

Although not members of the SRG, apologies had been received from Matt Phillips and Sarah Tipping.

SRG 24/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

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Lloyd Gareth
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**SRG 24/21 MINUTES AND MATTERS ARISING FROM
STAKEHOLDER REFERENCE GROUP MEETING
HELD ON 26 MARCH 2024**

The minutes were **RECEIVED** and **APPROVED** as an accurate record.

Clinical Services Plan (CSP) – Marie Davies reported that clinical colleagues across South East Wales had attended a Clinical Summit the previous week. The timetable for developing Cardiff and Vale Health Board’s CSP would be aligned with that being developed by Cwm Taf Morgannwg Health Board. CSP Workshops would be held during the autumn. Gareth Lloyd confirmed that a CSP workshop session was scheduled as an agenda item for the SRG in November.

Next Big Priority Areas – Gareth Lloyd reported that Public Health Wales were still working on identifying the next big priority areas. The specialties being considered included heart disease, chronic obstructive pulmonary disease and frailty. Marie Davies explained that there were a number of clinical implementation networks across Wales that were considering whole system pathways with an emphasis on prevention.

**SRG 24/22 TO APPROVE AMENDED MINUTES OF THE
MEETINGS HELD ON 26 SEPTEMBER 2023 AND 28
NOVEMBER 2023**

The SRG **RECEIVED** and **APPROVED** the amended minutes.

SRG 24/23 FEEDBACK FROM BOARD

The SRG had been sent a link to the papers for the Board meetings held on 28 March and 30 May 2024.

Marie Davies informed the SRG that the Health Board remained under Welsh Government (WG) escalation measures due to the financial position which means that along with most other Welsh Health Boards, it has been asked to produce an Annual Plan rather than a three year Integrated Medium Term Plan. The Health Board has developed a programme to reduce costs to achieve a £15.9m deficit which will require £47m of savings in year. The Chief Executive and wider Executive team have made it clear that in so doing the Health Board must retain its focus on improving quality and eradicating avoidable harm and have a clear line of sight on the development of a sustainable CSP.

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Marie Davies explained that as well as revenue funding, capital funding was another big constraint to the Health Board's ambitions. Many of the Health Board's facilities were in a very poor condition and no longer fit for purpose. WG capital funding was extremely limited and WG was therefore undertaking a comprehensive all Wales NHS capital investment prioritisation exercise. The Health Board also has a very limited Discretionary Capital allocation out of which it must fund all urgent maintenance and repairs to its infrastructure.

The SRG enquired how the Health Board would achieve these financial savings. Marie Davies acknowledged that it would be a huge challenge. The Executives and the senior clinical leaders attend a monthly financial Sustainability Programme Board. 1.5% savings must be achieved across all budgets. In addition, the Health Board is targeting savings in five broad areas: reducing bank and agency staff costs, continuing health care; medicines management; procurement and reducing length of stay.

It was noted that Local Authorities also had to make substantial financial savings and they were working jointly with the Health Board to identify innovative ways of working to both improve services and reduce costs. Health and social care were working ever more closely. Place-based planning was beginning to gain traction in Cardiff and the Vale. This brings together public bodies working in partnership to plan services and infrastructure (buildings) within a geographical 'place', aligned to the assets and needs of the population. Marie Davies suggested that this would be a good topic for discussion by the SRG.

Action: Sarah Tipping/Gareth Lloyd

SRG 24/24 PUBLIC TRANSPORT AND PLANNING OF HEALTH SERVICES

Marie Davies explained that access including public transport was a key consideration in the planning of health services. The needs of all groups must be considered, in particular those of vulnerable groups.

Geoff Walsh explained that there was an imperative to move away from private transport usage towards more sustainable public transport alternatives. WG guidance stipulates to local authorities that the allowance for car parking spaces for new facilities is significantly lower than it has been in the past. However, if people are to be persuaded to reduce the use of their own private vehicles there will have to be major improvements to the public transport infrastructure.

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There is a statutory responsibility on health boards to produce a transport document to accompany any new development. These reports provide details of how sites can be accessed including public transport facilities.

WG stipulates that for every new development, the Health Board must meet the BREEAM (Building Research Establishment Environmental Assessment Methodology) excellent standard. One of the BREEAM sections relates specifically to transport.

