BOARD MEETING

1pm on Thursday 28th September 2017

Board Room
University Hospital Llandough

CARING FOR PEOPLE
KEEPING PEOPLE WELL

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

BOARD MEETING
1pm on 28th September 2017
Board Room, University Hospital Llandough

AGENDA

PATIENT STORY A patient with complex care needs and his experience – recorded story		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral
	Apologies for Absence	Oral
	Declarations of Interest	Oral
4	Minutes of the Board meetings held on 27th July 2017	*Chair*
5	Action Log	Oral *Chair*
6	Chair's Report	Oral *Chair*
7	Chief Executive's Report	Oral *Chief Executive*
Deliver Outcomes that Matter to People		
8	Patient Safety Quality and Experience Report	*Executive Nurse Director*
Our Service Priorities		
9	Wellbeing and Future Generations Act – UHB Progress	*Director of Public Health*
10	IMTP 2018-2021 Development	*Director of Planning*
Sustainability		
11	Finance Report	*Director of Finance*
12	Performance Report	*Director of Public Health*
13	Major Trauma Network Development	*Director of Planning*
14	Shaping Our Future Wellbeing – Developing Our Estates Plan	*Director of Planning*
15	Future Shape of Thoracic Surgery Services in South Wales	*Director of Planning*
Culture and Values		
16	WAO Report – UHB's Contractual Relationship with RKC Associates Ltd and its Owner	*Chief Executive*
17	Financial Governance Review of the UHB – Deloittes Report	*Chief Executive*
18	Action taken by the Chair on Behalf of the Board	*Chair*
19	Corporate Risk and Assurance Framework Update	*Director of Corporate Governance*
20	Research and Development Implementation Plan	*Medical Director*

21 .1 .2 .3 .4	**Annual Reports** • Annual Report of the Director of Public Health • Health and Safety Annual Report • Substance Misuse Area Planning Board Annual Report • Directors of Primary, Community & Mental Health Annual Report	*Directors of:* *Public Health* *Corporate Governance* *Public Health* *COO*
22	Reform of Welsh Language Standards Consultation Response	*Director of Workforce and OD*
23	UHB Response to the White Paper "Services fit for the future, Quality and Governance in Health Care Wales".	*Director of Corporate Governance*
PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE BOARD AVAILABLE ON THE UHB WEBSITE http://www.cardiffandvaleuhb.wales.nhs.uk/board-meetings		
24 .1 .2 .3 .4 .5 .6 .7 .8 .9 .10 .11 .12	**Minutes from other Boards/Committees** Welsh Health Specialised Services Committee Joint Committee – June and July briefing Regional Partnership Board – March & June Quality, Safety and Experience Committee – June Strategy and Engagement Committee – July Resource and Delivery Committee – August Finance Committee – June & July Health and Safety Committee – July Charitable Funds Committee – March x 2 Mental Health Capacity and Legislation Committee – May Stakeholder Reference Group - July Emergency Ambulance Services Committee – March and Chair's summary – June Organ Donation Committee – June	 *Prof M Longley* *S Elsmore* *M Battle* *I Grey* *J Antoniazzi* *M McLaughlin* *Chair* *M Waygood* *M Waygood* *Prof M Longley* *P Martyn* *Dr S Hopkins* *M Battle*
25	Agenda of the Private Board Meeting	
26	To note the date of the next Board Meeting 30th November 2017 at 1pm	

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¶ 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

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¶ **Trustee meeting to be held after Board meeting at 4pm**

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD HELD AT 1PM ON 27 JULY 2017 BOARD ROOM, UNIVERSITY HOSPITAL LLANDOUGH

4

Present:

Maria Battle	Chair
Len Richards	Chief Executive
Akmal Hanuk	Independent Member – Community
Prof Elizabeth Treasure (part)	Independent Member - University
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Deputy Director of Public Health
Dr Graham Shortland	Medical Director
Ivar Grey	Independent Member – Finance
John Antoniazzi	Independent Member –Estates
Julie Cassley	Interim Director of Workforce and OD
Professor Marcus Longley	Vice Chair
Margaret McLaughlin	Independent Member - Third Sector
Martyn Waygood	Independent Member - Legal
Paula Martyn	Associate Member - Chair, SRG
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Steve Curry	Interim Chief Operating Officer
Stuart Egan	Independent Member – Trades Unions

In Attendance:

Alan Brown	Vice Chair, Cardiff and Vale of Glamorgan CHC
Dr Ben Hope-Gill (part)	AMD Postgraduate & Undergraduate Medical Education
Geoff Walsh (part)	Director of Capital and Estates
Keithley Wilkinson (part)	Equalities Manager
Marie Davies (part)	Deputy Director of Planning
Peter Allen	Aneurin Bevan CHC
Peter Welsh	Director of Corporate Governance
Dr Tom Lawson (part)	Interim Deputy Dean, Wales Deanery
Urvisha Perez	Wales Audit Office (Observer)

Secretariat Julia Harper

Apologies:

Abigail Harris	Director of Planning
Eileen Brandreth	Independent Member – ICT
Indu Deglurkar	Chair, SMSC
Dr Sharon Hopkins	Director of Public Health
Sue Bailey	Associate Member - Chair, HPF
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC
Cllr Susan Elsmore (part)	Independent Member – Local Authority

UHB 17/129 PATIENT STORY

The Chair introduced Ms Barbara Chidgey who shared her considerable experiences of care and treatment at the University Health Board.
Ms Chidgey cited the importance of conversations within the trusted patient / medic relationship and the impact this had on an individual's well-being. "Conversational leadership" approaches engaged patients to move into the driving seat of managing their own health, contributing to less use of NHS resources (prudent healthcare). Conversational Leadership was a style of working where the transformative power of conversation was understood and took a conversational approach to the way people connected, related, learned and worked with other people. Conversational Leadership was "how to be transformational".

Mrs Chidgey described how she managed to take control of her own health. She found new ways of communicating outside of the planned clinic appointments, such as being able to view her own test results online immediately they were available which allowed her to take action to regulate medication and diet. She also managed to use direct e mail correspondence with the appropriate department and asked consultants to write to her directly rather than the GP. She found that the more she took control, the quicker her health improved. Overall she needed fewer appointments, the number of drugs required reduced and her quality of life improved which was important for both partners as the UHB also saved valuable resources. In brief, Ms Chidgey strongly believed that the more she had good conversations and communications with medical advisors and the more she took on the management of her own health by utilising their guidance, then the better her health and the less NHS resources she used. Ms Chidgey thanked the medical and nursing staff for all their skill and knowledge in getting her well again.

The Board noted how this form of communication had changed Mrs Chidgey's life and was something that should be pursued at pace, in line with the UHB's 10 year Strategy. However, strong leadership would be needed to take this forward and clinicians would need time to think about how they could do things differently. Mrs Chidgey agreed to offer any help she could, going forward.

The Chair thanked Ms Chidgey for attending the Board and sharing her inspirational story, on which the Board would reflect. There were clearly practical things on which the UHB could improve and the challenge had been set with regard to alternative ways of communicating with patients.

UHB 17/130 WELCOME AND INTRODUCTIONS

The Chair, welcomed everyone to the main part of the meeting, in particular the new Chief Executive, Mr Len Richards who was attending his first meeting of the Board and Urvisha Perez, representing Wales Audit Office as part of the annual structured assessment.

The Chair advised those present that the Board had just held its AGM prior to the meeting, albeit that only two members of the public had attended. The Board had received the UHB's Annual Report for the year 2016/17.

UHB 17/131 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

UHB 17/132 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

UHB 17/133 MINUTES OF THE BOARD MEETING HELD ON 25th MAY 2017

The Board **RECEIVED** and **APPROVED** the minutes of the meeting held on 25th May 2017.

NOTE – After the minutes had been approved, it had been necessary to amend the Patient Story and remove references to the identity of the patient.

UHB 17/134 MINUTES OF THE SPECIAL BOARD MEETING HELD ON 1ST JUNE 2017

The Board **RECEIVED** and **APPROVED** the minutes of the meeting held on 1st June 2017.

UHB 17/135 ACTION LOG FOLLOWING THE LAST MEETING

The Board **RECEIVED** the Action Log from the meeting of 25th May 2017 and **NOTED** the following:

UHB 17/056 Performance Report – Further advice for cancer patients had been considered by Executives and waiting times had reduced. Work was ongoing, and the best place for monitoring was the QSE Committee through the cancer peer review reports.

UHB 17/092 Patient Safety Quality and Experience Report – Mrs Ruth Walker advised that the detail of "clinical diagnosis" concerns had been broken down in this month's report and even more detail would be possible once e datix was rolled out.

With regard to the UHB reporting the highest number of patient safety incidents, it was likely this was because the UHB actively encouraged open reporting as demonstrated by the reporting of a high number of incidents where no harm was actually caused to patients.

UHB 17/136 CHAIR'S REPORT

The Board **RECEIVED** the oral report of the Chair. The following points were highlighted:

1. **Thanks** – The Chair thanked Dr Hopkins for the work she had undertaken to lead the organization whilst awaiting the arrival of the new Chief Executive. Thanks were also given to the Planning Team for all the work undertaken for the very successful UEFA finals in Cardiff.

2. **Recruitment** – This was underway for the Vice Chair and Director of Workforce and OD whilst approval for 3 new Independent Members appointments was awaited from the Cabinet Secretary.

3. **New Committees** – Two new Committees had been established. The Strategy and Engagement Committee had held its first meeting and the Resource and Delivery Committee would meet shortly.

4. **Events/Meetings** – The Chair updated Board on a number of events and meetings she had attended in the last 2 months.

The Board **NOTED** the oral report of the Chair

UHB 17/137 CHIEF EXECUTIVE'S REPORT

The Board **RECEIVED** the oral report of the Chief Executive. The following points were highlighted:

1. **Wales Audit Office – Review of Contract with RKC Associates Ltd**
   This would be discussed in detail in the private meeting of the Board, but it was disappointing that action had been taken outwith UHB policies and processes. It was also clear that there was not transparency between Executive leads and the rest of the Executive Team and the Board which had led to a loss of trust and confidence in the leadership.

   Mr Egan commented that the result of this was extremely damaging to the UHB's reputation. It had also damaged staff confidence and trust and created unrest amongst the workforce who were working under extreme pressure and being asked to make savings. Staff had queried why it had been necessary to enter into such an expensive contract. It was important that Trades Unions were advised of the action that

would be taken, given assurance that this would not happen again and that confidence was restored so that staff could raise concerns. It was hoped there would be a full investigation and if there was blame, that the behaviour was dealt with appropriately. It was important that the Board was seen to be putting things right.

Board Members also raised the need to strengthen the Whistleblowing Policy. The number of Lead Executives would be reduced from four to one and additional support would be provided with the appointment of a Lead Independent Member. It was noted that the Chair and Chief Executive would be providing more detail in evidence to the Public Accounts Committee. In addition, meetings with Staff Representatives would continue.

2. **Car Parking** – The loss of the recent court case brought by staff against parking management company Indigo had attracted much public and media opinion. It was disappointing that a number of inaccuracies had been contained in reports and the UHB had tried to rebut these. Traffic management was more effective with better access and flow now which was an important safety aspect.

   The Board discussed parking and raised the following:
   - The park and ride was a success. From September the last bus would leave UHW later, at 7.45pm to accommodate staff changeover. The Director of Capital and Estates was asked to listen to staff feedback and re-examine this time as staff would miss this bus with a 7.30pm handover. It was noted that later buses would increase costs.
   - When parking became free in 2018, it was noted there would be two issues, parking management and traffic management.
   - The Communications Team had produced factsheets that were widely available.
   - It was hoped that day staff would be encouraged to use the park and ride service to ease the parking pressure on site.

3. **UHL Operating Theatres** – Two temporary theatres were at the end of their life. A plan had been developed for additional orthopaedic theatre capacity.

4. **Performance** – Referral to treatment times had improved for the 11th quarter in a row and cancer waiting times had reduced considerably. The UHB was now developing unacceptable waiting thresholds such as 12 hours waiting in A&E.

5. **Deloitte's Independent Review of Financial Governance** – The Board would be considering this Welsh Government commissioned report as part of targeted intervention, in the private meeting. Whilst some good practice had been noted, there were areas where improvements could be made and these would be considered in detail at the Finance Committee with oversight at Audit Committee.

6. **NHS Pay Review Body Visit 18th July** – the PRB had met with staff across the organization to hear their views on pay and conditions. The PRB had thanked the UHB for hosting the visit and for the open discussions. The PRB reported that staff were well motivated and willing to engage.

The Board **NOTED** the oral report of the Chief Executive.

UHB 17/138 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Executive Nurse Director, Mrs Ruth Walker, introduced the report and highlighted:

- 98% of patients responding to our patient experience survey stated that they felt safe whilst in our care.
- 61% of concerns were informal. The number of formal concerns responded to in 30 days had risen from 23% to 39%. Further work was required to continue this improvement.
- Serious incident (SI) closure had improved by 236 on last year. There were 87 SIs currently open.
- There had been a reduction in the number of complaints about car parking.
- A major issue was the number of patient falls with 3977 falls recorded in the last year. The Director of Therapies and Health Sciences was leading improvement work in this area.
- Emerging themes – CTG recording was a national trend along with bariatric equipment.

The Chair invited comments and the following points were raised:

- Asked what the aspiration was for the percentage of formal and informal complaints, there was no figure in mind, but the number of informal complaints was expected to rise with the inclusion of mental health services for older people.
- It was noted that the LED department offered stand-alone training in communication and as a module on a variety of training courses. The correlation between the attendance of training and complaints involving communication had not yet been made, however, it was envisaged that data would be improved with the roll out of e datix.
- Asked why 5,500 procedures of limited clinical benefit had been carried out, it was noted that each had caveats of when the treatment could be useful. The narrative would be strengthened to explain this in future reports.
  Asked why 5,500 procedures of limited clinical benefit (interventions not normally undertaken (INNUs)) had been carried out and what Board members should look for in terms of change in numbers, it was noted that this was a new indicator for the performance report and that INNUs were a mixture of interventions that the UHB would carry out according to certain clinical criteria and those that were not done

at all. It was therefore difficult to predict what a downward trajectory should look like. The Board was assured that a significant amount of work had been undertaken over the past 7 years to reduce INNUs and data was being re-examined to check for any high outlier activity in comparison with other Health Boards. It was agreed that the narrative would be strengthened to explain this in future reports.

- The worsening DNA position was worrying. It was noted that remodelling work was already underway.
- It would be helpful if the report had a section to identify the areas that needed improvement.
- In terms of patient feedback on departure, it was noted that this was already done through the outpatient kiosks (happy faces). Surveys were also undertaken on inpatient wards and several tools were becoming available to collect data from patients at home.
- Asked about feedback from primary and community areas, it was noted that getting this data remained a challenge and the CHC concurred.
- It was noted that the high number of patient safety incidents at St David's Hospital was because of a number of staffing issues.

ASSURANCE was provided by:

- The current position on all key indicators relating to Quality, Safety and Patient Experience presented in the Board Report.
- Comparison with peers across Wales.
- Evidence of the action being taken to address key outcomes that were not meeting the standards required.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

The Board:

- **CONSIDERED** the content of this report
- **NOTED** the assurance in relation to the action being taken to improve the quality, safety and experience of care.

UHB 17/139 ANNUAL QUALITY STATEMENT (AQS) 2016-17

The Executive Nurse Director, Mrs Ruth Walker, presented the UHB's AQS and thanked Carol Evans and Alex Scott for all their work in producing the comprehensive document.

The Chair invited comments and the following points were raised:

- The displaying of the Rainbow flag demonstrated openly that the UHB supported this network.
- It was noted that a long time scale was required for the review of nursing documentation as it was a significant piece of work.

- It was noted that the UHB would be pursuing the electronic patient record but the national architecture for going digital was quite slow.

ASSURANCE was provided by**:**

- Internal Audit assessment was rated as substantial assurance.

The Board:

- **ENDORSED** the 2016 / 2017 Annual Quality Statement (AQS).

UHB 17/140 FIRE SAFETY ASSESSMENT OF EXTERNAL CLADDING PANELS ON UHB BUILDINGS

The Director of Capital and Estates, Mr Geoff Walsh, advised the Board that investigation had demonstrated that the UHB had used steel and not aluminium and insulation materials were clear. This information had been relayed to Welsh Government and the Fire Service for confirmation.

The Chair invited comments:

- The Health and Safety Committee asked that the Board be made aware of the 50.9% compliance rate with mandatory fire training between April 2016 and February 2017. The target was 85% compliance and the Board would be culpable if there was a fire incident. As a minimum the 85% target had to be met.
- Poor compliance with mandatory training was a constant theme in the UHB's Fire Notices, and given recent events, it was expected that a harder line would be taken.
- Poor compliance with other mandatory modules was also raised.

REASONABLE ASSURANCE was provided by:

- Reference to Operating and Maintenance (O&M) Manuals for the respective buildings including 'As Installed' drawings and specifications.

The Board:

- **NOTED** the details of the report and the investigation works undertaken which were considered by the Management Executive on 10th July 2017.
- **SUPPORTED** the recommendation to undertake testing of the Link Block 4 cladding
- **SUPPORTED** an evacuation exercise utilizing ward B6 following refurbishment
- **NOTED** that the work being undertaken was being discussed with both South Wales Fire Service and NHS Shared Services Estates to ensure no further action was needed.

UHB 17/141 PATIENT SAFETY SOLUTIONS, ALERTS AND NOTICES

The Chair, Miss Maria Battle had asked for this report to be considered at the Board because the Quality Safety and Experience (QSE) Committee had been aware, for some time, that the UHB had been unable to comply with the patient safety notice on patient identification that had been published in 2007.

The Executive Nurse Director, Mrs Ruth Walker, reminded Board that due to financial pressures, the Board had previously agreed that this was not a priority. Periodically the work on a solution had been revised and the decision was always that this could not be pursued. The former QSE Chair, Professor Elizabeth Treasure concurred that the Committee had been told the solution was unaffordable, but it remained concerned about the number of repeated patient identification errors.

As technology had moved on, considerable work would be required to determine the current cost of a solution and it was queried whether this was an efficient use of time if there was still no funding. Given the conclusions of the Deloitte's report, it was vital that the Board was aware of the full cost of schemes before any decisions were taken and the QSE Committee should be given a timescale for when the decision could be reviewed.

The Board was advised that there were potentially two solutions: one did not meet clinical needs and the second was a six figure sum. Therefore, this would need to be discussed by the Management Executive again.
Action – Mrs Ruth Walker

In conclusion, the Executive Nurse Director reiterated that the UHB did not sign off any patient safety notice until there was certainty that work was embedded into practice and this was the reason that it often appeared that the UHB was moving at a slower pace than others. It was anticipated that a further 3 alerts would be signed off by the end of the month.

LIMITED ASSURANCE was provided by:

- The UHB was currently 81% compliant with all current Patient Safety Solutions (PSS), and this would increase to 89% by October 2017, based on work underway to address the requirements of recently issued PSSs and declare compliance with historical alerts.
- The actions that were being undertaken to address the outstanding areas of non-compliance.

The Board:

- **NOTED** current UHB compliance and **APPROVED** the proposed actions that were being taken to address areas of non-compliance.
- **AGREED** that the UHB was now able to declare full compliance with NPSA/2009/SPN002 – Risk to patient safety of not using the NHS number as the national identifier for all patients.

- **NOTED** the intention to present an update to the September 2017 Quality, Safety and Experience Committee, along with a full risk assessment for outstanding areas of non-compliance.
- **AGREED** to receive a further update at the January 2018 Board meeting.

UHB 17/142 FINANCE REPORT

The Director of Finance, Mr Robert Chadwick advised that the report had been presented to the Finance Committee the previous day and highlighted the following:

- The UHB was committed to delivering a £30.9m deficit plan.
- Savings of £35m were needed.
- Transformation schemes would take some time to deliver.
- The UHB needed to step up to close the £12.4m gap.
- 3 Clinical Boards were in financial difficulty – Medicine, Children & Women and Clinical Diagnostics and Therapeutics. Finance staff were working closely with them and recovery plans were being prepared.
- There were still many risks to delivery within available resources, in particular waiting times and winter pressures.

The Chair invited comments and the following points were raised:

- The £12.4m gap was a big risk and the UHB required certainty by month 7.
- Transformation schemes may deliver efficiency rather than financial savings.
- The Finance risk register would be shared with the Board.
  Action – Mr Robert Chadwick
- The £15m had to be found recurrently if the underlying position was not to deteriorate.
- The ambition was to get a Welsh Government approved Plan.

LIMITED ASSURANCE was provided by:

- The work that had been undertaken to develop the 2017/18 draft operational plan;
- The scrutiny of Financial Performance undertaken by the Finance Committee;
- The month 3 position which was broadly in line with the profiled deficit within the draft operational plan.

The Board:

- **NOTED** that the UHB had an unapproved draft one year operational plan that had a planned deficit of £30.900m for the year;
- **NOTED** the £7.695m deficit at month 3 which included a planning deficit of £7.725m, a shortfall in performance of £0.041m against savings targets and budget underspends of (£0.071m);

- **NOTED** the risks that needed to be managed especially the identification of £12.4m further savings required to deliver a £30.9m deficit plan.

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UHB 17/143 PERFORMANCE REPORT

The Interim Chief Operating Officer, Mr Steve Curry had nothing to add to the report other than advising that primary care was performing well but GMS was a fragile service that needed support.

The Chair invited questions and comments:

- Work was ongoing to avoid patients deteriorating whilst awaiting discharge. In addition the UHB was operating a discharge to assess scheme to get patients home with extra help. It was hoped these actions would help to improve the number of patients over 65 years who were discharged to their usual place of residence.
- Waiting time for the memory clinic had improved significantly following an injection of temporary funding. Since the funding had ceased, the waiting time was deteriorating. This was disappointing for GPs who had been encouraged to use the service. It was noted that further temporary funding had been identified for use in a targeted way in 2017/18. 3 Clinical Boards were looking to find a sustainable solution.
- Concern was expressed about the resilience of part 1 on the Mental Health Measure. It was noted that the profile had slipped when there was simultaneous increase in demand and staff sickness. There was also a need to work differently to manage GP demand.
- The roll out of the fully automated booking (FAB) system should support a reduction in the number of DNAs, but it still needed to be made easier to use.
- It was disappointing that hand hygiene rates had flat-lined. In May, 87 wards participated in the audit, more than previous months. Unfortunately only half completely fully complied with the audit as it had been strengthened. However, the IPC team undertook independent audits and were able to confirm that progress had been seen.
- It was suggested that compliance with a number of targets such as mandatory training, WHO checklist and hand hygiene appeared to suggest that there were areas of work that staff did not like doing. This was all linked to culture, values and behaviours and it was vital that staff were empowered to challenge undesirable behaviour.
- As staff had previously identified that they found the appraisal process useful, it was queried why only 56% of non medical staff had received one. It was noted that there was a huge variance across the UHB with some areas doing really well.

REASONABLE ASSURANCE was provided by:

- the fact that the UHB was making progress in delivering its Operational Delivery Plan for 2017/18 by achieving compliance with 20 of its 60 performance measures.

The Board:

- **CONSIDERED** 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.
- **NOTED** that the Chair would be appointing a Champion for hand hygiene and bare below the elbow.
  Action – Miss Maria Battle

UHB 17/144 INTEGRATED MEDIUM TERM PLAN (IMTP) DEVELOPMENT PROCESS

The Deputy Director of Planning, Mrs Marie Davies, advised Board that the report set out the proposed approach to the development of the IMTP which included lessons learned, key activities and timescales. A half day session was also being arranged for the Board in August.

The Chair invited comments:

- It was agreed to cover in the half day how the timetable for regional work fitted into the IMTP, ensuring that all processes were aligned.
- It was hoped that finance and workforce could be integrated into the IMTP, but it was recognized that there was much more work to be done in this area and relied on greater disciple from 8 Clinical Boards to submit the PODS. This required greater maturity and possibly more capacity in order to produce fully rounded plans. It was agreed that Management Executive would consider how this could be achieved.
  Action – Mr Len Richards
- It was suggested that it may be easier to land a position several times over the year rather than reliance on meeting a target at the end of the year.

ASSURANCE on the development of the UHB 2018/19 Integrated Medium Term Plan was provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process and planning liaison meeting.
- Compliance with the NHS Wales Planning Framework timeframes and requirements (updated 2018/19 Framework was not due to be published until October 2017).

The Board:

- **APPROVED** the key milestones and products for the development of Clinical and Service Board 2018/19 Operational Plans and the UHB 2018/19 IMTP.

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UHB 17/145 WINTER PLAN REVIEW 2016 AND PLANS FOR WINTER 2017-18

The Interim Chief Operating Officer, Mr Steve Curry advised the Board that the Review had demonstrated that the UHB had performed fairly well last winter when compared with the rest of Wales. The report included the key themes from the multi-agency review and these had been incorporated into the planning for the coming winter. It was anticipated that a complete plan would be available for Welsh Government in Autumn.

The Chair invited comments:

- Asked how the number of cancellations could be reduced this winter, it was noted that the UHB hit a 3 week bad patch in January but recovered fairly quickly. The reason for many of the cancellations was infections outbreaks. This winter there would be greater scrutiny of case mix and use of day surgery. However, there was more work to do on patient flow.
- The target for flu vaccination had increased to 60% this winter.
- In terms of nursing staff, this would be in line with the Nurse Staffing Wales Act with more scrutiny on skill mix and the model for specialling.
- This winter there would be only one additional ward available, and therefore it was vital that the work on reducing length of stay was successful and this was a considerable risk.
- The 36% increase in referral to the Emergency Unit from GP out of hours was because of changes to the triage process for paediatric patients. Two Clinical Boards were looking to see whether there were further opportunities in this area.
- There was a whole system approach to the reduction in the number of delayed transfers of care, but there was still further scope for joint posts and sharing data collectively.

ASSURANCE was provided by:

- The review, involving internal and external stakeholders, of winter 2016/17 had informed the approach to winter 2017/18.
- Consideration by the Management Executive team of both the review of winter 2016/17 and the approach to winter 2017/18.
- The final Integrated Winter Plan would be developed with partners over the summer months and would be submitted to Welsh Government for consideration and feedback.

The Board:

- **APPROVED** the approach to developing the Cardiff and Vale Area Integrated Winter Plan for 2017/18, which included the following key proposals:
  - Enhanced resilience of the GP out of hours service
  - Rebalance activity from acute hospitals to the community

- Commission additional hospital bed capacity in line with forecast demand patterns and based upon the success of this shift from hospital to community
- Enhance services for older people, in particular securing the benefits from the ICF and Primary Care investments
- Enhance senior decision-making capacity in the Emergency Unit and the Assessment Units
- Continue the integrated approach to developing the winter plan, working closely with WAST, local authority and third sector partners to promote the 'Home First' principle through admission avoidance and improved discharge processes.

UHB 17/146 PLANS FOR WINTER 2017-18

This item was considered as part of the previous report.

ASSURANCE was provided by:

- Stakeholder involvement in the review of winter 2016/17.
- The key learning points derived from the review process and their implication in future planning. The review of winter 2016/17 had informed the approach to winter 2017/18
- The review of winter 2016/17 had been considered by the Management Executive.

The Board:

- **CONSIDERED** the report in regard to the winter of 2016/17.
- **NOTED** the learning points identified for future winter plans.

UHB 17/147 CHAIR'S ACTION TAKEN ON BEHALF OF THE BOARD

ASSURANCE was provided by adherence to UHB Standing Orders. The Board **RATIFIED** the action taken by the Chair.

UHB 17/148 WALES DEANERY – EDUCATION CONTRACT AND FUNDING MODEL

The Interim Deputy Dean, Dr Tom Lawson, gave a short presentation on the role of the Wales Deanery and the development of the educational contract between the trainee, the local education provider (the UHB) and the Deanery. He also referenced the generic requirements of the trainee and the education provider as well as the specialty specific criteria. Dr Lawson described how the generic requirements would be monitored and the timescales for this. Real time data would be available and this would enable identification of trainees who were falling behind at an early stage and not at the end of the year. The impact of Health Education Improvement Wales (HEIW) was also considered.

The Chair thanked Dr Lawson for the presentation.

UHB 17/149 QUALITY OF MEDICAL AND DENTAL UNDERGRADUATE AND POSTGRADUATE TRAINING

Dr Ben Hope-Gill commented on the educational governance framework which was new this year, developed in response to previous problems. The UHB had a very small team to deal with 600 trainees, and therefore named leads had been identified in each department.

The Chair invited comments:

- The coming together of all health care professional training in one governance framework was welcomed.
- It was envisaged that the framework would support the evidence base for learning from incidents.
- It was important for the UHB to be represented on the HEIW, which was even more important if the Deanery was not included. It was agreed that the Chair would raise this with the Cabinet Secretary. **Action – Miss Maria Battle**
- Cardiff University currently hosted the Deanery. The question was asked as to whether trainers and trainees would continue to have access to the University's academic resources once hosting moved. This was an invaluable, expensive resource and exclusion from this was a significant risk.

ASSURANCE was provided by:

- Implementation of the educational governance framework.
- Action planning relating to Postgraduate and Undergraduate feedback mechanisms.
- Commissioning processes with Wales Deanery and Cardiff University.

The Board:

- **NOTED** the Report.

UHB 17/150 CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE

The Director of Corporate Governance, Mr Peter Welsh commented that Board would start to see heat maps and variations with regard to the UHB's risks and advised that protocols were being developed. It was important to tie the risks into the objectives for the next year.

ASSURANCE was provided by:

- Mitigation of our risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF required strengthening.

The Board:

- **CONSIDERED** the CRAF Update Report and the extreme risks currently contained within the CRAF.
- **AGREED** to provide feedback by the end of August as to what was useful and what should be changed in the report format.
  Action – All Board Members

UHB 17/151 SENSORY LOSS PROGRESS REPORT

The Interim Chief Operating Officer, as Chair of the Sensory Loss Group, advised the Board that significant progress had been made, much at no extra cost, but there was more to do on education and training. Overall however, progress was patchy. Many local schemes were working really well while there was no quick fix for other areas.

The Equalities Manager stressed the need to improve communication for patients with a sensory loss. This was fundamental to them and the community was fatigued and angry at what they considered slow progress. It was important therefore to listen and act on this feedback.

The Chair commended the demonstration of progress and the network of equality and sensory loss champions.

ASSURANCE was provided by:

- Development of and action taken by the UHB's Sensory Loss Standards Working Group.
- The UHB's report to Welsh Government against the All Wales Standards for Accessible Communication and Information for People with Sensory Loss.

The Board **NOTED** the progress made in relation to sensory loss.

UHB 17/152 EDHR SUB COMMITTEE LEGACY STATEMENT

The Interim Director of Workforce and OD, Mrs Julie Cassley thanked Independent Members Mrs Margaret McLaughlin and Mr Martyn Waygood for leading the equality work over a number of years. It was hoped that both would be agreeable to attend the October Board Development session to share their expertise even though their tenure of office would be compete.

Although equalities work would be included in all the UHB's committees in future, it was queried whether a Lead Committee should be identified. This would be discussed at the forthcoming meeting of the Resources and Delivery

Committee. In addition, the EDHR Sub Committee would reconvene in January for a one-off meeting to review the progress of the equality agenda.

The Chair reiterated her own thanks to the two Independent Members.

ASSURANCE was provided by:

- The proposals made within this paper filled the gap in assurance left as a result of the winding up of the Equality, Diversity and Human Rights Sub-Committee

The Board:

- **ENDORSED** the legacy document.
- **SUPPORTED** the recommendations as set out in Section 7.

PART 2 – ITEMS FOR INFORMATION ONLY

UHB 17/153 INTEGRATED MEDIUM TERM PLAN, PROGRESS AND IMPLEMENTATION REPORT – QUARTER 1

ASSURANCE on the progress made in delivering the UHB 2018/19 Integrated Medium Term Plan was provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process and planning liaison meetings.
- Quarterly Clinical and Service Board Integrated Medium Term Plan performance reviews.

The Board:

- **NOTED** the progress made against the key 2017/18 schemes in quarter 1

UHB 17/154 INTEGRATED MEDIUM TERM PLAN SUMMARY

ASSURANCE on the UHB Integrated Medium Term Plan 2017/18 Summary was provided through:

- Acknowledgement that it was based on the full IMTP 2017/18 – 2020/21 document, noting continued routine formal dialogue through the Welsh Government targeted intervention process and planning liaison meetings.

The UHB Board:

- **APPROVED** the draft IMTP 2017/18 Summary document and subsequent promulgation to stakeholders and the public.

UHB 17/155 MINUTES FROM OTHER BOARDS / COMMITTEES

The Board **RECEIVED** the following Minutes and the Chair invited any comments:

1. **Quality Safety and Experience Committee – April**
2. **Audit Committee – May and June**
3. **People Performance and Planning Committee – May**
4. **Local Partnership Forum – June**
   The LPF had identified inconsistencies in the quality of Equality and Health Impact Assessments that accompanied plans and policies. He reminded Board that Committees had a duty to ensure these were completed thoroughly.
5. **Stakeholder Reference Group – May**
6. **Finance Committee – April and May**
7. **Charitable Funds Committee – no minutes since March**
8. **Health and Safety Committee – April**
   The Chair reported attendance issues at the meetings.
9. **Welsh Health Specialised Services Committee – May and June**
10. **NHS Wales Shared Services Partnership Committee – May**
11. **Cardiff and Vale Regional Partnership Board – no minutes since January**

The minutes were **NOTED.**

UHB 17/156 AGENDA OF THE PRIVATE BOARD MEETING

The agenda was **NOTED.**

UHB 17/157 REVIEW OF THE MEETING

There was nothing further to add to the meeting.

UHB 17/158 DATE OF THE NEXT BOARD MEETING

The next meeting would be held at 1pm on 28th September 2017 in the Board Room, University Hospital Llandough.

UPDATED BOARD ACTION LOG FROM JULY 2017

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
UHB 16/140 UHB16/218 UHB 17/006	28.7.16 24.11.16 26.1.17	No Smoking And Smoke Free Environment Policy and Procedure	Give this further consideration to how Mental Health patients can purchase cigarettes.	F Kinghorn	A plan for introducing e cigarettes had been produced but would take some time to implement. was still being worked through. Plan timescale using phased approach is March 2017.
UHB 17/017 17/047	26.1.17 30.3.17	Traffic Management & Car Parking	Raise parking issues with Cardiff Council. Board's comments to be shared with the Working Group.	Cllr S Elsmore A Harris	Discussions have taken place with the Council on a regular basis. The working group includes staff representatives, CHC, Director of Governance. Comments are taken from a wide variety of stakeholders and it is intended to hold roadshows over the next few months to obtain the views of patients staff and visitors
17/054	30.3.17		Further report on the impact of the measures taken to address gridlock including further parking measures for UHW and UHL.	A Harris	The Park and Ride service commenced on 2nd May for UHW. For UHL the Vale LA have altered the timing of the traffic lights to ease the problem of

5

					delays exiting the site at peak times. These are now linked to the LA mova system.
			Revisit staff to visitor parking ratio at Barry and St. David's.	A Harris	Continue to find examples from other Health Boards and Trusts on what the ratio of staff to patient spaces. There does not appear to be any guidance.
			Check nurse shift times for park and ride.	A Harris	The P&R scheme and received positive media coverage.
			Complete an EHIA for the travel scheme.	A Harris	A full EHIA is being developed to cover the proposed sustainable travel plan
			Ensure parking spaces are created for staff to attend in emergencies.	A Harris	A proposal has been developed which is acceptable to Indigo is being rolled out across the CBs. Specific red passes have been procured and will be issued via the respective CB. These passes will only be valid outside normal working hours.
UHB 17/052	30.3.17	Patient Safety, Quality and Experience	Explore improvements in out of hours emergency CAMHS inpatient treatment through WHSSC.	Dr S Hopkins	Discussions commenced, no progress yet to report in May. Discussion has taken place in

5

UHB 17/089	25.5.17		Share with Mr Hanuk UHB's use of foreign languages and opportunity to work with Cardiff University Business School.	R Walker	exploring opportunities to work with Cardiff University. A further meeting to take place on 18 May 2017.
UHB 17/059	30.3.17	Revised Committee Structure	Refocus agenda setting meetings to be specific about what reports were required and the reasons.	P Welsh	This will continue to be emphasized at each agenda setting meeting
UHB 17/065	30.3.17	WHSSC	Discuss system rules separately.	M Battle	Discussions ongoing in many different fora.
UHB 17/100	25.5.17	Capital Programme	Investigate problems with lift buttons and the time people had to wait for the lifts in B Block.	A Harris	The cause has been established and details of the correct lift operation is being circulated. Major refurb of 2 of 6 lifts is currently underway creating more capacity. There is a short term rolling refurbishment programme. A capital paper is being developed for all C&V ageing estate issues requiring replacement funding.
UHB 17/141	27.7.17	Patient Safety Solutions, Alerts and Notices	Fully cost and discuss again with Management Executive, the funding of patient identification solutions.	R Walker	Business case being prepared and will be taken to BCAG
UHB 17/143	27.7.17	Performance Report	Appoint Champion for Hand Hygiene and Bare Below Elbow.	M Battle	Board Champion being reviewed due to change in Board Membership
UHB 17/144	27.7.17	IMTP Development Process	Full integration of finance and workforce plans to be given more consideration as to how this could be achieved.	L Richards	
UHB 17/149	27.7.17	Quality of Medical and	Discuss with Cabinet Secretary the need for the UHB to be	M Battle	

5

		Dental Education	represented on the Board of HEIW.		
UHB 17/150	27.7.17	CRAF	Comments on layout and content to be fed back to Peter Welsh by the end of August.	All Members & Attendees	Up-date provided to Audit Committee on 26th September 2017
ACTIONS TO BE BROUGHT FORWARD ON ANOTHER AGENDA					
UHB 15/122 UHB16/218	5.5.15 24.11.16	SOs and SFIs	Defer the review of the Scheme of Delegation and earned autonomy framework to September 2015	P Welsh	Welsh Directors of Finance actioning in 2017. Minor local Amendments to go to **Audit Committee in April 2017**.
UHB 17/093	25.5.17	Turning the Curve to Transformation	Report on Delayed Transfers of Care and pooled budgets at next Board.	S Curry	July Board deferred to September 2017. This was further deferred to **November 2017.**
UHB 17/066	30.3.17	Health and Safety Committee	Produce Estate rationalization plan for discussion at Board meeting.	A Harris	A tender has been has been issued for the appointment of a team to undertake a radical review of space utilization across the UHB including Health Centers & Clinics, Community staff bases and admin facilities on our acute sites. As part of the review we will be looking at the options to: -Reduce the number of buildings we have across the UHB – fewer but better quality -Reduce the floor area for admin and community staff by proposing a ratio of desk spaces to staff -considering the benefits and costs of agile working across