The SRG made a number of comments and observations

- If patients use their own transport to attend appointments this creates parking issues on the Health Board sites. However, if patients miss appointments due to unreliable public transport this increases the number of 'did not attends'.
- The Equality Act 2010 places socio-economic duties on Health Boards and it is the more socio economically disadvantaged who suffer most as a result of poor public transport provision.
- Public transport providers seem to be able to unilaterally change or withdraw services. Some formal channel of communication is required between public transport providers, local authorities and the Health Board.
- Is there an argument for Local Authorities and the Health Boards contributing to public transport costs to maintain services that are considered commercially unviable? Geoff Walsh explained that the Health Board had, on occasion, made a Section 106 planning contribution to public transport. There has been a reduction in subsidies for some non-profitable routes and he would be open to further discussions with the Local Authorities regarding this. The Health Board has a very good relationship with Cardiff Bus and the Health Board has invested heavily in the park and ride service for UHW. The now ceased park and ride service for UHL had been far less successful as the parking facility had been located in Cardiff. The Health Board had tried without success to identify as potential site on the Dinas Powis side of UHL.
- Consideration should be given to providing a shuttle bus service from UHL to central Penarth which has good public transport infrastructure.
- A third sector transport audit has been undertaken. Common themes were the difficulties these organisations had with funding and recruiting sufficient volunteer drivers. Voluntary Emergency Service Transport (VEST) had indicated that it did not provide a service to Hospitals or a service in the Vale
- It would be helpful to arrange a workshop to highlight and discuss potential solutions to specific transport issues. Attendees could include representatives from the Health Board, Local Authorities, third sector,

patient groups and public transport providers. Marie Davies suggested that this could be arranged via the Regional Partnership Board

Action: Marie Davies

- The emphasis should be on providing local health services thereby reducing the need to travel to hospital sites for routine appointments.
- It would be helpful to analyse the reasons why people chose to drive to hospital when there are good public transport alternatives as it's this cohort that need to be encouraged to change their behaviours.
- Is there an opportunity for the Health Board to form an agreement with local taxi companies?

SRG 24/25 LLAIS

The SRG **RECEIVED** a presentation from Jessica Mannings on the first twelve months of Llais. A report had also been produced a link to which was included on the Llais website.

The SRG made a number of comments and observations

- What is the requirement in terms of responding to Llais representations following site visits? Jessica Mannings explained that Health Boards and social care providers must acknowledge all Llais representations and inform Llais how they will be implemented. Where representations cannot be implemented, an explanation must be provided.
- Changes resulting from complaints should be shared with other Health Boards.

SRG 24/26 NEXT MEETING OF SRG

It was agreed that meeting scheduled for Tuesday 30 July 2024 be cancelled. The SRG would therefore meet next 13.30-16.00 on Wednesday 25 September, Nant Fawr 1, Woodland House.

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Development of an Integrated Community Care System for Cardiff and Vale

CVUHB Stakeholder Reference Group 25.09.24

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Cath Doman, Director of Health and Social Care Integration

Alex Bridgeman, Senior Programme Manager, Six Goals for Urgent and Emergency Care

Six Goals for Urgent and Emergency Care

Goal 1 Population Planning and Support

What: Co-ordination planning and support for populations at greater risk of needing urgent or emergency care

Aim: Health and social care organisations should work in collaboration with public service and third sector partners to deliver a coordinated, integrated, responsive health and care service, helping people to stay well longer and receive proactive support, preventative interventions or primary treatment before it becomes urgent or an emergency

Goal 2 Signposting – Right Place, Right Time

What: Signposting people with urgent care needs to the right place, first time

Aim: When people need or want urgent care they can access a 24/7 urgent care service via the NHS 111 Wales online or telephone service where they will be given advice and, where necessary, signposted or referred to the right community or hospital-based service, first time. This will be achieved through the development of an integrated 24/7 urgent care service.

Goal 3 Alternatives to Admission

What: Clinically safe alternatives to admission to hospital

Aim: People access appropriate and safe care close to home, and with as much continuity of care, as possible. Admission for ongoing care to an acute hospital bed should only occur if clinically necessary.

Goal 4 Rapid Response

What: Rapid response in physical or mental health crisis

Aim: Individuals who are seriously ill or injured or in a mental health crisis should receive the quickest and best response commensurate with their clinical need – and, if necessary, be transported to the right place for definitive care to optimise their experience and outcome

Goal 5 Optimal Hospital Care and Discharge

What: Optimal hospital care and discharge practice from the point of admission

Aim: Optimal hospital-based care provided for people who need short term, or ongoing, assessment or treatment for as long as it adds benefit to outcome, with a relentless focus on good discharge practice

Goal 6 Home First

What: Home first approach and reduce the risk of readmission

Aim: People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes and experience, and to avoid deconditioning

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How do we keep people safe at home in the community?