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					the UHB. A project initiation document will be developed over the next few weeks together with a programme plan with key deliverables identified. A full paper containing approach and time scales will be presented at **September Board**.
UHB 17/056	30.3.17	Performance Report	PPP to undertake a deep dive into reasons for cancelled admissions.	Prof M Longley	**Referred to PPP on 5th April**
UHB 17/099	25.5.17	FBC Specialist Neuro, Spinal Rehab and Gerontology	Update the EQIA with a new Equality and Health Impact Assessment.	A Harris	The original EHIA was being refreshed and would be circulated for the **September Board.** This was delayed and anticipated at the end of the month.
UHB 17/141	27.7.17	Patient Safety Solutions, Alerts and Notices	General update to be received in 6 months' time.	R Walker	**Board January 2018**
ACTIONS COMPLETED SINCE LAST MEETING					
UHB 17/056 UHB 17/135	30.3.17 27.7.17	Performance Report	Consider providing additional advice to cancer patients waiting long times for treatment as has been done in endoscopy.	Dr G Shortland	Considered by Executives. Monitoring via QSE Committee through the cancer peer review reports. **CLOSED**
UHB 17/092 UHB 17/135	25.5.17 27.7.17	Patient Safety Quality and Experience Report	Provide detail of complaints category "clinical diagnosis" and how it was being addressed. Give further consideration to why the UHB had the highest number	R Walker R Walker	This was broken down in this month's report. More detail would be possible once e datix was rolled out. The UHB actively encouraged

			of patient safety incidents per 10,000 population.		open reporting as shown by reporting high numbers of incidents where no harm was caused to patients. **COMPLETE**
UHB 17/009	26.1.17	Patient Safety, Quality and Experience	Update Board on patient notification exercise - cardiac patients (heater – cooler).	F Kinghorn	**COMPLETE**
UHB 16/225 UHB 17/006	24.11.16 26.1.17	Sensory Loss	(i)Determine if IT systems can flag sensory impairment as first stage. (ii)Explore options for enabling this and (subject to resources) implement solution for recording communication preference.	Dr F Jenkins	A flag can be raised, though this is not deemed to be sensitive enough – as there are different requirements for different sensory impairment needs. This has been explored and the group looking into this continues to meet. **CLOSED**
UHB 17/142	27.7.17	Finance Report	Share Finance Risk Register with Board.	R Chadwick	**Complete**
UHB 17/009	26.1.17	Patient Safety, Quality and Experience	Consider application to Charitable Funds for ward information boards.	R Walker	Application to Charitable Funds Bids Panel on 12 April was successful. **Complete**

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT	
Name of Meeting : Board Meeting	**Date of Meeting :** 28 September 2017

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality, 029 2184 6117 Assistant Director Patient Experience, 029 2184 6108
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact: There are significant potential financial implications associated with this work in relation to clinical negligence claims.
Quality, Safety, Patient Experience impact: The work outlined within this paper reflects the significant activity taking place to improve patient safety and experience leading to improved quality and care outcomes for patients.
Health and Care Standard Number 2.1, 2.2, 2.3, 2.4, 2.6, 3.1, 3.3, 6.3
CRAF Reference Number 5.1, 5.1.5, 5.6, 5.7
Equality and Health Impact Assessment Completed: Not Applicable

8

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current position on all key indicators relating to Quality, Safety and Patient Experience presented in the Board Report.
- Comparison with peers across Wales.
- Evidence of the action being taken to address key outcomes that are not meeting the standards required.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

The Board is asked to:

- **CONSIDER** the content of this report.
- **NOTE** the assurance in relation to the action being taken to improve the quality, safety and experience of care.

Executive Summary

- Significant progress has been made on Serious incident (SI) closures, the number of open SI's is almost at the target of 60 at any one time.
- Hospital acquired pressure ulcers showed a decrease to March but have remained constant since then.
- The response time to formal concerns demonstrates a sustained improvement.
- There have not been any never events since March 2017.
- Overall Patient satisfaction is above 90%.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT – FROM APRIL 2017

Key patient safety targets dashboard

Quality Indicator	Target	Jan	Feb	Mar	Apr	May	June	July	Aug
New Serious Incidents (SI) reported to Welsh Government (WG)	-	27	19	30	17	14	10	16	18
Never Events (included in New SIs if any have been reported to WG)	0	1	2	3	0	0	0	0	0
Total number of SIs open to WG	-		169		130		89	81	64
Number of SIs currently breaching WG timeframes	-		110		84		58	53	47
Number of SI closure forms submitted to WG	35	14	37	44	35	35	30	24	22
Of the Serious Incidents due for assurance within the month, % which assured in agreed timescale	100%	16%	33%	29%	17%	20%	8%	25%	58%
Total number of Patient Safety Incidents (PSIs) in Patient category only:									
UHW	-	700	591	683	614	681	655	630	608
UHL	-	324	287	321	295	285	289	325	273
Community and community hospitals	-	381	355	369	335	383	380	372	329
Medication Incidents	-	122	91	120	112	155	135	110	119
% medication Incidents in patients >65 years					Awaiting Datix Development				
Patient falls resulting in significant injury and reported to WG (fractures, head injuries, deaths)	-	5	8	10	4	1	2	4	3
Serious falls in patients >65 years		5	8	8	2	1	2	3	3
Pressure ulcers (all)									
%Pressure ulcers in patients over 65 yrs		Awaiting Datix Development							

8

Total active concerns *(awaiting a final response)*	≤ 280	219	214	205	196	192	185	181	179
% of concerns managed via informal resolution	60%	59%		61%	57%	58%	61%	70%	63%

Quality Indicator	Target	Jan	Feb	Mar	April	May	June	July	Aug
Informal response time (2 working days)	80%	61%		69%	64%	59%	55%	59%	52%
Formal concerns response time - 30 working days	80%	43%		59%	50%	61%	59%	62%	
Conversion of informal concerns converted to formal	≤ 10 Number	0	0	0	0	0	2	1	1
Concerns raised in relation to a protected Characteristic	QI	0		0	0	0	1	1	4
Compliments across the UHB	▲	48	53	173	129	34	37	63	71
Freedom to speak up	QI	0	0	0	0	0	0	0	0
Number of new Redress cases	NA	4	5	3	2	7	8	2	9
Number of new clinical negligence claims	QI	2	5	6	7	6	9	6	10
Number of new Personal Injury claims	QI	4	6	6	2	10	5	5	7
Number of new PSOW referrals	QI	2	4	1	2	6	2	1	2
Number of national surveys issued/% return		1290 48%	615 48%	1180 59%	605 46%	1180 52%	595 51%	1275 57%	585 62%
Overall patient satisfaction scores UHW UHL	85%	88% 88% 90%	91% 89% 94%	90% 90% 91%	90% 90% 91%	89% 89% 89%	87% 90% 84%	93% 94% 95%	91% 92% 90%

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Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

During July and August 2017, the following Serious Incidents and No Surprises have been reported to Welsh Government:

Serious Incidents		
Clinical Board	**Number**	**Description**
Children and Women Clinical Board	1 1	• An information governance issue was reported to the Information Commissioner. • A woman sustained a fourth degree tear during an instrumental delivery.
Clinical Diagnostics and Therapeutics	1	• A patient misidentification error led to a near-miss incident in the mortuary.
Dental	0	Not applicable
Executive Nurse	1	• An incident was reported where the Procedural Response to Unexpected Death in Childhood (PRUDiC) process has been instigated.
Medicine	2 1 1 2 1	• Patients delayed in having diagnostic or surveillance procedures in Gastroenterology. • There has been a delay from diagnosis to treatment for a patient referred to Dermatology with a suspected basal cell carcinoma. • Grade 3 or 4 healthcare acquired pressure damage sustained on a patient has been reported. • Falls where the patient sustained significant injury, such as fractured neck of femur. • Death of a patient where a healthcare associated infection has been recorded on the patient's death certificate.
Mental Health	2 1 7 1	• Falls where the patient sustained significant injury, such as fractured neck of femur. One patient died several days following the incident and is subject to investigation by HM Coroner. • An information governance issue was reported to the Information Commissioner. • Unexpected deaths of patients known to Mental Health services, including Addictions services. • Grade 3 or 4 healthcare acquired pressure damage sustained on a patient has been reported.
Primary Care and Intermediate Care	1	• An information governance issue was reported to the Information Commissioner.
Specialist	1	• Grade 3 or 4 healthcare acquired pressure damage sustained on a patient has been reported.

8

Surgery	1 4 3 1 1	• A patient experienced a delay in returning to the operating theatre as there was a delay in recognising the cause of the patient's deterioration. This was subsequently subject to investigation by HM Coroner. • Grade 3 or 4 healthcare acquired pressure damage sustained on a patient has been reported. • Falls where the patient sustained significant injury, such as fractured neck of femur. • An error on an operating list led to a site block commencing on the incorrect limb. • There was a delay in senior surgical assessment of a patient with a serious acute abdominal condition.
Total	**34**	

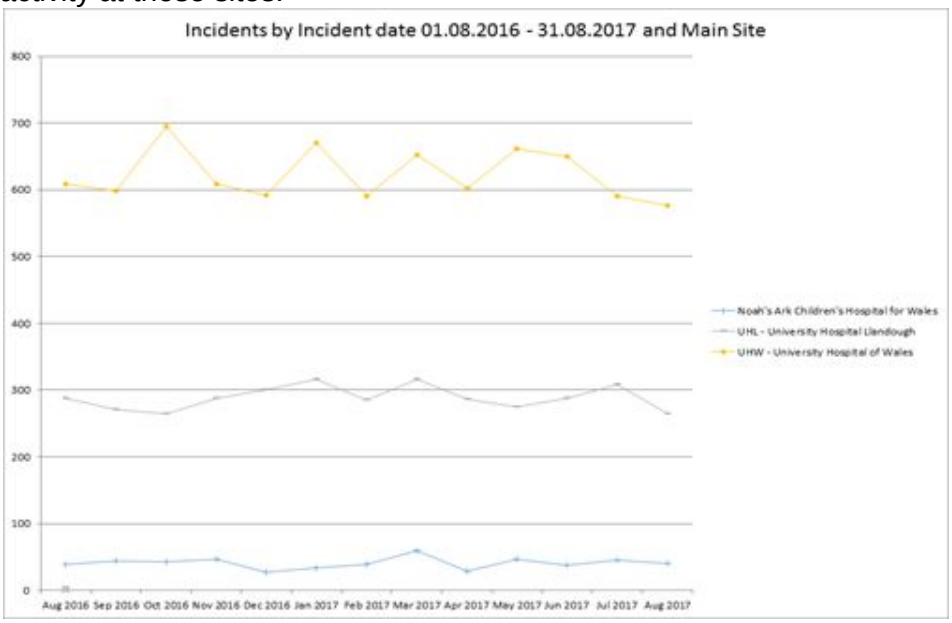
No Surprises		
Clinical Board	**Number**	**Description**
Children and Women	1	• A media enquiry was received regarding a patient story presented to a Board meeting where media attention was anticipated.
Clinical Diagnostics and Therapeutics	1	• An inspection was undertaken at the mortuary on the UHW site by the Human Tissue Authority. The inspection highlighted a number of deficiencies which need to be addressed.
Dental	0	Not applicable
Executive Nurse	1 1	• A complainant approached the media in relation to former concerns she has raised with the UHB. • A complainant approached the media in relation to concerns with the Wales Interpretation and Translation Service on behalf of the local deaf community.
Medicine	1 1	• A member of the public reported concern to the media regarding a deceased patient being on a ward for a prolonged period following their death. • Increased incidence of 3 patients with Clostridium difficile was reported whilst it was investigated with Infection Prevention and Control.
Mental Health	1	• The UHB advised Welsh Government of a court case that was proceeding where media attention was anticipated.
Primary Care and Intermediate Care	0	Not applicable
Specialist	0	Not applicable
Surgery	0	Not applicable
Total	**7**	

Information from General Patient Safety Incident Reporting

Staff are actively encouraged to report adverse incidents and near misses. The UHB considers incident reporting to be integral to its safety culture and the UHB is known to report more patient safety incidents per head of population than other Health Boards in Wales. The UHB usually reports in the region of 15,000 patient safety related incidents to the NRLS annually, the vast majority of which fall within the 'near miss', no harm and low harm categories. This is set in the context of approximately 1.8 million patient contacts which represents less than 1% of patient related activity occurring within the UHB.

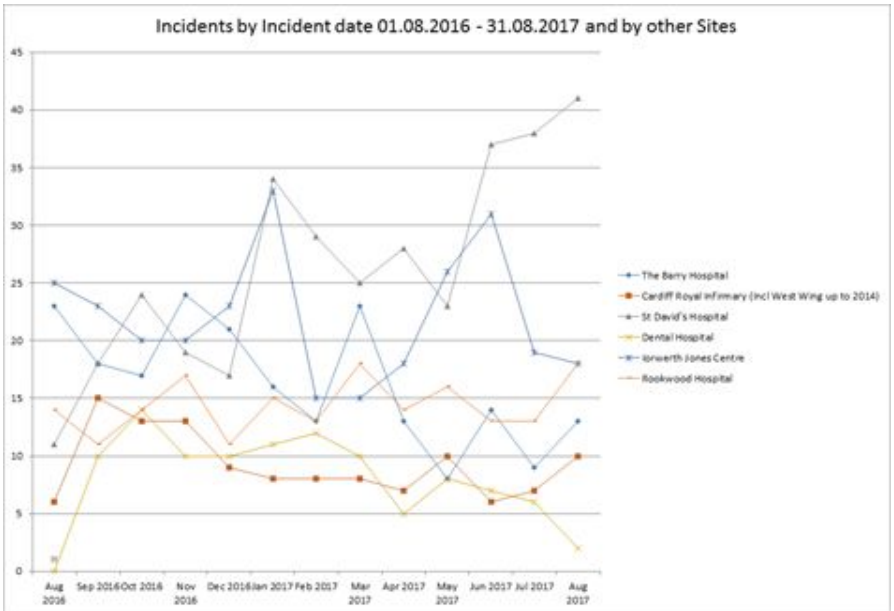
In terms of general incident reporting, the following graph demonstrates the patient safety incidents reported on to the UHB's Datix risk management system by main sites over the last 12 months.

The majority of the incidents were recorded at the University Hospital of Wales (UHW) followed by University Hospital Llandough (UHL) which reflects the size and activity at those sites.



The table below demonstrates the patient safety incidents reported onto the UHB's Datix risk management system by other sites over the last 12 months.

Whilst the volume of incidents reported is much lower, it is evident that staff are reporting incidents across the UHB.



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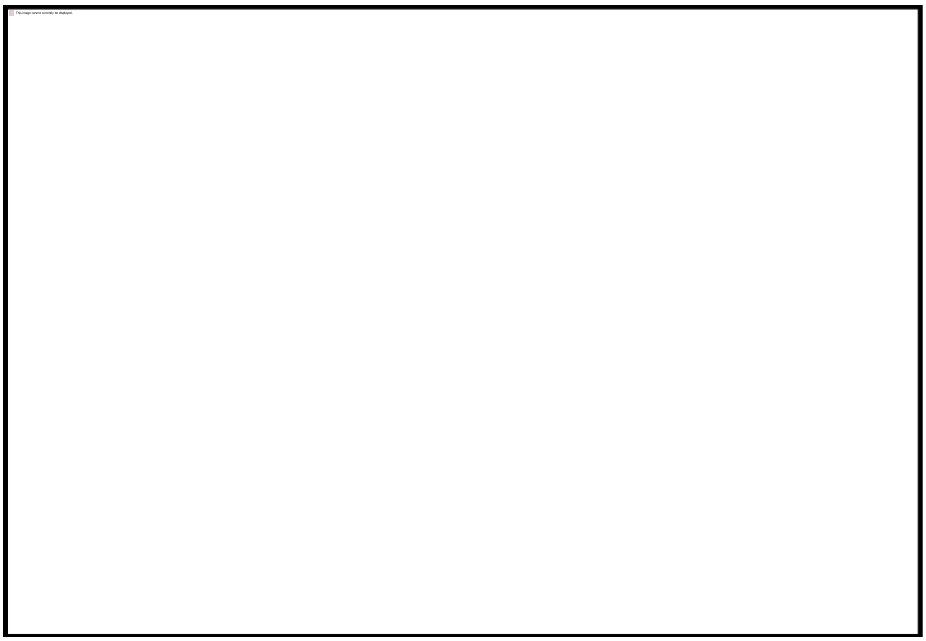
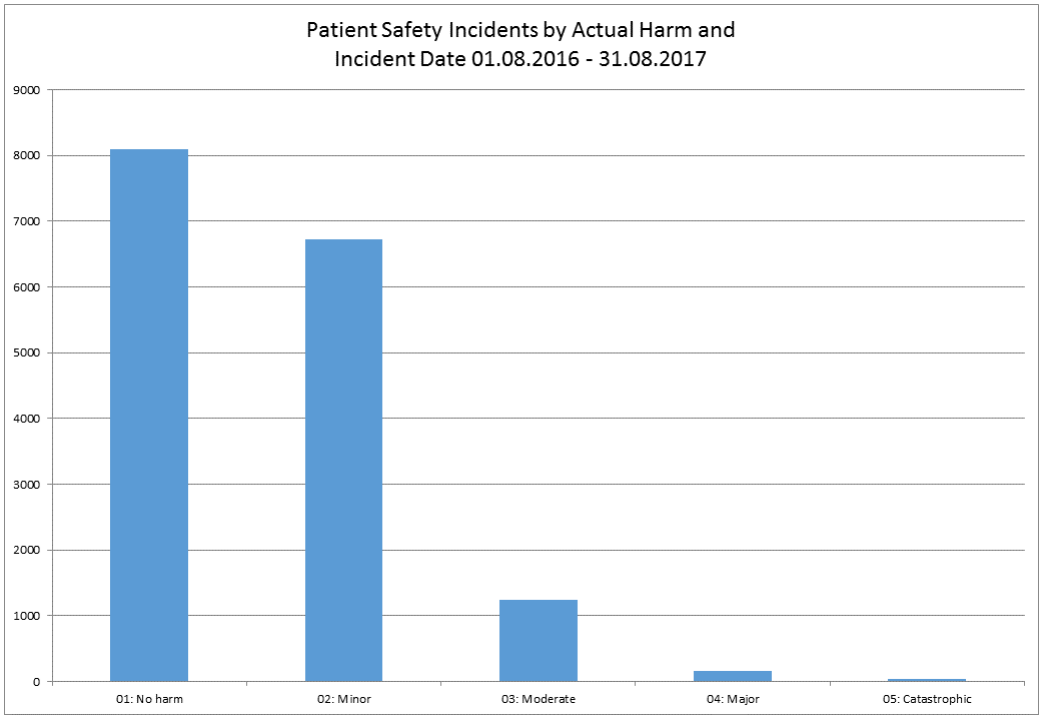
There has been a noticeable increase in reported incidents at St David's Hospital. This relates to an increased number of reported falls. The Board should be advised however, that there are a number of repeated falls in the same patients; one patient is reported to have fallen 6 times but has not sustained any harm. The Clinical Board are aware and have been asked to focus on this particular issues in St David's Hospital. The trend will continue to be monitored.

The highest number of reported Incidents is in relation to Patient accidents/ falls and pressure ulcers. This is demonstrated in the graph below:



The table below demonstrates that in most reported incidents the patient experiences either no harm or minor harm.



How do we compare to our Peers?

We have a high number of reported incidents across Wales because Cardiff and Vale encourages staff to report all incidents and near misses.

It should be noted that a high number of reported incidents is not reflective of an unsafe Health Board. In fact, conversely, it demonstrates a culture where staff feel able to report all incidents and near misses and know how to do so. It demonstrates a culture which is receptive to learning and developing.

All Serious Incidents and Never Events follow a robust process to ensure they are appropriately investigated with a focus on strong actions to mitigate against risk of recurrence.

What are we doing about it?

Examples of key actions underway, pending conclusion of the investigation process, from Serious Incidents reported in July and August 2017 include:

- Work is in a testing phase to support the Information Governance Department with strengthened monitoring of incidents reported on to the Datix system
- The patient identification policy is in the process of being updated

- A pressure damage task and finish group, led by the Director of Nursing for the Surgical Services Clinical Board, is progressing it's work
- Recruitment to a Falls Strategy Implementation Lead post has progressed to interview stage
- Infection Prevention and Control Department has revised the toolkit used to investigate Clostridium difficile infection incidents and monitoring of healthcare acquired infections continues to be a key focus within performance monitoring mechanisms for the Clinical Boards. A refreshed focus on Infection Prevention and Control will be taken to key internal, Executive and Clinical Board meetings this month. A refreshed
- The Mental Health Services Clinical Board continues to test and refine its investigation toolkit to use following unexpected deaths of patients known to their services.

Never Events

Never Events are a particular type of serious incident that meet all of the following criteria:

- They are wholly preventable, where guidance or safety recommendations that provide strong protective barriers are available at a national level, and should have been implemented by all healthcare providers.

- Each Never Event type has the potential to cause serious patient harm or death. It does not need to have caused serious harm or death for it to be categorised as a Never Event.

- There is evidence that the category of Never Event has occurred in the past through reports to the NRLS and a risk of recurrence remains.

- Occurrence of the Never Event is easily recognised and clearly defined.

How are we doing?

The Health Board has not reported any new Never Events in the current financial year. The Health Board continues to work with the Delivery Unit who provide external scrutiny to our processes. Their feedback is considered as part of our ongoing commitment to improve and strengthen the governance around our Serious Incident and Never Event management.

How do we compare to our Peers?

All Wales Report

A Welsh Government feedback report indicates that in the 6-month reporting period between October 2016 – March 2017, 11 Never Events were reported across NHS Wales. Unfortunately, 5 of the Never Events reported in this timeframe were within

Cardiff and Vale Health Board. The Never Event type and month reported is set out in the table below:

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Misplaced naso or oro-gastric tubes	1	0	1	0	0	0
Retained foreign object post-procedure	0	0	1	0	0	3
Wrong implant/prosthesis	0	1	1	0	0	0
Wrong route administration of medication	0	0	0	0	0	1
Wrong site surgery	0	0	0	1	1	0
Total	**1**	**1**	**3**	**1**	**1**	**4**

Cardiff and Vale UHB

The five Never Events reported by the UHB were:

- Wrong procedure in a patient undergoing an orthopaedic procedure
- Wrong site surgery in a patient undergoing a dental extraction
- Wrong route administration of medication where an oral preparation was administered intravenously
- Retained foreign object post procedure in a patient undergoing central line insertion where the guidewire was inadvertently retained
- Retained foreign object post procedure in an Obstetrics patient whereby a pack was inadvertently retained following a forceps delivery

What are we doing about it?

The Health Board has established a working group to address the Welsh Government Patient Safety Notice 034 Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSSIPs).

The QSE Committee received a report on progress at its last meeting. This will be followed up with a more detailed report at the October 2017 meeting, so that a decision on compliance status can be agreed.

The group has representation from across the Clinical Boards with good engagement and opportunities for shared learning being identified.

An intranet site with supporting information and guidance has been published.

The Patient Safety Team is engaging with clinical experts on NatSSIPs in NHS England in order to promote local implementation

Submission of closure forms to Welsh Government

How are we doing?

Following a SI being reported by the UHB, WG will acknowledge receipt of the SI notification; clarify any immediate queries should they arise and provide the UHB with a 60 working day timeframe to submit a closure form. The closure form sets out an overview of the investigation undertaken; findings; recommendations and confirmation of actions undertaken or planned. WG review the submitted closure form and will advise the UHB when they are satisfied that the incident can be closed.

Closure forms in relation to Serious Incidents

The following table outlines the position with submission of SI closure forms to Welsh Government:

Clinical Board	Trajectory	Number of open SIs at the time of preparing this report	April 2017	May 2017	June 2017	July 2017	August 2017
Children and Women	3	7	1	1	4	0	2
Clinical Diagnostics & Therapeutics	Aim to submit to WG on time	2	0	3	0	0	0
Dental	Aim to submit to WG on time	0	0	0	0	0	1
Executive	5	12	0	1	0	1	3
Medicine	4	10	9	6	7	8	3
Mental Health	10	23	18	17	8	9	5
Primary Care and Intermediate Care	Aim to submit to WG on time	1	1	1	1	0	0
Specialist	4	9	3	2	3	4	2
Surgery	5	0	3	4	7	2	6
Total	31	64	35	35	30	24	22

There has been considerable progress in relation to submission of closure forms to Welsh Government.

How do we compare to our Peers?

The Welsh Government feedback report is very positive regarding the quality and submission rates of closure forms to Welsh Government. However, they request that the UHB continues to address the outstanding overdue closure forms. The Board should be advised that significant progress has been made and the UHB is now very

close to a position where the majority of incidents are within prescribed WG timeframes.

The feedback report highlighted in the previous report to Board does not provide information that allows the UHB to compare with other Welsh NHS organisations.

What are we doing about it?

The trajectory will be revised in order to reflect the current position. The UHB is increasingly approaching the aim of closing SIs within the required timeframe, acknowledging that, on occasion, complex investigation processes that are undertaken concurrently with the Concerns Department or HM Coroner for example, may impact on our ability to meet the WG timeframe.

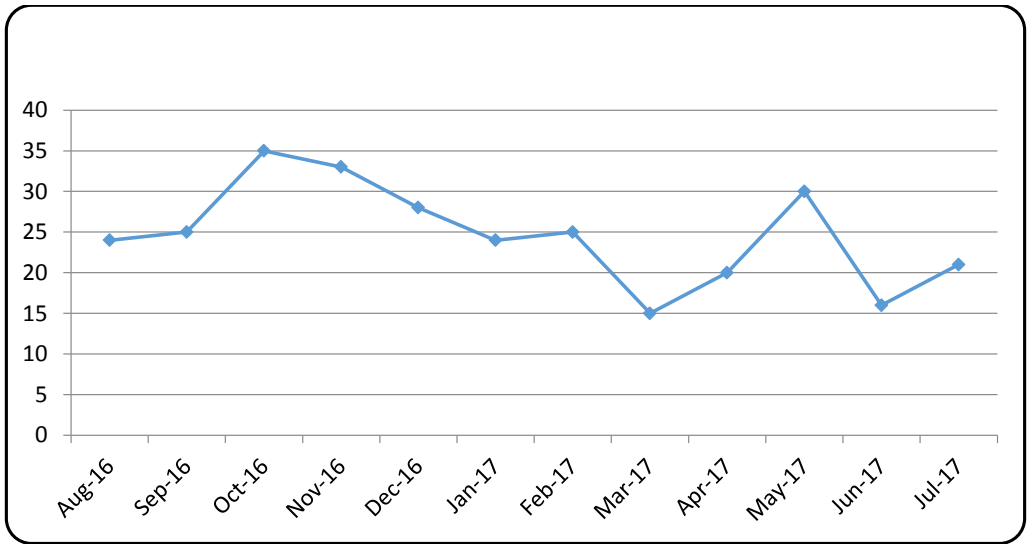
The Datix team have developed a suite of live dashboards which enable day to day monitoring and management of open Serious Incidents.

Compliance will continue to be monitored at the Clinical Board performance review mechanisms.

Pressure Ulcers

How are we doing?

The number of Health Care associated Pressure ulcers (HAPU) reported by the Health Board on the All Wales pressure ulcer care indicator since August 2016 is displayed in the graph below. In July 2017, the Health Board reported 21 pressure ulcers, the majority of which were reported from the UHW site.



How do we compare to our Peers?

Comparable data from other health board/ trust in Wales is not available.

What are we doing about it?

A pressure damage task and finish group, led by the Director of Nursing for the Surgical Services Clinical Board, is progressing its work.

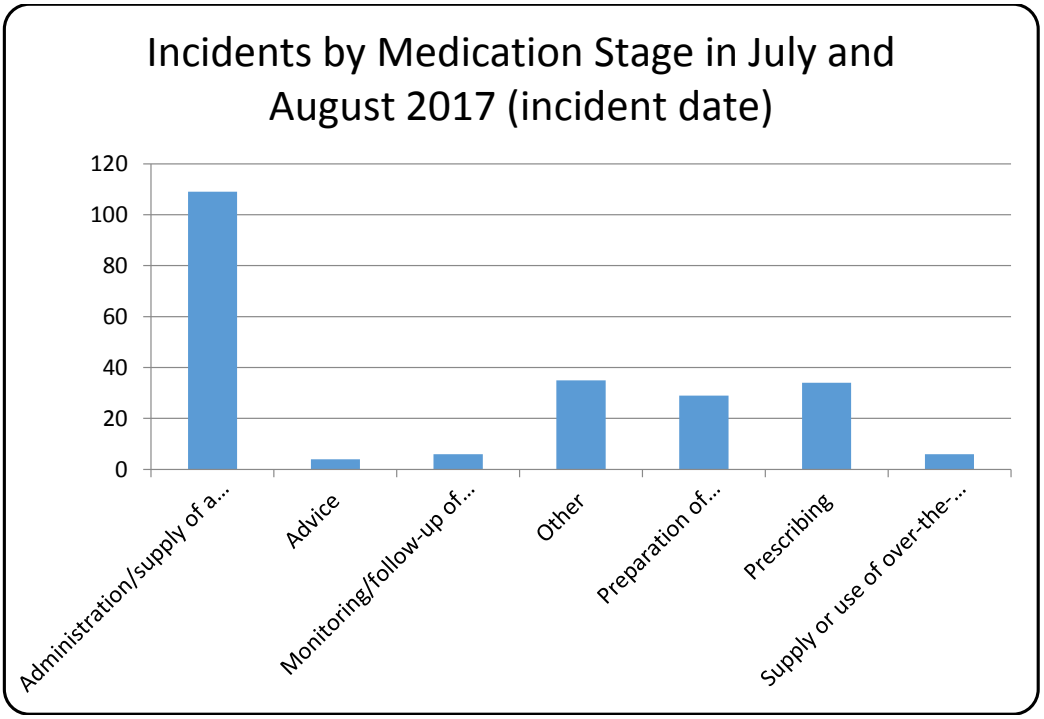
- A Pressure Ulcer Task and finish group has been convened to drive improvements in pressure ulcer prevention the group reports to the Nursing and Midwifery Board. The current focus of the group has been on the following:

- Influencing the all Wales pressure ulcer reporting and investigating guide
- Exploring the use of technology to enable review and follow up of pressure ulcers
- Exploring options to influence the Total Bed Management contract
- Preventative measures and the number of pressure ulcers are discussed in the Professional Nursing performance review
- Compliance with completion of Waterlow risk assessment is checked during unannounced inspections conducted by corporate nursing.
- Supporting the work to develop a one Wales system for reporting pressure ulcers. For the current time, reports will continue to be generated from the Health and care monitoring system.
- The foot assessment tool will identify those patients at greater risk of developing foot pressure ulcers. Work on the tool continues to make sure that it is completed by the right person at the right time.

Medication Incidents

How are we doing?

The following table indicates medication-related incidents that were reported across the UHB in July and August 2017 by medication stage.



When compared to the previous financial year, the profile is largely unchanged although an increased volume of prescribing incidents have been reported in July and August 2017. This warrants further investigation and monitoring.

How do we compare with our Peers?

At present there is no reliable All Wales benchmarking data available. There is also no new National Reporting and Learning System information available.

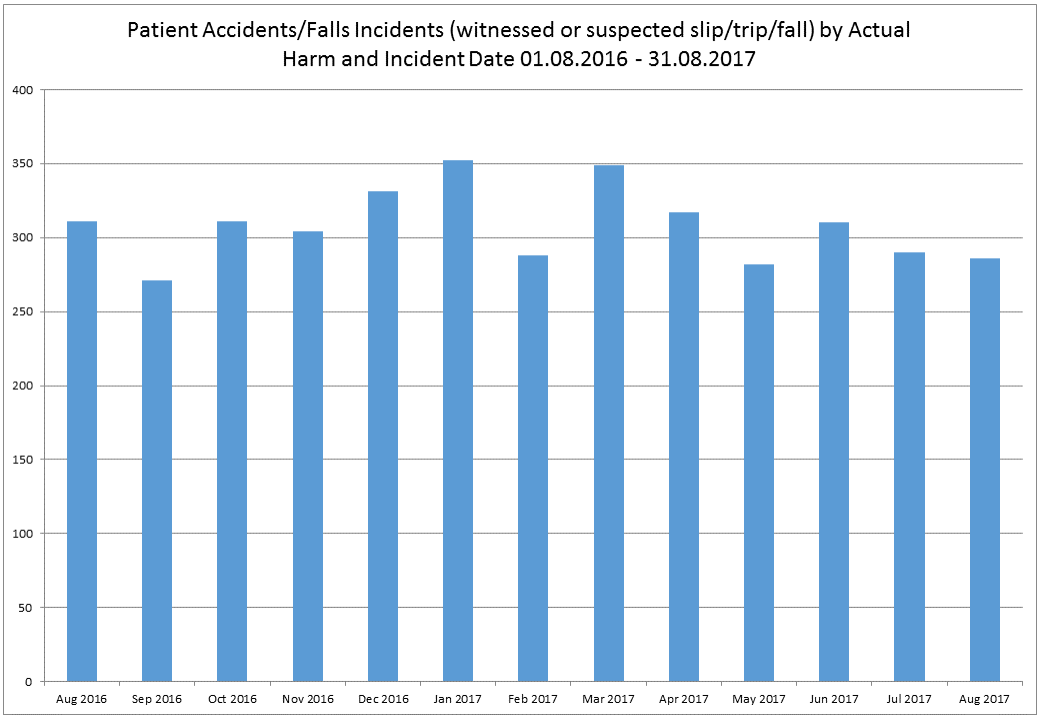
What are we doing about it?

The Pharmacy Directorate continues to lead a Medication Safety Executive Group and produces regular safety briefings that are circulated across the UHB. These regularly contain feedback to UHB staff on lessons learned from the investigation of medication-related incidents.

Patient Falls

How are we doing?

The following table indicates the numbers of patient accidents/falls incidents and the level of harm sustained as were reported across the UHB in July and August 2017.



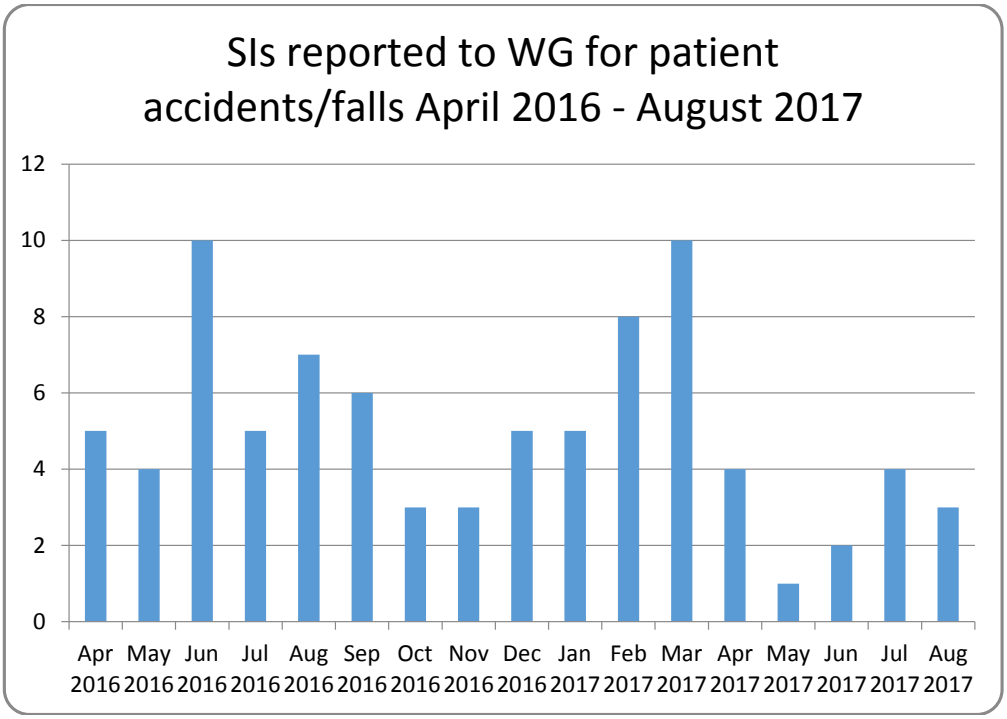
When compared to the previous financial year, the profile is largely unchanged.

How do we compare with our Peers?

At present there is no reliable All Wales benchmarking data available. There is also no new National Reporting and Learning System information available.

However, review of the Welsh Government Serious Incident feedback report indicates that injurious falls are a frequently reported incident across NHS Wales.

The following table demonstrates the trend of injurious falls reported to WG between April 2016 and August 2017 which is encouraging.



What are we doing about it?

A UHB-wide multi-disciplinary, multiagency falls group has been established and continues to meet.

Recruitment to a Falls Strategy Implementation Lead post has progressed to interview stage.

Clinical Negligence Claims during 2016/17

How are we doing?

There were 16 new Clinical Negligence Claims received from 1st July 2017 to the end of August 2017. 8 Clinical Negligence claims were closed. The UHB has also received 12 new Personal Injury claims and 8 case files concluded in these two months. In July/August there have been 11 Redress cases opened and 7 closed.

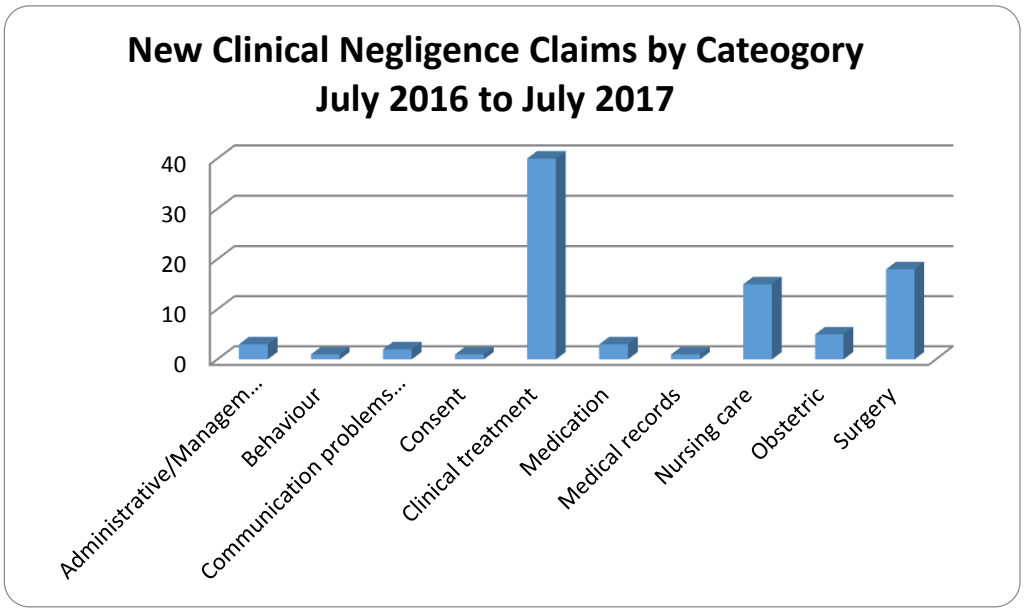
New Clinical Negligence Claims by Clinical Board

1st August 2016 to 31st August 2017

Children and Women's Services	19
Clinical Diagnostics and Therapeutic Services	6
Medicine Services	15
Mental Health Services	2
Primary, Community and Intermediate Care	2
Specialist Services	18
Surgical Services	39
Totals:	101

New Personal Injury Claims by Clinical Board 1st August 2016 to 31st August 2017

Capital, Estates and Facilities	33
Dental Services	2
Clinical Diagnostics and Therapeutic Services	2
Executive and Corporate Services	2
Medicine Services	12
Mental Health Services	9
Primary, Community and Intermediate Care	2
Specialist Services	3
Surgical Services	5
Total	70



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The highest reported incidence of Clinical Negligence claims is in relation to clinical treatment which is a broad category and covers a range of specialties, the next highest being Surgery.