People need safe and effective alternatives to admission, what are they and how do we provide them?

How do we provide the best care within hospitals and get people home ASAP?



The Programme Structure

1

How do we keep people safe at home in the community?

Triumvirate – Cath Doman, Geraldine Johnston & Rachel Lee

Enhanced Community Care

- CAV 24/7 – single point of access and digital hub
- Urgent Treatment/Care Centre
- Urgent Primary Care Centres
- Safe@Home Phase 2
- Enhanced community diagnostics
- Tech-enabled care
- Sub-acute community beds

2

People need safe and effective alternatives to admission, what are they and how do we provide them?

Leads – Chris Morris and Rachel Thomas

Alternatives to admission

- Medical SDEC
- Surgical SDEC
- Trauma SDEC
- Gynaecology SDEC
- *Frailty SDEC*
- Virtual Wards

3

How do we provide the best care within hospitals and get people home ASAP?

Leads – Claire Main & Tom Holmes

Reducing Time in Hospital

- Proactive & Reactive
- Patient pathways and workflows
- Quality & Standards
- "When Can I Go Home?"

HIGH RISK COHORT

Acute in-patient medicine
 3 – How do we provide the best care within hospitals and get people home ASAP?

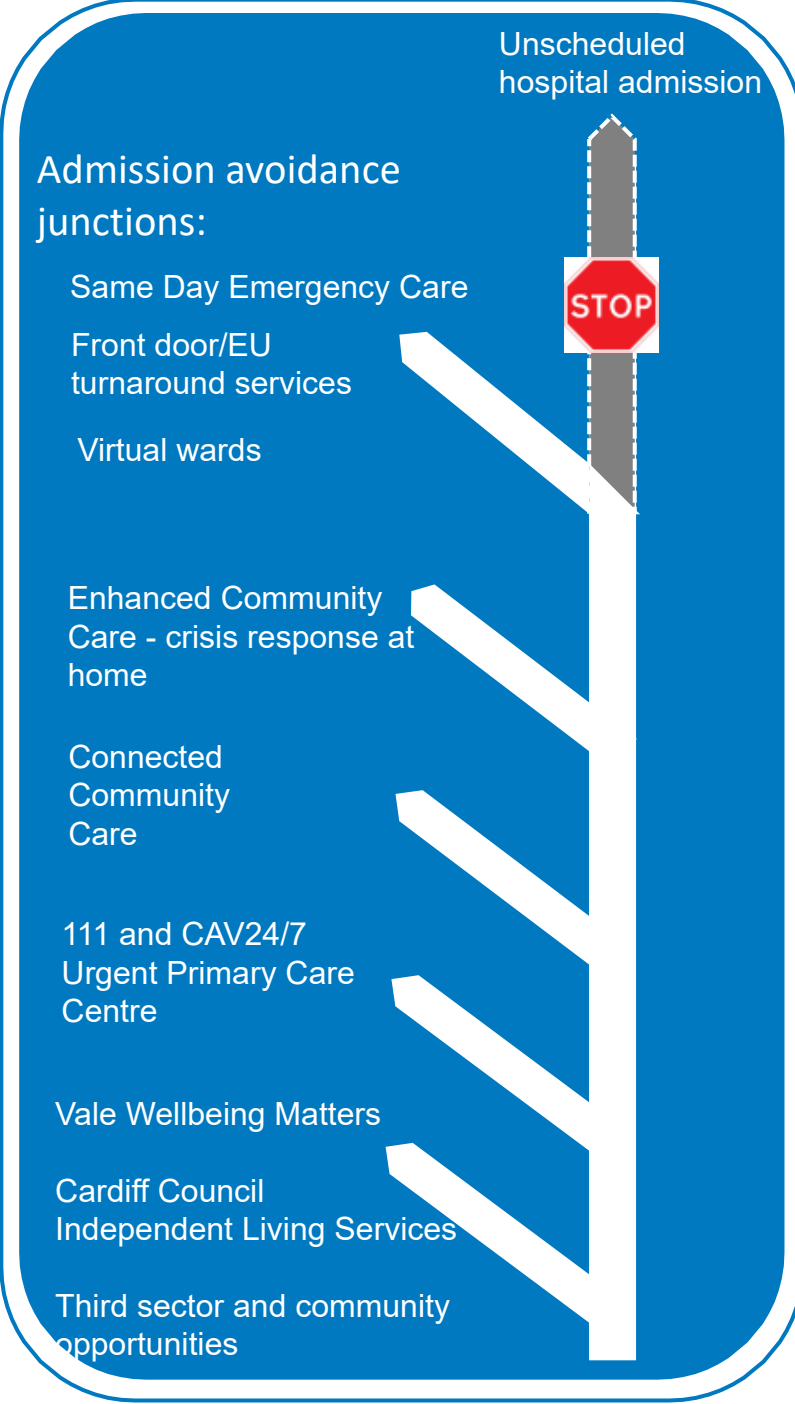
Alternatives to admission
 2 -People need safe and effective alternatives to admission, what are they and how do we provide them?

NHS, social care, third sector
 1 – How do we keep people safe at home in the community?

Urgent primary care

Information, advice and assistance

Community connections and resources



Mortality and Morbidity

EU performance and Length of Stay

SDEC performance and direct referrals

Urgent Primary Care Utilisation + Redirects

MDT admission avoidance

Healthy Days at Home

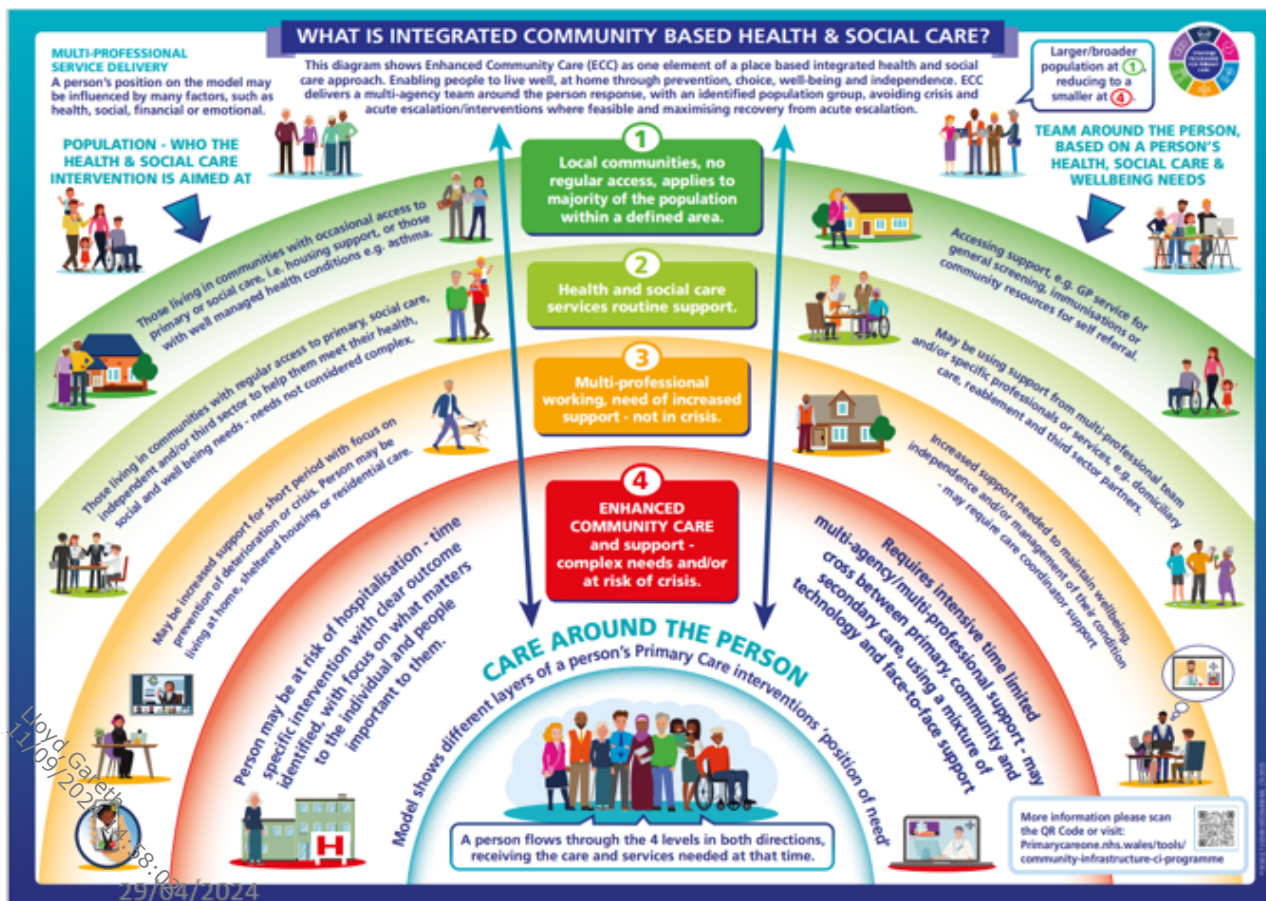
Person centred care

How will we judge ourselves?