The Personal Injury claims have a consistently high number of slips, trips and falls as the main theme.

How do we compare with our peers?

At present there is no new reliable All Wales data available.

What are we doing about it?

Clinical Negligence

In order to help our staff understand and learn from claims following settlement of a case a meeting with a solicitor and the clinical staff occurred to discuss the rationale for settlement. This was very helpful to all parties. The Claims Team continue to engage with clinicians to provide specific and targeted training to promote an increased understanding of the complex litigation process.

Personal Injury

On occasion the Health Board will receive claims from repeat Claimant's, who are employed by the Health Board. The Claims Managers will ensure that these claims are thoroughly scrutinised. In such cases, the Claims Managers and Legal and Risk Solicitors will take a proactive role in obtaining witness evidence. Recommendations have also been made to Managers for staff to have repeated training to ensure they are fully aware of policies and procedures to ensure safety during their employment. If evidence of fraudulent claims are identified the appropriate action would be taken in line with employment policies.

Inquests

How are we doing?

When the Concerns Department and/or Patient Safety Team are advised that Her Majesty's Coroner has opened an investigation or inquest following the death of a patient, a record is made on the Datix risk management system in order to monitor and record the inquest process through to its conclusion.

In July and August 2017, the UHB's corporate departments were aware of five inquests involving former UHB patients. The inquests concluded without concerns being raised by HM Coroner and no Regulation 28 Prevention of Future Deaths reports were issued to the UHB.

How do we compare with our peers?

At present there is no reliable All Wales data available to review numbers of inquests held.

The recent Welsh Government feedback report indicates that in the six-month reporting period, 13 Regulation 28 reports were issued to NHS Wales. In that timeframe, the UHB received two such reports.

What are we doing about it?

The UHB continues to support staff in order to ensure, as far as possible, that the Coroner's inquest procedures take place whilst meeting the needs of families, the Coroner and staff.

Outcomes of internal and external inspection processes

How are we doing?

Internal observations of care

In July and August 2017, 17 internal inspections were undertaken to wards and departments across 5 clinical boards. Of these, 15 inspections were undertaken as part of the planned programme of unannounced inspections, one on the request of the Executive Nurse Director, and further inspection on request from the Specialist Services Director of Nursing.

As previously reported, the inspections continue to provide a positive picture of staff delivering care in a professional and dignified manner. The key findings are reported back to the clinical area and Clinical Board

Key findings have been:

- Professional and kind staff
- Medicines management
- Maintenance requirements for the environment of care
- Clutter and lack of storage
- Adherence to the All Wales Dress Code
- Inconsistency in the standard of documentation
- Delays in responding to call bells
- Principles of protected meal times applied

How do we compare with our peers?

This information is not available on an all Wales basis.

What are we doing about it?

In addition to what has been reported in previous reports, the following actions are also being undertaken:

- Corporate nursing team are meeting with the Pharmacy nurse advisor to discuss the variety of medicines management issues observed during the inspections

- Nursing and Midwifery compliance with dress code audits have been undertaken across wards and department
- Daily escalation of staff concerns is being addressed in the clinical boards and the executive directors are reviewing the incidents of reported staff shortages on a weekly basis.

Healthcare Inspectorate Wales (HIW)

Hospital inspections

HIW undertook a follow up inspection to the Children's Hospital of Wales on the 12th and 13th June 2017. Whilst the UHB awaits the final written report it is pleasing to inform the Board that the initial feedback was of high praise for the care delivered and the recognition of the improvements made. The verbal feedback from the inspection team and the draft report received from HIW following inspection provides a positive picture of staff working with patients to provide care in a professional and dignified manner. It is also pleasing that the inspection team was able to confirm that there was a continued emphasis on the provision of safe and effective care. They also found good leadership and that staff felt supported, and that almost without exception, feedback from children and parents praised the care delivered by all staff. The final report will be reported to the Quality, Safety and Experience Committee in December 2017.

Primary Care Inspections

The routine Welsh Government practice and performer inspection programme has been commissioned from Healthcare Inspectorate Wales (HIW) from August 2014. All General Practices and General Dental Services / Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC.

Since January 2017, the following inspection reports have been published.

- myDentist (Quay Street) June 2017
- Gwena Dental Care June 2017
- Wilton House Dental Practice May 2017
- The Orthodontic Centre April 2017
- Cathedral Orthodontics Ltd March 2017
- Oasis Dental Care (Canton) February 2017
- Cardiff Smile Centre February 2017
- Meddygfa Albany GP Surgery February 2017
- Ellen Davies Dental Practice January 2017
- Cloughmore GP medical centre January 2-017
- Four Elms GP Surgery January 2017

In addition, the following inspections have been undertaken and the reports await publication:

- G O'Keefe and J Jones July 2017
- My Dentist – Llanrumney July 2017
- Restore Dental group June 2017
- Hillcrest Dental Surgery June2017
- Calgary Dental practice - May 2017

All HIW inspection activity is routinely reported to the Quality, Safety and Experience Committee and a detailed report on primary care inspections and emerging trends and themes will be reported to the December 2017 QSE Committee

Community Health Council (CHC)

During November and December 2016 the Cardiff and Vale of Glamorgan CHC Undertook visits to 22 branch Surgeries and sought the views and experiences of patients who use these facilities. In total the CHC received 1476 patient experience surveys. The report highlighted significant issues with patients obtaining appointments at their Branch Surgery but reported that once an appointment had been received patient satisfaction was very high with 97.3% of patients rating their experience form good to excellent. The detailed report was received at the September 2017 Quality, Safety and Experience Committee

Real Time Short Surveys Used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out-patient appointment)	**Retrospective** Surveys post discharge or any clinical encounter in any setting to gain in-depth feedback of service user experience. They can also incorporate quality of life measures and Patient Reported Outcome/Experience measures (PROM/PREM)
Proactive/Reactive Provide opportunities for all service users/families/carers to provide feedback. Includes feedback cards, permanent and temporary online surveys and emerging methods such as text, QR codes and social media.	**Balancing** Concerns and complaints Compliments Patient stories Focus groups Third party surveys such as Community Health Council and voluntary organisations

8

Primary and Community Care

At the last Board meeting the Board asked us to report on the activity specifically in Primary and Community Care.

Whilst much of the Patient Experience information relates to secondary care it should be noted that in the next report we will address many of the activities in the community setting, such as a report on the PRIDE event, the issues in primary care raised by the transgender community and what we are doing to address these concerns.

In the last 2 Months we have met with the parents of Children with complex needs and with the RNIB (Royal National Institute for the Blind) and their feedback has been shared with the relevant groups to try to improve their experience of our services

We are undertaking 5 patient stories with patients who are cared for by the district nursing service.

Staff in the community have been provided with information about suitable kiosks that could be moved around GP practices to gain some real time feedback.

We are working with our schools and GP Practices to identify young carers.

These are the commitments based on the feedback from the work in schools to identify young carers and the carers consultation event regarding the way forward to support carers in the future.

- We will employ a full time School Development Worker and a full time Carer Development Worker up to 30th June 2018 to work across Secondary Schools and identified Health and Social Care settings to promote and support the achievement of the Carer Accreditation Award.
- We will work with the identified secondary schools to set up support in schools
- We will deliver at least one event to promote the schemes, in particular, as settings achieve the award.
- We will work with Cardiff and the Vale Councils, UHB and Third Sector Councils to develop a proposal to provide a one stop shop facility for carers as per their request based in the community.
- We will form a task and finish 'Expert Panel' of carers to help inform planning and to provide a voice for carers during the project lifetime
- We will employ a Carer Engagement Officer for 37 hours per week up until 30th June 2018 to help develop the above proposal and co-ordinate and facilitate Cardiff and Vale Carer engagement for carers aged 18 or over, caring for someone aged 18 or over.

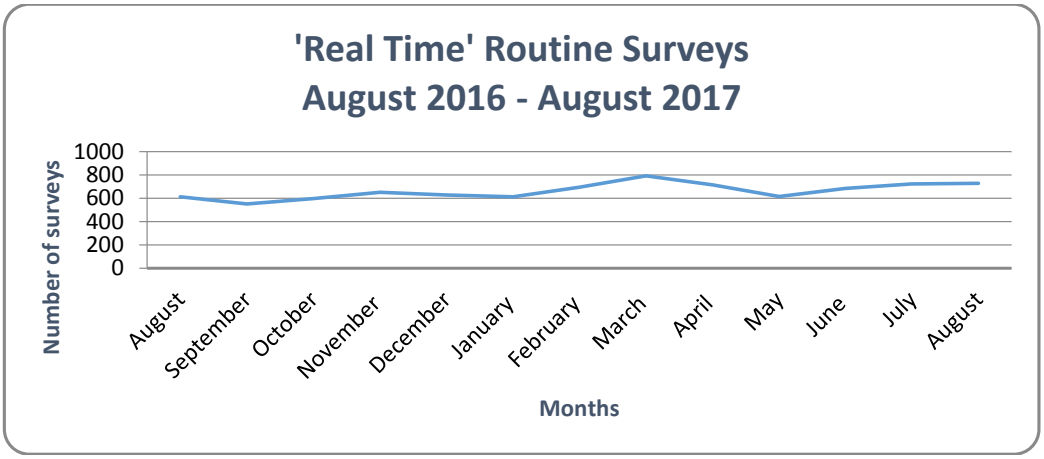
We will work to identify potential collaboration, funding and partnership arrangements to enable the sustainability of a Carers Hub post funding to be community based

As part of the previous Carers Strategy (Wales) Measure, a Carers GP accreditation Scheme was developed within Cardiff and the Vale, as it was recognised that for many carers, the GP practice is the first place that they will contact for help and support. The scheme has a set of criteria that GP practices need to achieve to obtain recognition for their support to carers and their families. This scheme has been developed and over the next year we will be supporting practices to achieve the silver accreditation

Real Time

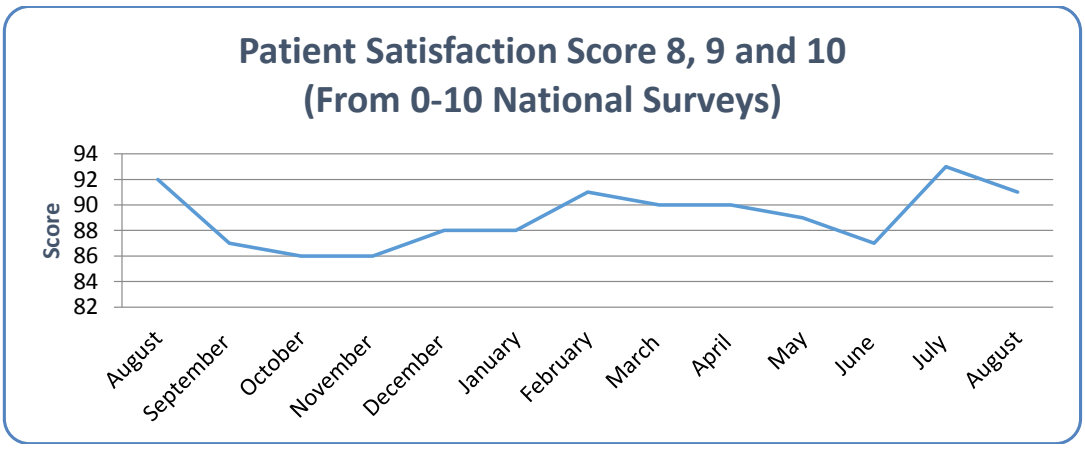
How are we doing?

The table below illustrates the number of routine 'real time' surveys completed within Medicine, Surgery, Children and Women, Specialist Services, and Clinical Diagnostics and Therapies Clinical Board during the last twelve months.



During July and August there were an additional **534** surveys completed in Paediatrics, Mental Health Services for Older People, Acult Acute Mental Health Services and Podiatory. Comments and information from the surveys are fed back to the relevant directors of Nursing and are usually shared at the Clincal Board Quality and Safety meetings

Patient Satisfaction as noted within the National Survey in July and August was **93%** and **91%** consecutively; with the last twelve months illustrated in the table below.



Within the reports there are numerous qualitative comments which provide rich data; a positive example from one of our surgical patients;

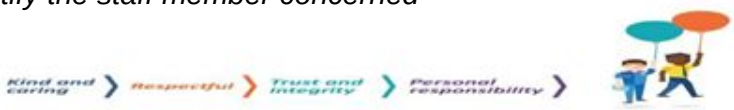
"*Having worked in Customer Service for over 20 years I can safely say that the staff I have met whilst here have behaved exemplary, with huge commitment and knowledge. Wonderful atmosphere on the ward and the team really support the patients and each other. A real credit to the hospital and the NHS.*"

Many of the qualitative comments are consistently positive, particularly in regards to staff behaviors. It is anticipated that the ongoing awareness raising of our revised values and behaviors will ensure they become the foundation for all; totally embedded in everyone's day to day practice with all staff 'living our values'.

However, not all feedback shared with us is positive. On review of the comments it has been noted that unusually several comments have been raised regarding staff attitude which is quite unusual they are not related to any particular area. They may be as a result of the raised awareness regarding the living our values and the behavior that should be expected.

On one occasion not spoken to very politely, member of staff was quite rude.

There was an occasion when I was treated indifferently but I do not want to complain and could not identify the staff member concerned

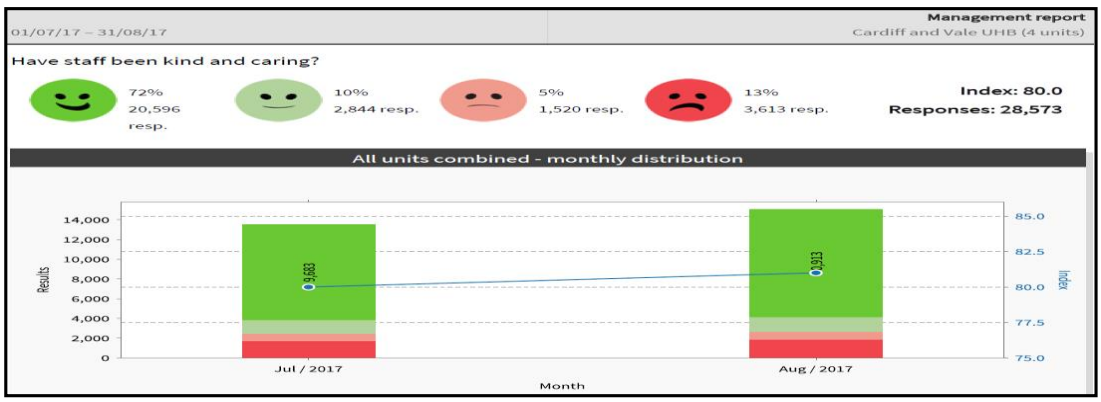


Happy or Not

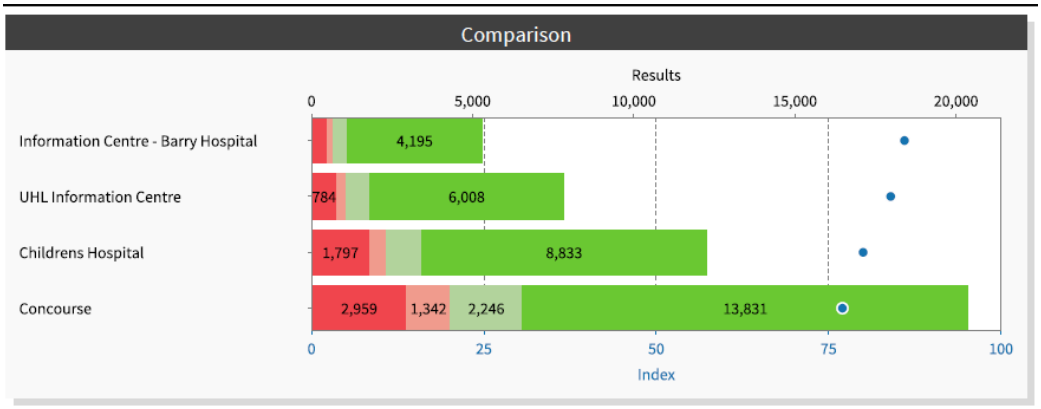
The Health Board currently has six 'Happy or Not' Kiosks across our sites. Four ask '**have staff been kind and caring?'** and are situated at;

1. University Hospital Llandough Information and Support Centre
2. University Hospital of Wales; the Concourse
3. Barry Hospital
4. The Children's Hospital of Wales

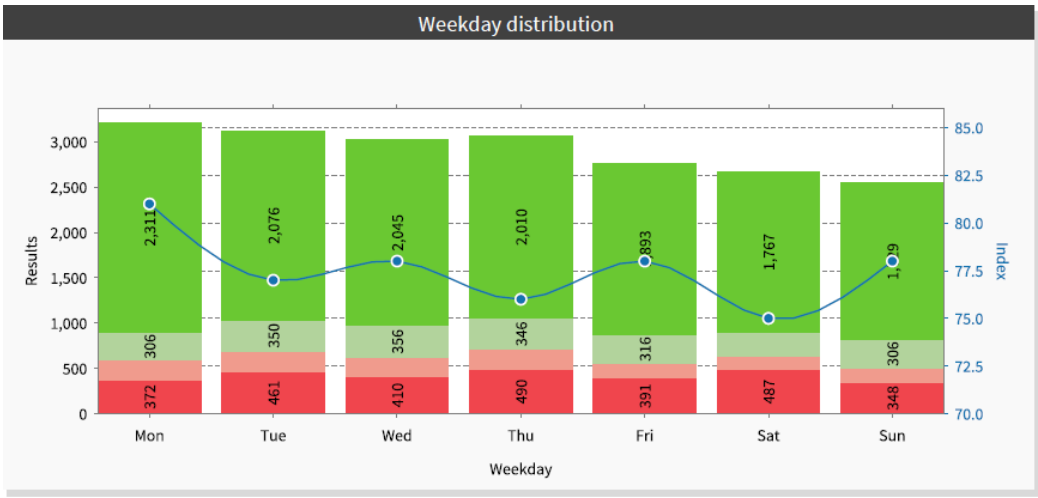
Nearly 30, 000 responses were received during July and August on four of the machines; with 82% responding positively.