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Context: Creating a place-based integrated community health and social care system



- GP, optom, dental, pharmacy
- Enhanced services and clinics
- Social prescribing and self referral services
- Third sector and community resources
- Telecare
- Housing-related support
- Information, Advice and Assistance

- Cluster Discharge Hubs
- Cluster MDT
- Wellbeing services
- Telecare, equipment, adaptations

- Urgent care centres
- Community Resource Teams
- Cluster discharge hubs and MDT

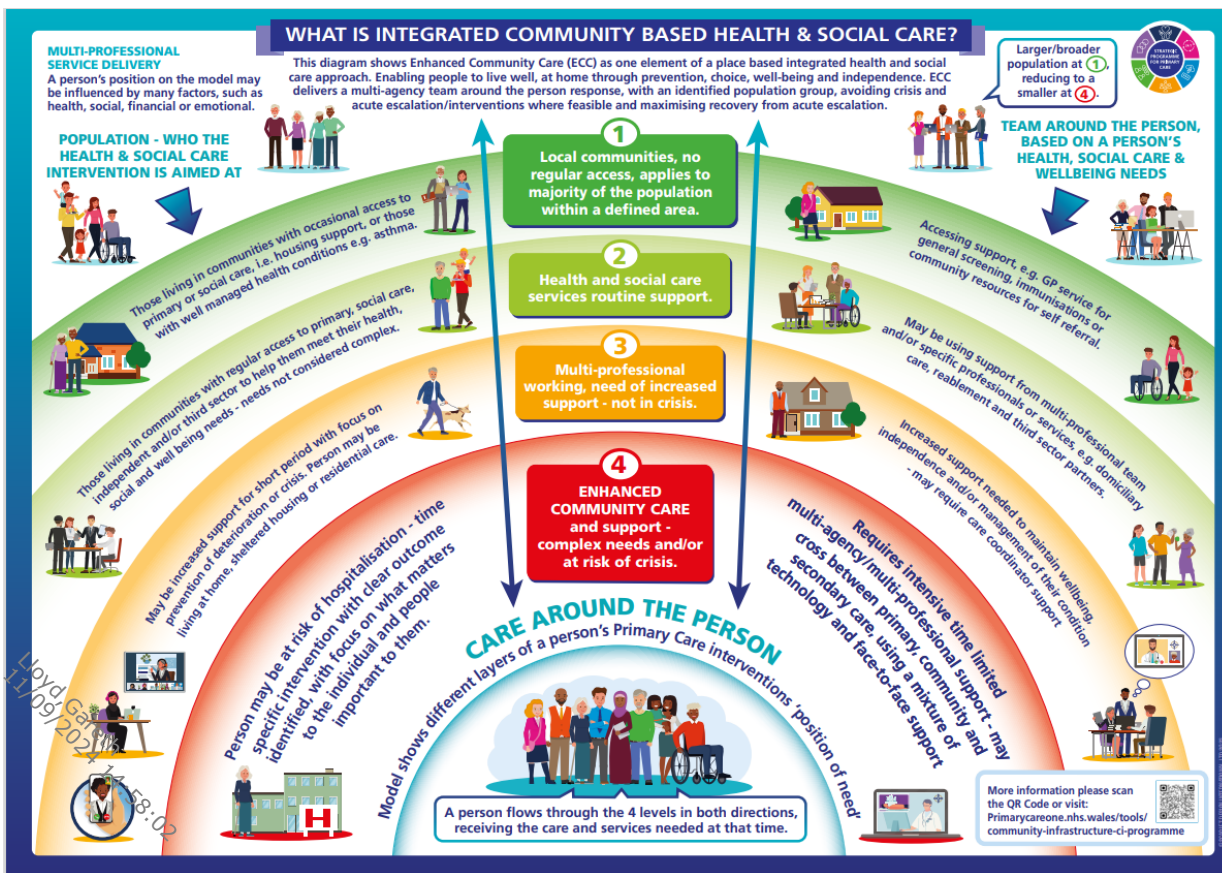
- Safe@home phase 2
- Urgent Treatment Centres
- Enhanced Community Diagnostics
- CAV 24/7:
 - Digital Hub and remote monitoring
 - Single point of access with enhanced technological capabilities
- Emergency Unit redirects
- Sub-acute community beds

- Cross cutting:**
- Access to services
 - Housing-related support
 - Domiciliary care and reablement
 - Community nursing specification and palliative care
 - Community AHP capacity
 - Digital solutions and tech-enabled care
 - Integrated assessment and care planning, inc. Anticipatory Care Planning



What is @home?