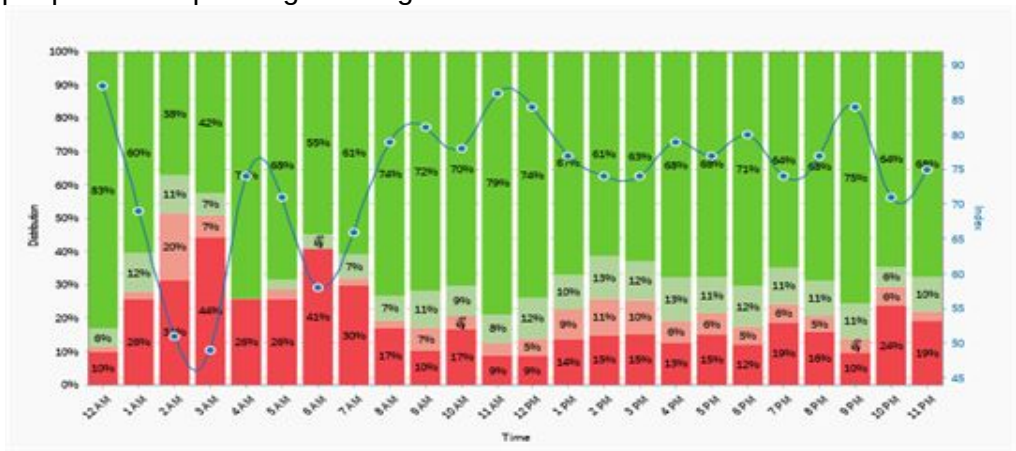
In order to analyse this data the site distribution can be identified and it is noted that concourse and the Children's hospital require further investigation



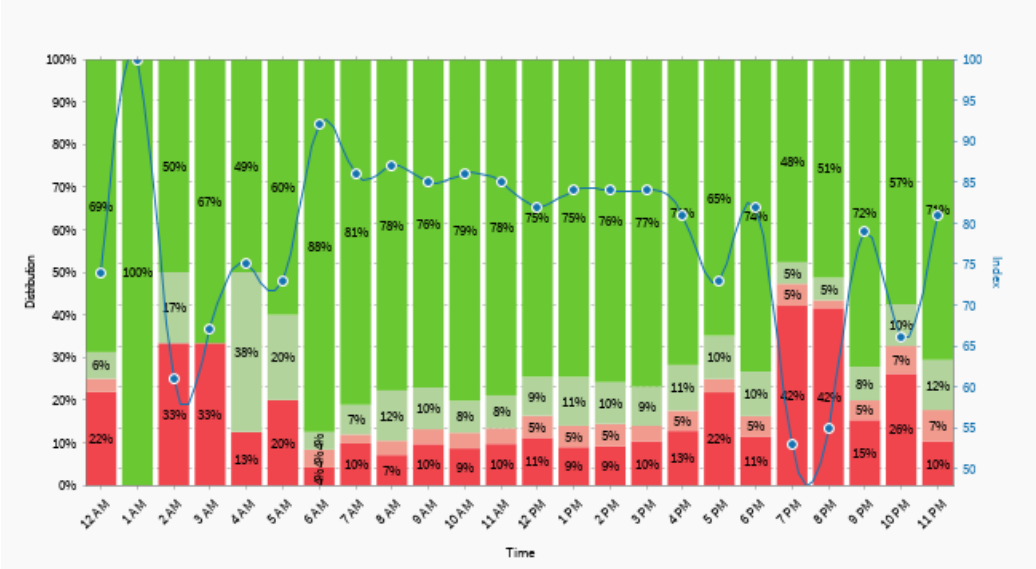
Concourse by weekday distribution



Concourse by time-this data enables us to see on what days and times we need to undertake further analysis to identify who is in the area and why people are responding in a negative manner at these times.



The children's hospital hourly distribution in the graph below demonstrates people are responding negatively in the early hours of the morning and 7 to 8 pm



The additional two ask **'How was your visit today?'** these are situated at;

1. University Hospital Llandough Children's Centre
2. St David's Hospital Children's Centre

Of the **839** responses received at the Children's Centre's during July and August 74% responded positively.

How do we compare to our Peers?

At present there is no reliable All Wales data available.

What are we doing?

July's Board report advised that focused surveys would be devised utilising the 'feedback in 5' concept. Surveys have been drafted, and themes will include;

- Way finding; incorporating a sensory loss element for completion within our Outpatient Departments
- Support provision at our three Information and Support Centre's

These will commence September/October, using digital tablets and our Health Board Volunteers will undertake them.

Proactive and Reactive

How are we doing?

This quadrant encourages the use of varied methods of feedback, we are currently using on line surveys, surveys on tablets, ward based kiosks, a kiosk in out patients, bespoke surveys and feedback cards and leaflets.

Carers

During August proactive 'Carer' surveys were undertaken on three wards at University Hospital Llandough. The aim was to ascertain staff's knowledge of carers, and also for carers to share with us their experience. This additional information will build on prior data previously collated from East 10, A1 and B6.

Outpatients Kiosk

The outpatient's kiosk was introduced to the department in May, this year and is a means of gathering feedback from patients, relatives, friends and carers. The survey tool, currently loaded on the kiosk, is of a bespoke design

Since placing the kiosk in the Outpatient department, UHW on the 3rd May 2017, we have had 577 surveys completed. Of these, 443 (77%) are by patients, 94 (16%) by relatives/friends/loved ones and 40 (7%) by carers/helpers.

The most recent report includes feedback from 13th July – 25th August 2017, during which time we had 180 survey completions, both full and partial.

All feedback is shared with the clinical board and department so they can identify areas for improvement and share the positive feedback with staff.

<u>Basic findings of the most recent report</u>

- Of the 180 surveys completed, 134 (74%) were by patients, 31 (17%) by relatives/friends/loved ones and 15 (8%) by carers/helpers.

8

- 14% of surveys were completed before the appointment, 12% whilst waiting and 73% after the appointment.

- When asked about car parking, 21% found it difficult to find a parking space and of these, 44% stated that this made them late for their appointment.

- When asked about finding where their appointment was being held, 11% experienced difficulties and of these, 53% stated that this made them late for their appointment.

- Of those completing the survey before or whilst waiting for their appointment, 37% said that their appointment was running late and of these, 56% stated they had not received an apology or been given a reason why.

- Of those completing the survey after their appointment, 60% indicated that the appointment started more or less on time. However, 38% stated that their appointment started late and of these, 69% stated they had not received an apology or been given a reason why.

Currently, we are developing a new set of questions which will be uploaded to the kiosk in the next few weeks. These will be available in both English and Welsh. If we are able we will also include the survey in Arabic as this is the language that we have the highest number of translation requests for across the UHB. The results of the revised survey which will be outlined in the next Board report.

Ward Feedback Kiosks

The ward feedback kiosks were introduced to the wards in June, this year and are a means of gathering real time feedback from patients, relatives, friends, carers and staff. The survey tools, currently loaded on the kiosks, are based on the 'Feedback in 5' survey and are available in both English and Welsh. During each survey period, the kiosk remains on its designated ward for 1 week. A detailed report is then sent to the area the following week.

To date, 10 areas have been surveyed at UHW and 9 areas at UHL. The table below gives a breakdown of which areas have been surveyed so far, number of surveys completed in each area and the percentage of those completed by patients, relatives/friends/carers and staff.

Ward / Area	Surveys completed by			Surveys completed (n)
	Patients (%)	Relatives, friends and carers (%)	Staff (%)	
A1 North/South	6	21	74	34
West 1	29	13	58	31
Dental Outpatients	49	8	44	39
West 5	27	20	53	49
C1 North/South	45	16	39	38
East 1	11	19	70	27
A2 North/South	14	12	74	57
East 7	6	18	76	34
Stroke Rehabilitation Centre	5	68	27	37
A1 Link	18	15	67	33
Anwen Ward	29	13	58	24
A3 Link	11	14	75	28
A3 North/South	0	60	40	20
West 2	0	13	87	23
B3 North/South	2	44	54	57
West 4	6	20	74	35
C3 North/South	8	28	64	25
West 6	15	25	60	55
Overall	**16**	**23**	**61**	**679**

8

Basic findings *(based on data from 19th June – 3rd Sep 2017 inclusive, including changeover days)*

- Overall 920 surveys (*both full and partial*) have been completed, 581 (63%) by staff, 193 (21%) by relatives/friends/carers and 146 (16%) by patients. However, this distribution does vary depending on ward, please see table above.

- 98% of surveys were completed in English, 2% completed in Welsh.

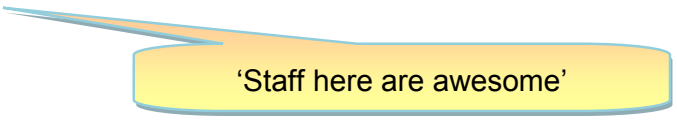
- 87% of patients felt safe whilst in our care, 95% of relatives/friends/carers thought that patients felt safe and 87% of staff thought patients felt safe whilst in their care.

- 78% of patients thought staff were always kind and caring towards them and 77% of relatives/friends/carers thought staff were always kind and caring towards the patient. However, only 56% of staff, believed that patients thought staff were always kind and caring.

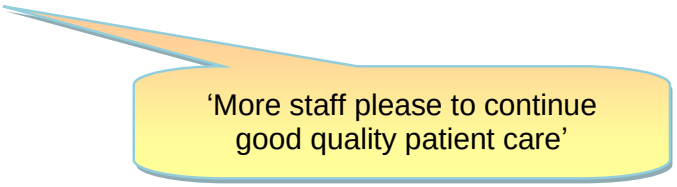
- 87% of patients felt they were involved when decisions were made about their care/treatment, 86% of relatives/friends/carers felt they were involved and 82% of staff thought patients felt involved.

- 71% of patients rated their care as excellent and 73% of relatives/friends/carers rated the care the patient received as excellent. However, only 53% of staff believed that patients rated the care they received as excellent.

- The vast majority of comments left by patients and relatives/friends/carers were very positive and linked to staff. A small number of comments were left in relation to the ward environment, facilities, food, cleanliness, waiting times, understaffing and these were either positive or negative.



- Comments left by staff centered mainly on understaffing issues, poor facilities and a poor ward environment. There were some positive comments made around team work.



How are we doing?

Patient Stories:

During the last quarter four patient stories were undertaken three within District Nursing Services and one on the Model ward. During July and August the District Nursing story undertaken, this was the third of five; ensuring representation from all five teams. We are training more staff fin the patient experience to undertake stories.

Many people are trained within Clinical Boards to undertake stories but the mechanism to feed back key themes is not utilized as effectively as it could be Patient experience will liaise with clinical boards to improve the collation of themes.

How do people contact us if they wish to provide stories?

- we discuss at events
- we discuss at training sessions
- opportunistic – we ask people when we meet them
- Referrals from clinicians or departments

Planned Stories

Patient Experience is developing a more structured approach to patient stories to ensure that we reflect the diverse population and activity. Elements of living our values can be tested in the collation of patient stories.

We have focused upon families of children with complex needs and 3 stories are planned to be undertaken on 15th, 25th September and one to be filmed on the 11th October with a view to sharing with the board at a future meeting

How do we compare to our Peers?

At present there is no reliable All Wales data available.

What are we doing?

'Happy or Not'

We will continue to monitor the responses and where indicated more in depth analysis of results will be undertaken. The questions will be periodically changed and will link in with the Health Board's values. More in depth analysis of the data will be undertaken

Out patients Kiosk

The information is informing the department and changes are being implemented such as reminding staff to keep patients informed about waiting times and delays etc.

Ward Kiosks

Over the next year all wards in UHW and UHL will have received a report from the Kiosk they will see the information from patients, staff and carers with any comments provided from their clinical area. The reports are shared with Ward mangers and the relevant Director of Nursing for each area**.** In patient experience we will monitor any specific actions or themes. We are identifying some interesting data in the varied perceptions of patients and staff with regards to safe care as staff rate this lower than patients and relatives. This will be further analysed on receipt of the year's data. Kiosks can be used to provide timely and anonymous feedback if there an area of concern. Generally staff are appreciative of the feedback as it is mainly positive if any concerns are noted the area will be contacted to request what has been done in relation to the feedback.

Patient Stories

The Patient experience team continues to undertake patient stories and these can be widely used for teaching and enabling staff to truly appreciate the impact that both positive and negative experiences can have on patients and families. Moving forward we wish to undertake more stories across the spectrum of health care and focus upon some experiences in primary care and the community. We will increase the numbers of staff trained to undertake stories and will work towards a more targeted approach.

Balancing continued

The UHB receives approximately 2,600 concerns per year this is set in the context of approximately 1.8 million patient contacts

Concerns

How are we doing?

The latest overall Health Board performance in response to 30 day concerns is 62%. There is however much variability across the UHB. The focus upon the proportionate investigation of concerns in a timely manner remains a focus.

Performance Times

The Table below demonstrates the performance by Clinical Board.

	Jan	Feb	Mar	Apr	May	June	July	Aug
Clinical Board Dental								
60% of concerns managed via informal resolution	NA	63%	90%	90%	100%	50%	43%	0
Informal response time		60%	80%	67%	0%	0%	100%	na
Conversion of informal to formal (< 5%)	0	0	0	0	0	0		na
% formal complaints responded to within 30 days	40%	0%	100%	100%	n/a		100%	
Clinical Board Mental Health								
60% of concerns managed via informal resolution	6%	22%	25%	14%	12%	10%	15%	9%
Informal response time	0	50%	100%	100%	50%	100%	50%	50%
Conversion of informal to formal (< 5%)	0	0	0	0	0	0		0
% formal complaints responded to within 30 days	48%	38%	92%	58%	62%		47%	

Clinical Board Primary, Community and Intermediate Care								
60% of concerns managed via informal resolution	34%	75%	16%	57%	50%	67%	60%	85%
Informal response time	0	100 %	0	25%	50%	50%	78%	64%
Conversion of informal to formal (< 5%)	0	0	0	0	0	0		0
% formal complaints responded to within 30 days	50%	50%	71%	33%	67%		83%	
Clinical Board Surgery								
60% of concerns managed via informal resolution	63%	53%	70%	68%	71%	70%	74%	73%
Informal response time	48%	62%	62%	67%	57%	54%	51%	53%
Conversion of informal to formal (< 5%)	1	0	0	0	0	2		
% formal complaints responded to within 30 days	47%	43%	41%	38%	43%		52%	

8

	Jan	Feb	Mar	Apr	May	June	July	Aug
Clinical Board Specialist								
60% of concerns managed via informal resolution	75 %	80%	65%	68%	63%	71%	87%	68%
Informal response time	78%	55%	62%	67%	65%	56%	42%	48%
Conversion of informal to formal (< 5%)	0	0	0	0	0	0		
% formal complaints responded to within 30 days	32%	40%	62%	71%	67%		82%	
Clinical Board Clinical Diagnostics and Therapies								
60% of concerns managed via informal resolution	60%	68%	83%	41%	67%	58%	75%	67%
Informal response time	100 %	92%	70%	60%	42%	88%	67%	56%
Conversion of informal to formal (< 5%)	0	0	0	0	0	0		
% formal complaints responded to within 30 days	83%	83%	89%	83%	83%		100 %	
Clinical Board Children and Women								
60% of concerns managed via informal resolution	40%	53%	47%	55%	42%	36%	73%	54%
Informal response time	40%	77%	60%	67%	60%	63%	88%	46%
Conversion of informal to formal (< 5%)	0	0	0	0	0	0		
% formal complaints responded to within 30 days	26%	33%	71%	45%	50%		73%	
Clinical Board –Medicine								
60% of concerns managed via informal resolution	57%	61%	62%	40%	53%	58%	61%	59%
Informal response time	61%	74%	70%	81%	74%	56%	64%	42%
Conversion of informal to formal (< 5%)	0	0	0	0		0		
% formal complaints responded to within 30 days	16%	50%	42%	25%	32%		33%	

Website development

The majority of concerns continue to be received via email; however, from the table below that it is evident that there has been a sustained increase in the volume of people accessing the Concerns Form (introduced in October 2016) on the website.

An increased awareness of the website and the concerns form has been actively disseminated to front line staff and they are using the form in discussion with people who wish to raise concerns.

Visits to Concerns Pages 2017

	February	March	April	May	June	July	August
Concerns Home	947	948	906	981	797	846	866
Concerns / Complaints	722	812	646	669	557	610	597
Putting Things Right	107	143	183	173	129	127	103
Advocacy	98	100	103	112	102	78	83
PALS				170	109	206	177
Compliments	503	550	613	475	523	586	499
Parking Appeals	98	91	102	75	52	84	71
Publications etc	56	59	70	75	61	53	64
Documents							
Concerns Form	11	12	74	268	212	249	232
Concerns Feedback form	13	11	17	32	20	25	19
PTR A5 Eng	48	53	70	76	45	52	34
PTR Large print Eng			12	16	9	7	5
PTR young people Eng			15	16	8	10	8
PTR A5 Welsh				10	8	5	8
PTR Large print ~Welsh				10	8	3	6
PTR young people Welsh				10	7	8	7

8

PALS (Patient Advisory Liaison Service)

The PALS team supports our informal concerns process to ensure accessibility for patients, relatives, friends and staff.

The number of concerns being processed informally continues to increase. It should be noted that the performance time is measured against a 2 working day target but often complainants wish to continue in the informal process. We monitor the conversion rate from informal to formal concerns which remains low and we evaluate the service of the PALS team on a continuous basis.

The PALS team are based in the information centers at UHW, UHL and Barry Hospital for weekly sessions. This commenced in March 2017. The PALS team are advertising their sessions at the information centers to encourage awareness and utilisation of this service. The plan is to increase the number of sessions over the next few months to ensure that we have an accessible and visible PALS service.

How do we compare to our Peers?

At present there is no new All Wales data available regarding concerns.

What are we doing?

Concerns Themes

Communication remains a theme identified in most concerns. It is envisaged that the embedding of the Living our Values in the organization will improve communication for patients and staff.

Response Times

The concerns team continues to work with the Clinical Boards to improve the response times to formal concerns. It is pleasing to note the sustained improvement in response times to formal concerns.

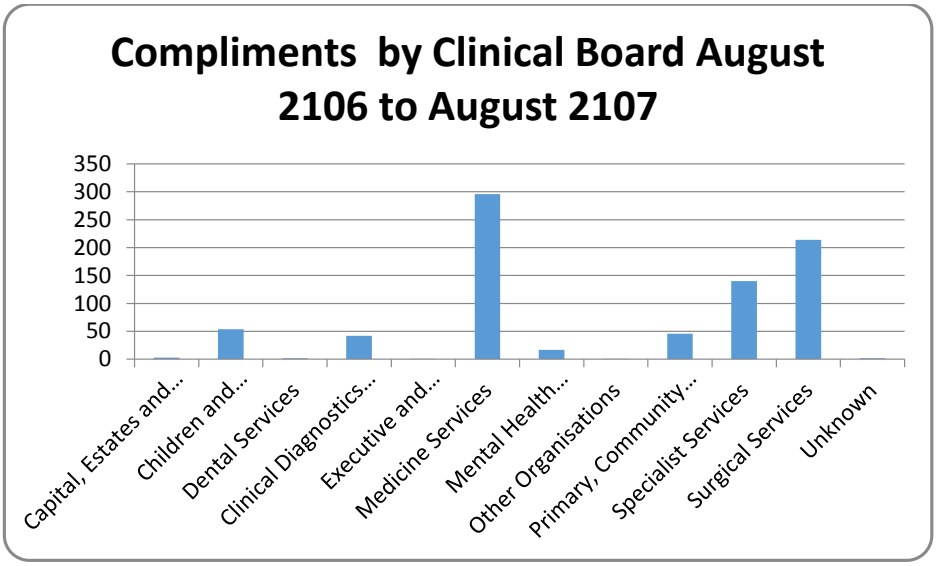
What are we doing?

- We are providing structured response templates for Clinical Boards where possible to ensure that the questions identified by the complainant are responded to
- We have weekly tracker meetings with teams from all Clinical Boards to review progress with all active concerns.
- There is training/support sessions for Investigating Officers in the Medicine Clinical Board.
- We are preparing for the implementation of E datix for complaints on 4 October 2017, which will help to monitor performance across the central concerns team and within the Clinical Boards.

How are we doing?

Compliments

During August 2016 to August 2017, the Health Board logged 818 Compliments. The Medicine Clinical Board consistently receives the highest volume of compliments. We encourage staff across the Clinical Boards to forward any compliment cards/correspondence on to the Concerns Team so that we can capture all positive feedback.



How do we compare to our Peers?

At present there is no reliable All Wales data available regarding compliments

What are we doing?

We will continue to log and respond to all compliments received by telephone, e mail, and letter and in person that are shared with the Concerns Team. All compliments are shared with staff and the Executive Nurse Director writes to individual staff members, the clinical area and the person who has sent the compliment.

How are we doing?

Ombudsman

The UHB has not had a section 16 public report since June 2015.

How do we compare to our Peers?

The Ombudsman published his Annual Report and Accounts 2016/17 and he commented upon:

Improvement Officers:
Last year I introduced into the roles of a number of investigation staff in my office, the additional role of 'improvement officer'. Whilst the main element of their role remains the investigation of complaints, their improvement role will include stakeholder engagement with certain bodies in jurisdiction as well as subject leads for areas which continue to affect quality public services

I am pleased to say that I do not consider Cardiff & Vale University Health Board a priority for improvement engagement with my office any longer and so it no longer has an improvement officer linked to it. However, an improvement officer has been assigned to one new body for the coming year.

So for 2017/18 those organisations assigned an Improvement Officer are:

•Abertawe Bro Morganwg University Health Board
•Aneurin Bevan University Health Board
•Betsi Cadwaladr University Health Board
•Ceredigion County Council
•Cwm Taf University Health Board
•Hywel Dda University Health Board
•Powys County Council

The Ombudsman Annual Letters have been received.

A. Complaints received and investigated with Health Board average adjusted by population

Health Board	Complaints received	Average	Complaints investigated	Average
Abertawe Bro Morgannwg UHB	94	115	26	31
Aneurin Bevan UHB	90	127	26	35
Betsi Cadwaldr UHB	192	151	61	41
Cardiff & Vale UHB	91	106	26	29
Cwm Taf UHB	76	65	23	18
Hywel Dda UHB	113	84	23	23
Powys Teaching HB	20	29	0	8

In Cardiff and Vale the number of concerns received and investigated by the Ombudsman were below the average

B. Complaints received by Subject with Health Board

Cardiff and Vale Health Board	Complaints Received	Health Board Average
Complaints Handling - Health	13	9
Finance and Taxation	1	0
Health – Appointments/admissions/discharge and transfer procedures	5	5
Health – Clinic treatment in hospital	51	56
Health - Clinic treatment outside hospital	5	6
Health - Confidentiality	2	1
Health – Continuing Care	4	7
Health – Medical records/standards of record keeping	2	1
Health - Other	6	8
Health – Patient list issues	2	1

This table demonstrated those concerns where issues were alleged.
In relation to the 13 cases where complaint handling was alleged 5 were not investigated by the Ombudsman following review of the initial correspondence. In 3 cases the responses were delayed and there were no exceptional circumstances identified for the delays, but the complainants were kept informed of the delays by the central concerns team.

C. Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

Health Board	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Discontinued	Early Resolution / Voluntary Settlement	S16 Report-Upheld-in whole or in part	Other Report-Upheld-in whole or in part	Other Report-Not Upheld-	Withdrawn	Total Cases Closed
Cardiff & Vale	11	24	25	1	8	0	15	9	0	93

It is pleasing to note that the UHB did not have any public interest reports and a significant number of cases were not upheld in 2016/17.

What are we doing?

We work with the Clinical Boards to develop and monitor action plans to completion, in relation to any Ombudsman recommendations. We review Ombudsman reports and disseminate any that have wider learning implications across the Health Board via the Clinical Board Quality and Safety meetings.

8

Retrospective

How are we doing?

The results from the 'Wales Cancer Patient Experience Survey' undertaken during 2016 were reported during July. Highlights for Cardiff and Vale are visualized in the information below.

1,136 residents of this Health Board were invited to take part in this survey and 715 responded to the survey. This survey highlighted many positive aspects of patient experience for patients living in the catchment area of Cardiff and Vale UHB that include;

Categories	Cardiff and Vale UHB	How do we compare to our Peers
Before Treatment	**81%** more likely to feel involved in decisions about their care and treatment	**78%**
	85% more likely to receive written information about side effects that were easy to understand	**81%**
Support	**72%** of our residents were significantly more likely than to feel that they had received the right amount of information about support/self-help groups	**66%**
	67% had been told about voluntary and charity support	**59%**
	55% said that they received enough information about financial help and benefits	**49%**
Home Support	**66%** two-thirds of Cardiff and Vale UHB residents felt they were given enough care and help from health or social services.	**60%**
Care Plan	**53%** reported that they had been offered the opportunity to develop discuss and develop a care plan	**49%**
Overall Rating	**95%** rated their overall experience as seven or more out of ten	**93%**

8

Areas for improvement include;

- **Written care plan:** While the discussion happened for 53% of residents, only 18% of Cardiff and Vale UHB residents reported that they had been offered a written care plan.

- **Home Support:** Only 55% of residents felt that their GP had been given all the necessary information after their hospital stay and only 47% discussed the impact of cancer on day-to-day activities.

An Action Plan will be devised that will be agreed and monitored by the Medical Director as lead executive providing assurance that the Health Board is listening to our patients and acting upon what they are telling us.

What are we doing?

You Said We Did - the table provides examples of actions taken in relation to concerns (Incidents, Complaints and Claims) and Patient Feedback

You Said	We did
Toilet flushes could be improved	Reported following feedback and repaired
Toilet door does not close	This was reported and door is now working properly
Television broken	Request to replace television was granted and funded from the ward's endowment fund
Poor communication resulting in delay in being reviewed at Outpatient appointment	Patient was contacted by Unit Sister who apologised for the delay. She also discussed the issue with both the receptionist and nursing staff to prevent possible reoccurrence
Nurse call bell out of reach in shower	Call bell relocated
Unable to speak to ward staff about post knee surgery advice	Mobile number provided to patients for post op advice
Healthcare Support Worker had been abrupt	The HCSW was booked onto communication and dignity training days. A competency assessment would be undertaken following completion of the training.
Problems with wheelchair	Parts to be expedited/or alternatives sought for complex clients Review of procurement processes for urgent orders is now in place
Records not available at clinic appointment	Computer to be made available to access records Hard copy of notes as well as portal records to be made available
No formal protocol in place regarding the transfer of patients from general adult mental health wards to psychiatric intensive care.	A protocol was ratified by Mental Health Services Clinical Board and has since been audited to ensure that staff are clear on the protocol.

You Said	We did
Handover from dialysis unit staff at Suite 19 UHW to ambulance service staff required improvement.	Ambulance staff now collect patients from within the unit and ensure they are satisfied the patient is well enough to transport home before they transfer the patient to their vehicle.
There was a risk of potentially significant radiological findings being delayed in identification by the referring clinician.	A Radiology Notification Procedure has been implemented by the Clinical Diagnostics and Therapeutics Clinical Board. This is in a pilot phase and will be audited later in 2017.
Staff were unclear of the requirements of the major hemorrhage protocol following the need to activate it on a surgical ward.	Additional training has been provided and it has been incorporated into induction for junior doctors and new nursing staff.

LEADING THE WAY – STRENGTHENING AND EXTENDING OUR UHB APPROACH TO DELIVERING THE WELLBEING OF FUTURE GENERATIONS (WALES) ACT 2015	
Name of Meeting: Board Meeting	**Date of Meeting:** 28.09.17

Executive Lead: Director of Public Health
Author: Deputy Director of Public Health: 02920 748886
Caring for People, Keeping People Well: The focus in the Act on wellbeing, prevention and collaboration links to the UHB's strategic themes of keeping people healthy and delivering outcomes that matter to people.
Financial impact: No current direct financial impact. This is about how we frame, plan, make decisions and deliver action in line with the sustainable development principle.
Quality, Safety, Patient Experience impact: Acting in accordance with the sustainability principle (five ways of working) should provide positive enablers that contribute to the quality and safety of our services and the experience of our patients.
Health and Care Standard Number: 1.1, 2.7, 3.3, 6.1, 6.3, 7.1
CRAF Reference Number: 1.1, 2.1, 3.1, 4.2, 4.3
Equality and Health Impact Assessment Completed: This work is about embedding an approach rather than a single initiative and in this regard, an EHIA has not been completed.

9

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The Health Board has achieved its initial statutory requirements with regard to the Wellbeing of Future Generations (Wales) Act
- The Health Board is making progress in identifying and articulating what it will do to embrace opportunities to embed the Act across the organisation

RECOMMENDATION

The Board is asked to:

- **SUPPORT** the proposals to extend our approach to delivery of our WFGA duties into 2018-19
- **NOTE** the UHB response to the WAO call for evidence as the first stage of its Year One Commentary

SITUATION

As a Health Board we are required to carry out sustainable development, in line with the duty placed on us through the Well-being of Future Generations (Wales) Act 2015. We also play a statutory partnership role in this regard, through Public Services Boards. Board members were introduced to the Act in

a development session in Autumn 2015. This paper focuses on our statutory role as an individual public body.

Management Executive approved a paper in late 2016 which proposed that the UHB's duty to set and publish well being objectives should be enacted through use of our *Shaping Our Future Wellbeing* strategy objectives for this purpose. This drew on the understanding that public bodies should not treat the requirement to set wellbeing objectives as separate from the objectives that guide and steer the actions and decisions of the organisation.

From workshops in 2016 involving a range of NHS Wales' leaders, organised by Directors of Planning, a set of documents (initially planned as Welsh Health Circulars but not formally published) outlined the combined thinking on how the WBFG Act could be taken forward in Health Boards, including that the application of WBFG Act translation through corporate plans related to application through Integrated Medium Term Plans.

As a UHB we therefore articulated the contribution that the UHB's objectives can make to the seven wellbeing goals in the narrative of the IMTP for 2017-18, drawing on a high level mapping exercise outlined to Management Executive. This constituted our organisational wellbeing statement.

Embedding WFGA thinking into our planning, decision making and delivery presents us with a huge opportunity to make a sustainable difference for the future of our population. This paper outlines further progress made to date and seeks approval for proposals to extend our approach to delivery of our duties into 2018-19 and beyond.

BACKGROUND

The well being duties on specified public bodies under the Well-being of Future Generations (Wales) Act 2015 commenced in April 2016, providing a legally binding common purpose - the 7 wellbeing goals for public sector organisations. These duties require gradual alignment of strategic objectives across the public sector in Wales towards the national wellbeing goals, through the application of the sustainable development principle or 'five ways of working': *long term, prevention, integration, involvement and collaboration*.

The duties require us to take all reasonable steps, in exercising our functions, to meet these objectives. We must articulate achievements annually in our annual report.

The Wales Audit Office (WAO) has a duty to carry out examinations of most public bodies to assess the extent to which they have acted in accordance with the sustainable development principle when setting and taking steps to meet wellbeing objectives. The WAO has issued a call for evidence, as the first stage of its Year One Commentary, to enable public bodies to provide views on, and experiences of, implementing the WFGA. We have prepared a draft response through our Board Secretary, attached with this paper. The deadline for responses is 25/08/17.

ASSESSMENT

Since publishing our IMTP annual plan we have made progress by further articulating what we are already doing in the UHB that contributes towards the sustainable principle, in preparing a more detailed mapping of the range of work we are already planning and starting to deliver, for example the sustainable travel plan and the REFIT strategic energy management programme. For several action areas we have framed them in line with the wellbeing goals and the five ways of working. These include the School Holiday Enrichment Programme 'Food and Fun'; Our Orchard, the Art Gallery and Outdoor Gym and UHW's Park and Ride service.

We have examined the learning from the Welsh Local Government Association (WLGA) Early Adopters programme with 11 Local Authorities (including both Cardiff and the Vale of Glamorgan) and the 3 national parks, which commenced in late 2013 and which enabled participating organisations to prepare and share best practice in advance of the start of the Act in April 2016. Such work included a range of different approaches including use of strategic organisational diagnostic tools to assess readiness, and embedding the principle into service redesign or business improvement planning. This work was supported with resource from the WLGA (supported by Welsh Government).

Through our UHB Wellbeing of Future Generations Steering group we have identified a series of actions which will strengthen, extend and embed our approach over forthcoming years, leading the way across Health Boards in Wales:

1. Complete a **leadership baseline assessment** of Board members and senior leaders in the organisation (using an assessment tool) to assess perceptions of our current position regarding strategic readiness to meet the requirements of the WFGA This will help us identify strategic priority and action areas requiring particular attention. We have adapted this tool from learning from local authority/national parks' Early Adopters work
2. We have agreement from the Chair that the **Vice Chair of the Board will act as champion for our WFGA work** – with the new Vice Chair and together with the Board Secretary, we will work through how we can best use this Board champion opportunity
3. **Raising awareness/harnessing enthusiasm in the organisation** – it is clear that the spirit, intention and focus of the WFGA has a way of capturing the interest and enthusiasm of staff, but most staff in the organisation are probably not yet aware of the WFGA. We plan to change that, as follows:
    a. Together with strategic planning, public health and communications, we have developed a **logo** for our WFGA work, incorporating both the 7 wellbeing goals and the 5 ways of working – see appendix 1

b. We will develop & implement a **communications plan** to get people involved – this will include the logo, a **UHB webpage** and a variety of communication mechanisms. The web page will showcase examples of actions staff are taking to embed the sustainability principle. A standard template has been developed to make it easy for staff to demonstrate the contribution their work is making
c. We will incorporate a WFGA award in the **Staff awards scheme**

4. Taking account of the national documents from 2016 workshops previously mentioned, we will **test an approach** to embedding the WFGA in the **corporate arena** of Workforce and Organisational Development, then use the learning to gradually **roll out the approach across corporate arenas** (the national workshops identified these as integrated planning; governance; business processes; risk management; asset management; performance; finance; procurement and workforce planning)

5. **Identifying key *sustainability principle* exemplars to showcase the work of the UHB** – we already have several exemplars which are embracing and working with the sustainability principle. We want to grow a range of examples that can not only identify with the approach but can develop and change in line with the whole ethos of the WFGA, and whose learning can influence the next generation of examples

Appendix 1 – UHB logo for Well-being of Future Generations work

9

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Date issued: 13 July 2017

Year One Commentary: Call for evidence

The call for evidence is the first stage of the Year One Commentary. Its purpose is to enable public bodies to provide views on, and experiences of, implementing the Well-being of Future Generations (Wales) Act 2015. Wales Audit Office will review the evidence provided and follow up with a small number of interviews, to be conducted at each body later in the year.

When answering the call for evidence questions, please aim to focus on the key issues you would like to bring to our attention. We do not expect extensive detail on all of the activity you have undertaken.

9

Name	
Title	
Organisation	Cardiff and Vale UHB
Date completed	Draft vs 2- 14August 2017

While we do not intend to publish individual responses from public bodies in their entirety, we will list the organisations who respond to this call for evidence unless you request anonymity. We may also quote from comments you make in an anonymised form. We would consult with you before making any reference to a named organisation.

We must, however, make you aware that responses may be subject to requests for information from third parties and, as public authorities, the Auditor General and the Wales Audit Office, must consider such requests in accordance with relevant access to information legislation, especially the Freedom of Information Act 2000 and the Data Protection Act 1998.

If you want information to be treated as confidential, please say so clearly in writing when you send in your response. It would help us if you could explain to us why you regard the information as confidential. If we receive a request for disclosure, we will take full account of your explanation but we can't give assurance that confidentiality will be maintained in every circumstance. An automatic confidentiality statement generated by your IT system will not, of itself, be regarded by us as a confidentiality request.

Questions

Question 1: The Well-being of Future Generations Act became law in 2015 and the main provisions, including the well-being duty, came into force from April 2016.

1a How would you describe the Act and what it means for your organisation? Please tick as many boxes as you consider relevant.

A	A distraction	The Act will not help us address the major challenges facing the organisation.	
		We will need to devote time and resources meaning there is a cost and an opportunity cost to the organisation.	
B	Unnecessary	The Act doesn't offer a new or useful way of viewing what we do or how we work.	
		Much of the Act is sensible and valuable but it legislates for things we were already seeking to do.	
		Much of the Act is sensible and valuable but it legislates for things we were already doing.	
C	Opportunity	The Act can help us address some of the major challenges facing our organisation.	Y
		The Act has the potential to improve our strategic planning and decision-making.	Y
		The Act has the potential to help us deliver more sustainable services and better outcomes for citizens.	Y
		The Act has the potential to drive positive change in culture and behaviour.	Y
D	Necessity	We need the Act to help us address some of the major challenges facing our organisation.	
		We need the Act to improve our strategic planning and decision-making.	
		We need the Act to help us deliver more sustainable services and better outcomes for citizens.	
		We need the Act to enable us to deliver the right culture and behaviours.	Y
E	None of the above		

1a Please provide any explanatory comments on the above.

Answer 1a
The UHB factored the draft Wellbeing of Future Generations Act provisions into the development of our ten year Shaping Our Future Wellbeing ('SOFW') Strategy (2015-2025) as a means of informing our future decision-making process. This has ensured that the Act is viewed by the organisation as an opportunity to make progress in some areas.

It is clear that the Act captures staff imagination with many innovative and forward-thinking projects being identified and progressed. The UHB is hoping to develop a staff recognition award to recognise and reward these ideas in an effort to shift behaviours and culture to become more forward-looking.

There are some major challenges that the UHB faces where the Act can help our thinking, decision making and planning, for example the development of the UHW site as a sustainable travel hub and making strategic decisions that are fit for the long term.

1b How would you **describe the change** you intend to make to deliver the Act? Please tick as many boxes as you consider relevant.

A	Compliance	We will ensure we meet key statutory requirements and that we can demonstrate we have done so.	Y
B	Realignment	We will ensure the changes we were/are planning to make are aligned to the Act.	Y
C	Adaptation	We will use the Act to help us reconsider how we work and what we are seeking to achieve.	Y
		We will use the Act as a means of helping us make progress in areas where we need to make improvements.	
D	Transformation	We will use the Act to help us address some of the major challenges facing our organisation.	Y
		We will use the Act to improve our strategic planning and decision-making.	Y
		We will use the Act to deliver more sustainable services and better outcomes for citizens.	Y
		We will use the Act as a means of driving culture and behaviour change.	Y
E	None of the above		

1b Please provide any explanatory comments on the above.

Answer 1b

There are huge benefits to using the lens of the Act to help redesign our services and our environments in a sustainable way. We recognise this will take some time but we intend to grow our approach across the organisation.

The UHB is developing an organisation-wide transformation programme that is aimed at delivering more sustainable services for our patients. The transformation programme is focusing on improving patient outcomes and delivering a cultural shift towards prevention and home first principles in line with the organisation's SOFW strategy.

Question 2a: Your organisation has set, or is in the process of setting, well-being objectives. How different was the process compared to the process for setting corporate objectives in the past?

A	The process was the same.	The process was the same as the process for setting corporate objectives in previous years in your organisation.	
B	We did some things differently.	We continued to build on improvements that we have been making in recent years, which already reflect the five ways of working.	
		We made some changes to better reflect the five ways of working.	Y
C	We did several things differently.	We made some notable improvements as a result of the Act, applying the five ways of working.	
D	We made significant changes.	We applied the five ways of working to a far greater degree as a result of the Act.	Y
		Having made significant changes, we feel the process for setting well-being objectives was much improved on the process for setting corporate objectives in previous years.	Y
E	None of the above		

Question 2b:

If you answered A or E, please explain why.

Not applicable.

If you answered B-D, please describe what was/is different about this process compared to the process for setting corporate objectives in the past and what impact it had. Please make reference to how you applied the five ways of working.

Answer 2b
As noted above, the UHB factored the draft Wellbeing of Future Generations Act provisions into the development of the SOFW Strategy as a means of informing our future decision-making process. As a result, the UHB was able to ensure that the corporate objectives are aligned to the principles of the Act. Our priorities and objectives were developed through a co-production process, working with more than 350 people from staff and clinical groups, local communities and the voluntary sector. The UHB used different mechanisms such as workshops and visual minutes to capture the thoughts and opinions of people. This helped us to establish our vision of the future and our strategic objectives.