@home is the Regional Partnership Board programme which coordinates the work of our partners to design and deliver our **Integrated Community Care System** for Cardiff and Vale.



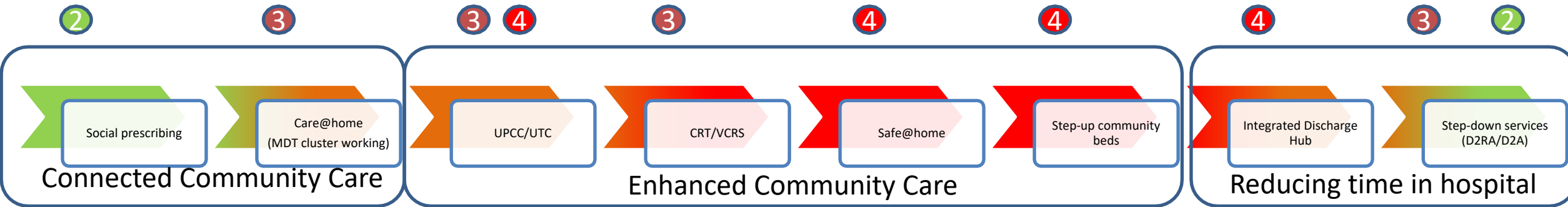
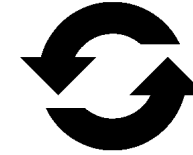
More at home

Less in hospital



- 6 Goals for urgent and emergency care
- Planned Care
- Clinical Services Plan

@home: building an integrated community care system

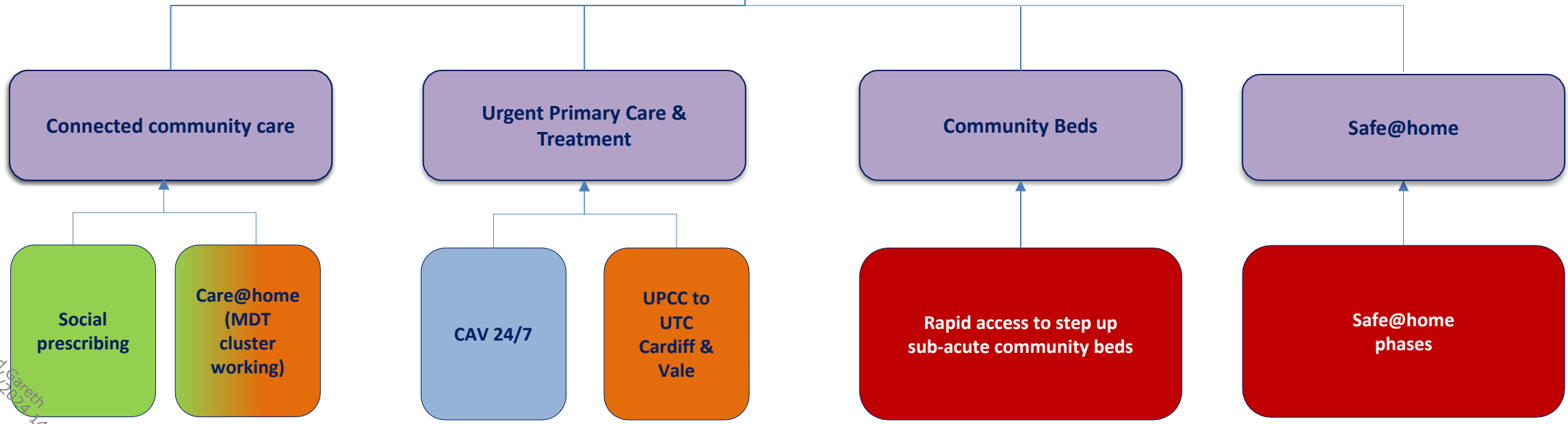


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@home programme board
(with assurance provided to Six Goals Delivery Board)

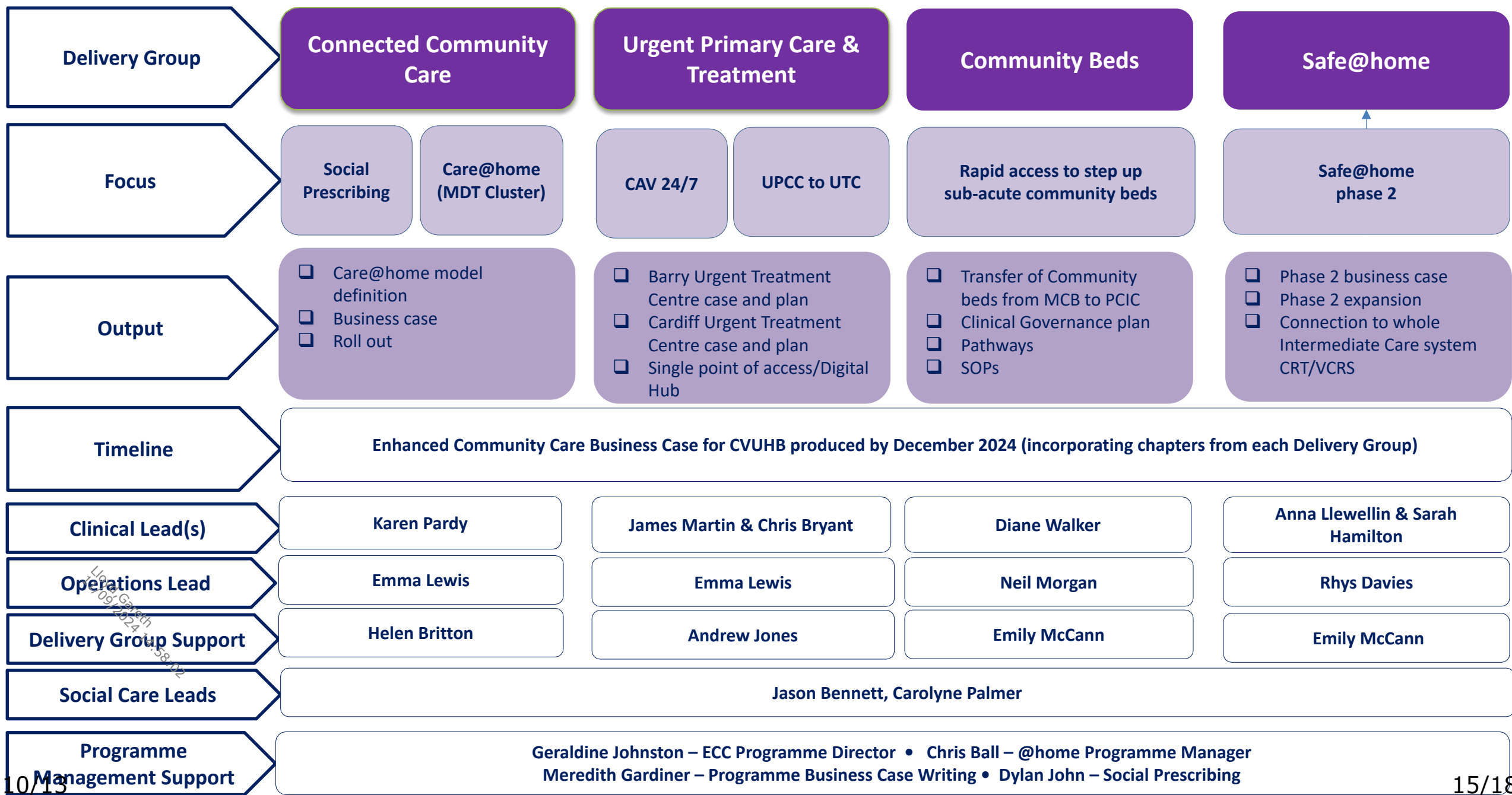
Leadership triumvirate
Dr Rachel Lee – Clinical Lead
Geraldine Johnston – Operational & Programme Lead
Cath Doman – Partnership Lead/@home programme director

Enhanced Community Care Steering Group



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CVUHB Enhanced Community Care Business Case development



Governance



C&V Regional Partnership Board

@home integrated community care system Programme Board



SRO: Paul Bostock
 RPB Programme Director: Cath Doman
 RPB Programme Manager: Chris Ball
 Scope: out of hospital
 (All partners)

ECC Steering Group


Connected community care	Urgent primary care and treatment	Community beds	Safe@ home
Access			

Digital Care Region+ Tech-enabled care	Planning: (Place planning and capital)	Future Care Planning	Workforce model
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CVUHB

6 Goals Delivery Board



SRO Paul Bostock
 Snr Programme Manager: Alex Bridgeman
 Scope: in hospital
 (CVUHB only)

Assurance to

Enhanced Community Care	Alternatives to admission	Reducing time in hospital
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2024-25 Delivery Plan @Home



North Star:

Accelerating the delivery of our place-based, integrated care model in 2024

Area Plan commitment:

Establish integrated, locality-based, health and care services focussed on meeting and improving the health and wellbeing of the local population.

Governance:

1. @Home Programme Board – bi-monthly
2. 6 Goals Board – monthly
3. @Home Engine Room – monthly
4. Project groups – various

SRO	Paul Bostock
Programme Director	Cath Doman
Programme Manager	Chris Ball
Project Support Officer	Abbi Williams

Clinical Leads	Rachel Lee, Katja Empson, Chris Bryant, Huw Williams, Ben Roper, Karen Parry
Finance Lead	Chris Markall
Partner Leads	Cardiff: Carolyne Palmer, Lisa Wood Vale: Jason Bennett UHB: Anna Llewellyn, Geraldine Johnstone, Diane Walker 3rd Sector: Duncan Innes, Lani Tucker

Priority Area	Deliverable	Priority	Lead	Timeline/milestones	Expected impact
Connected community care	1. All 57 GP practices have access to social prescribing	1. SPPC	1. Karen Parry, PCIC	Q1 - Social prescribing steering group established – Q1	<ul style="list-style-type: none"> • Reduced numbers of referrals for community mental health support • Increased input of third sector/social value at community level
	2. Place plans completed for all 9 clusters	2. UHB, Cardiff Council	2. Ashleigh O'Callaghan, UHB	Q1 - Social prescribing services mapped across the region	
	3. Role of Housing With Care Centres agreed including co-location of teams	3. UHB	3. Jane Thomas, Cardiff Council	Q2 - Gaps explored and business case developed if needed	<ul style="list-style-type: none"> • Decrease in unplanned attendances/admissions from EU for >65 • Increase in people dying in their place of choice
	4. MDT meetings operational in all 9 clusters, or at locality level if needed	4. SPPC	4-5. Karen Parry, PCIC	Q3 - Social prescribing processes agreed across all localities	
	5. Model agreed and rollout of Integrated Care Hubs completed	5. SPPC	6. Tbc, TEC Cymru	Q1 - Mapping of current maturity finalised for MDTs and Integrated Hubs	
	6. Telehealth model defined and pilot implemented and evaluated	6. FF, Cardiff Council	7. Rachel Lee, PCIC	Q1 - Future care planning group established	
	7. Future Care Planning model and standard operating procedures designed and agreed	7. FF	8. Anna Llewellyn, PCIC	Q1 - Recruitment to additional roles to deliver Community Nursing specification	
	8. Delivery of the Community Nursing specification as part of cluster/locality delivery model	8. FF		Q2 - Funding requirements for gaps established and business case submitted to investment group	
Enhanced community care	9. Capacity and demand analysis defined to determine workforce model for intermediate care	9. 6 Goals (3), ECC	9. Anna Llewellyn, PCIC	Q2 - TEC/Telecare pilot explored and costs outlined and agreed	<ul style="list-style-type: none"> • Reduced waiting times for intermediate care support • Improved outcomes for people supported across multiple services/organisations
	10. Rollout of Safe@home including; GP and care home referrals	10. 6 Goals, SPPC, FF, ECC	10. Anna Llewellyn, PCIC	Q3 - Development of future care planning model and rollout of training and SOPs	
	11. A defined ECC integrated delivery model comprised of; CAV247, UTCs	11. 6 Goals	11. 6 Goals triumvirate	Q1 - Rightsizing data analysis run	
Reducing time in hospital	12. A joined-up integrated discharge model	12. 6 Goals, FF, ECC	12. Diane Walker, UHB Operations	Q2 - Place planning asset mapping carried out	<ul style="list-style-type: none"> • Increase in people >65 years supported at home • Decrease in unplanned attendances/admissions from EU for >65 • Reduced pathway of care delays
	13. Defined blueprint which describes the governance, models of care and how services fit together as a cohesive whole	13. SPPC, UHB	13. Cath Doman, RPB	Q3 - Services in agreement about co-location and model	
Blue print				Q2 - Business case finalised and approved by investment group	<ul style="list-style-type: none"> • Increase in people >65 years supported at home • Decrease in unplanned attendances/admissions from EU for >65 • Reduced pathway of care delays
				Q3 - Engagement of wider services and finalised processes agreed	
				Q3 - Recruitment and implementation	<ul style="list-style-type: none"> • Increase understanding of the programme and shift to community
				Q3 - Detailed mapping and analysis of discharge pathways and planning	
				Q1 - Plan agreed for development of the blueprint	
				Q2-3 - Blue print developed and presented to Execs	



Lloyd Gareth
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