9

Question 3: Other than applying the sustainable development principle when setting your well-being objectives, what other key actions have you taken to embed the sustainable development principle in how you work and what impact are they having? Please focus on the key actions you would like to bring to our attention.

Answer 3

We have established an internal steering group, chaired by the Deputy Director of Public Health / Director of Public Health in order to drive forward and embed the ways of working outlined in the Wellbeing of Future Generations Act. :

1.Leadership and Corporate Development:

- A Board Development session was held in October 2015 to outline the requirements of the Act and to begin highlighting how the organisation would need to work differently.
- The UHB has developed an online baseline assessment tool to understand the extent to which the UHB has progressed towards implementing a new way of working as envisaged by the Act. This survey has been circulated to members of the Board and senior leaders in the UHB for completion.
- The UHB has recently advertised the role of Vice Chair to include a provision that the appointed individual acts as a champion for the Act.

2. Strategic planning -

- Integrated Medium Term Plan (IMTP') – the provisions of the Act are outlined in the strategic context section of the IMTP and the wellbeing objectives are specified in the document.
- Inclusion of the Act into commissioning intentions
- Mapping of programmes and projects to wellbeing objectives
- The SOFW in the Community programme
- The UHB's Turning the Curve to Transformation programme
- Equalities and Health Impact Assessment (EHIA) template incorporating prompts regarding alignment to wellbeing goals.
- The UHB's Sustainable Travel Plan
- C&V Local Public Health Plan 2016/17-2018/19
- The UHB has also developed a whole system model that can be used to develop service specifications. The framework is based upon the patient or citizen's need and considers this in the following areas:-
    - Independence and wellbeing;
    - First point of contact – stable non-complex care;
    - Intensive and/or enhanced;
    - Long term stable – complex care; and
    - Specialist services.
    -

The framework is deliberately structured to provide a greater concentration of services targeted at independence and wellbeing. The model also recognises that a stepped approach might be required for some patients who may move up and down the steps.

9

3. Awareness raising

- The UHB has developed an awareness raising session that was trialled with the corporate Workforce and Organisational Development Team. This session included outlining the key provisions of the Act and identifying any areas of work or opportunity that the team might be aware of.
- A communications plan has been developed, incorporating the design of a logo to denote that a project has been developed and delivered in line with the sustainable development principle and the five ways of working.
- The Act has been incorporated into celebration events e.g. Public Health celebration day with the WFGA theme. In attendance at the celebration event were the HB's Chair, Vice Chair, Chief Executive, and the Chair, Public Health Wales.

4. Exemplars

- *Perfect Locality*
- *Wellbeing Project*
- *Our Orchard / Ein Berllan*
- *Wales for Africa Programme*
- *Sustainable Park and Ride service*
- *Food and Fun, School holiday enrichment programme(SHEP)*

5. Impact

- Heightened awareness of the Act throughout the organisation, including at UHB Board level'
- Strengthened partnership working with Public Health Wales
- Future service models will be designed around patients rather than organisational need
- The SHEP programme delivered 6,168 meals to children and their families/carers (additional metrics were collected and are available for review).
- The UHB recently completed a program of installing 45 Burner Management Units (BMU) to existing boilers which regulates and optimises the firing of the burner system. The average saving expected for each BMU is circa 8% - 16% however this will be dependent on operating conditions.

Question 4a: What are the key actions you intend to take to continue embedding the sustainable development principle in how you work? Please focus on the key actions you would like to bring to our attention.

Answer 4a details

1. Follow up Board Development session in 2018
2. Continued programme of awareness raising with other corporate functions and Clinical Boards
3. Explore opportunities to embed the 5 ways of working into corporate templates
4. The UHB is currently preparing to install a total of 4 no. solar panel schemes at UHW, UHL and Barry Hospital. This will complement the existing solar scheme the UHB operates at Hafan-y-Coed at UHL. The investment of £216k should release energy savings of £27.5k per year.
5. Growing the approach corporately
    - Appointment of a new Vice Chair as champion for the Act
    - Identification of recurring themes and actions from the online survey / baseline assessment of Board members and senior leaders in the organisation
    - Incorporation of a WFGA award into the annual Staff Recognition Awards, recognising and rewarding innovative projects that support our work to achieve our wellbeing objectives.

Question 4b: How will you know that you have embedded the sustainable development principle in how you work? Please describe this in terms of the impact you would expect to see.

Answer 4b details

- Examples of projects/programmes adopting 5 ways of working to be captured in template and shared across the organisation
- When the online survey / baseline assessment is re-run in a year's time, an upwards shift in the scores will indicate that the UHB is making progress.
- Completion of a programme of awareness raising with corporate functions and Clinical Boards with a number of projects identified through this work.
- Increasing number of exemplars developing their approach in line with the Act
- Inclusion of sustainable development principle in corporate templates
- Positive shift in SOFW indicator dashboard

Question 5: Are there any internal barriers to implementing the Act and embedding the sustainable development principle, and if so, what are they? Please make reference to the main internal barriers.

Answer 5 details
The stepped change required by the Act is focused on whole systems changes which can be difficult for large complex NHS Organisations to achieve in practice. The financial position of the organisation is often a barrier to progress as new ways of working often require 'pump priming' which is difficult to prioritise when facing such a significant financial deficit. The staff and teams are extremely busy delivering services and it is sometimes a challenge for them to think differently about how they might deliver services in line with the Act.

Question 6: Are there any external barriers to implementing the Act and embedding the sustainable development principle, and if so, what are they? Please make reference to the main external barriers.

Answer 6 details
There is a clear linkage between our Public Service Board ('PSB') partners' wellbeing objectives and plans and our internal planning and delivery in line with the Act. Partnership delivery, however, as we know faces multiple challenges: financial, governance, behavioural, cultural barriers and differing risk appetites. The relationship between the WFG Act and the Social Services and Wellbeing Act and the associated partnership arrangements and plans are still evolving. There are significant challenges to ensuring that we develop approaches which both meet the different statutory requirements and result in coherent plans that are sufficiently aligned, focused and provide clarity on responsibility for delivery.

Question 7: What external support would help you further embed the sustainable development principle?

Answer 7 details
The UHB would welcome support in the following areas:- • Direct support from the Sustainability Hub to NHS organisations • Organisational development through Team Wales for executives, NHS Confederation and Academi Wales for Independent Members (IMs), senior leaders and teams.

9

Question 8: Are there any examples of practice you would like to share with us that have not already been referenced? These could relate to service or project delivery or to governance and corporate processes. They could relate to your own organisation or to a collaborative project.

Please feel free to attach any relevant documents or case studies.

Answer 8

1. Our new UHB logo denoting that a project has been developed and delivered in line with the provisions of the Act
2. Online baseline assessment (using survey monkey) for Board members and senior leaders
3. Participation in the Vale PSB self-assessment framework pilot
4. Perfect locality specification
5. Coloured crockery for patients' meals, supporting healthy nutrition and addressing issues of waste
6. The combined Heat and Power plant at UHW – This plant at UHW is the largest of its size within the NHS in Wales. The plant generates circa 70% of the sites electricity and thermal requirement and results in energy savings of £500k to £800k per annum. The performance of the plant is monitored to ensure optimal financial and environmental performance and reduces the Health Boards annual Carbon emissions by 1500 – 2000 tonnes
7. Completed WFG templates

- Our Orchard / Ein Berllan – an initiative to create an Orchard at the University Hospital of Llandough to facilitate wellbeing for patients and staff.
- Wellbeing project – the UHB has become the first in Wales to achieve Bee Friendly status as a result of the development of the Bee Garden at Our Orchard / Ein Berllan
- Park and Ride service for University Hospital Wales (UHW)
- Wales for Africa Programme
- Food and Fun – School Holiday Enrichment Programme (SHEP) – this won an NHS Wales Award in 2016 and was described as "a brilliant example of the Well-being of Future Generations (Wales) Act in action"

Thank you for taking the time to complete this call for evidence.

Please send the completed questionnaire to wfg@audit.wales / Catryn.holzinger@audit.wales

C&V UHB documents for Document Review: - Stored in the Shared Drive

- *IMTP 17/18 and Summary Document*
- *Shaping Our Future Wellbeing Strategy*
- *SOFW in the Community/Perfect Locality Engagement Plan*
- *Board Development session resources*

- *Management Executive paper Dec 2016 proposing adoption of UHB strategic objectives as WB objectives, with mapping to WG goals*
- *WFG template and logo*
- *Equality and Health Impact Assessment (EHIA) template*
- *Completed WFG templates e.g. Our Orchard / Ein Berllan, Sustainable Travel Plan, Perfect Locality, Wales for Africa Programme, Wellbeing Project*
- *Mapping of UHB programmes of work to WB objectives*
- *Vale PSB self-assessment form for UHB*
- *Local Public Health Plan*
- *Notes of the internal WFGA Steering Group*
- The Self-Assessment Tool for members of the Board and senior leaders in the UHB

2018-21 INTEGRATED MEDIUM TERM PLAN DEVELOPMENT	
Name of Meeting : Board	**Date of Meeting :** 28th September 2017

Executive Lead : Director of Public Health & Director of Planning
Author : Head of Commissioning & Deputy Director of Planning
Caring for People, Keeping People Well : Commissioning Intentions outline the UHB's intended service performance and patients outcome expectations for the resources it commits on behalf of the population. The Integrated Medium Term Plan describes the next 3 years of implementing the UHB Shaping Our Future Wellbeing Strategy, delivering the UHB strategic objectives; for our population, our service priorities, our sustainability and our culture
Financial impact : Financial consequences arising from the Plan are set out at key milestones throughout its development
Quality, Safety, Patient Experience impact: The Plan supports the delivery of improved quality, safety and patient experience.
Health and Care Standard Number: The Plan supports the delivery of all Health and Care Standards
CRAF Reference Number: The Corporate Risk Register informs the development of the Plan with risks identified within Clinical Board and Corporate Department Plans feeding back through
Equality and Health Impact Assessment Completed: EHIAs are produced as each Clinical Board develops their plans

10

ASSURANCE AND RECOMMENDATION

ASSURANCE on the development of the UHB 2018-21 Integrated Medium Term Plan is provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process and planning liaison meeting
- Compliance with the NHS Wales Planning Framework timeframes and requirements (updated 2018/19 Framework is not due to be published until October 2017)
- Regular review by the Strategy and Engagement Committee

The Board is asked to:

- **APPROVE –** 2018-2021 Cardiff and Vale UHB Commissioning Intentions (Appendix 2)

SITUATION

The UHB is required to produce annually refreshed commissioning intentions that describe the UHB's approach to commissioning services on behalf of the population in alignment with national and local priorities in order to ensure that we are delivering outcomes that matter to

our population. These highlight the specific health needs of our population, and are supported by the needs profiles for our three localities. The UHB's commissioning intentions are underpinned by the priorities identified in the corporate strategy and the 10 year future view described in 'Shaping our Future Wellbeing'

As the main provider organisation of the service commissioned by the UHB, the UHB's Integrated Medium Term Plan (IMTP) is essentially the corresponding provider document that details the delivery plan in response to the UHB's, and others', commissioning intentions.

BACKGROUND

The UHB has a statutory duty to operate within the bounds of a Welsh Government approved IMTP. Reviewed annually, the NHS Wales Planning Framework sets out the core content expected within the UHB's IMTP. In responding to the NHS Wales Planning Framework, the UHB annually reviews and refreshes its IMTP to update and add further detail to plans. The process by which this is undertaken is also reviewed and refined annually in order for the UHB to learn from and build on previous experience. The IMTP is the key planning document for the organisation and sets out the milestones and actions we are taking, and the expected outcomes, in order to progress implementation of Shaping Our Future Wellbeing, our ten year strategy.

The commissioning intentions document, developed to inform the IMTP, has been reviewed and refreshed to ensure appropriate line of sight to our strategy whilst sharpening the focus on the requirement for accelerating service transformation to achieve organisational and service sustainability.

A corresponding "key deliverables" document describes the UHB's medium-term planning principles and assumptions and focuses on the key delivery priorities against which the UHB will be held to account. The document provides focus and clarity to enable the Clinical Boards to produce their own 3 year service, workforce and financial plans that will support the UHB's corporate IMTP.

ASSESSMENT

The commissioning intentions and suggested key priorities for delivery present a significant organisational challenge. There is a requirement to maintain performance and improve financial stability whilst meeting the demand from an increasing population and addressing existing and foreseeable critical service, facilities and IT infrastructure sustainability challenges.

In line with the Board approved timetable for the development of the IMTP(appendix 1), and guided by the Management Executive, the draft commissioning intentions and key priorities for delivery have been reviewed by the assistant directors' group – Strategy Development and Delivery Group (SDDG), with input from the Clinical Boards. The Strategy and Engagement Committee recommended the Commissioning Intentions for approval to the Board on the 5th September.

APPENDIX 1 - TIMETABLE FOR DEVELOPMENT AND APPROVAL OF IMTP

Forum / Group	Date	Purpose	Product
UHB Board Development	31st August 2017	• Presentation to review 1st Draft Commissioning Intentions	• Updated Draft Commissioning Intentions • IMTP Deliverables
Strategy and Engagement Committee	5th September 2017	• Presentation to review Commissioning Intentions & IMTP Deliverables	• Final Draft Commissioning Intentions including 2018-21 IMTP Deliverables
Senior Clinical / Service Board and Corporate	14th Sept 2017	• Dedicated workshop session to review / discuss IMTP delivery expectations and objectives	• Understanding of cross cutting priorities & CB IMTP requirements
UHB Board	28th Sept 2017	• Formal approval of 2018/19 process, commissioning intentions and presentation of high level delivery expectations	• Final Commissioning Intentions • Final IMTP Deliverables
UHB wide	29th Sept 2017	• Issued subject to formal Board approval Commissioning Intentions including 2018/19 IMTP Deliverables	Issued (subject to Board approval) • Commissioning Intentions including 2018-21 IMTP Deliverables
Clinical / Service Boards	9th Nov 2017	• Final submission date for Business Cases • Submission of 1st Draft Clinical / Service Board narrative, summary dashboard and Planned Care Schemes and PODs inc financial plan	• Draft Narrative • Draft Summary Dashboard • Draft PODs • Draft Planned Care Templates • Draft Financial Templates • Any previously approved Business Cases
IMTP Chapter Leads	24th Nov 2017	• Submission of Draft UHB IMTP Corporate Sections to enable the creation of a single document	• Draft UHB IMTP Corporate Sections

10

Forum / Group	Date	Purpose	Product
UHB Board Development	7th Dec 2017	• Presentation to Board on the draft financial framework and high level IMTP themes	• Draft Financial Framework approved for wider circulation
Mgt Exec	11th Dec 2017	• Prioritisation of Business Cases and PODs • Sign off of Planned Care Schemes	• Business Cases approved for implementation on 1st April 2018
Clinical / Service Boards Performance Reviews	17th & 18th Jan 2018	• Clinical / Service Boards present their Plans for draft approval	• Final Draft Clinical / Service Board Plans
HSMB	18th Jan 2018	• Noting of 2018-21 Draft IMTP	• Final Draft 2018-21 IMTP
UHB Board	25th Jan 2018	• Formal approval of 2018-21 Draft IMTP	• Final Draft 2018-21 IMTP
Mgt Exec	February	• Receive and review WG comments on draft	• Revised IMTP reflecting WG comments
Clinical / Service Boards	TBC February / March	• Engagement session with IMs, CHC, LPF, SRG HCPF	• Engagement on Clinical / Service Board Plans
Clinical / Service Boards IMTP Approval Session	March	• Formal approval of Clinical / Service Board 2018-21 IMTPs	• Final Clinical / Service Board 2018-21 IMTPs
UHB Board	29th Mar 2018	• Formal approval of 2018-21 IMTP	• Final 2018-21 IMTP

Further engagement will be untaken with the CHC and through the UHB's Local Partnership Forum and the Stakeholder Reference Group**.** Throughout the process there will ongoing discussions with WG officials and the Chair will keep the Cabinet Secretary briefed on progress.

Cardiff and Vale University Health Board

Commissioning Intentions

2018-2021

Final v2.0

10

CARING FOR PEOPLE
KEEPING PEOPLE WELL

CONTENTS

1. INTRODUCTION 3
2. NATIONAL CONTEXT 3
3. LEGISLATIVE CONTEXT 5
A. SOCIAL SERVICES AND WELLBEING ACT 5
B. WELLBEING OF FUTURE GENERATIONS ACT 5
C. WELSH LANGUAGE STANDARDS 5
4. LOCAL CONTEXT 6
5. RECENT ACHIEVEMENTS 8
6. QUALITY AND PATIENT EXPERIENCE 9
7. EQUALITY AND DIVERSITY 10
8. FINANCIAL PLANNING ASSUMPTIONS 10
9. TARGET PLANNING 11
10. PRUDENT HEALTHCARE PRINCIPLES 11
11. THE INTEGRATED CARE FUND 11
12. WELSH GOVERNMENT PRIMARY CARE INVESTMENT 12
13. WORKING WITH OTHER COMMISSIONERS AND SPECIALISED COMMISSIONING 12
14. REFERENCE SOURCES 12
APPENDIX 1 – DETAILED COMMISSIONING INTENTIONS FOR 2017-20 13
IMMEDIATE PRIORITY 13
APPENDIX 2 – DETAILED COMMISSIONING INTENTIONS FOR 2017-20 21
MEDIUM-TERM PRIORITY 21
APPENDIX 3 – DETAILED COMMISSIONING INTENTIONS FOR 2017-20 30
LONGER-TERM PRIORITIES 30
APPENDIX 4 – WHSSC DRAFT COMMISSIONING INTENTIONS 2018-21 35

10

1. Introduction

This document sets out the high level commissioning intentions of Cardiff and Vale University Health Board for 2018-21. This is a generic document which gives a broad overview of our commissioning intentions, for internal provision and across other providers.

The Cardiff and Vale population is 496,000 and the current financial allocation is £1,220.5m. Over the next 3 years, in order to achieve financial balance, Cardiff and Vale UHB needs to realise in the region of £40m recurrent cost reduction.

It is informed by the Primary Care cluster plans in conjunction with the Cardiff and Vale of Glamorgan population needs assessments and the Wellbeing assessments of the two local authority areas to ensure we are delivering outcomes that matter to our population. These highlight the specific health needs of our population, and are supported by the needs profiles for our three localities.

These commissioning intentions build on the priorities identified in the corporate strategy and the 10 year future view described in 'Shaping our Future Wellbeing'

2. National Context

The All Wales Planning Guidance will be issued in October and it is anticipated it will build on the priorities set out in last year's guidance. In 2018/19 the UHB will continue to respond to nationally identified principles including, but not limited to:

10

a) Planning to improve population health outcomes
   - improving the health and wellbeing of our populations
   - reducing health inequalities

b) Planning and service delivery that are patient-focused
   - listening to and acting on what our patients and communities are telling us
   - integrating services across the health and social care sector to facilitate continuity of care
   - supporting greater health self-management and earlier prevention, treatment and reablement.

c) Planning for quality services
   - ensuring clinical practice and models of service delivery are consistent with best practice and in pursuit of recognised standards
   - ensuring a systematic approach to realising quality and efficiency benefits of new technologies
   - ensuring services, wherever possible, are based on strong qualitative and quantitative evidence.

d) Planning for sustainable services
   - developing, linking and delivering services in a way that is sustainable from a clinical perspective
   - ensuring workforce models are sustainable
   - making efficient and effective use of resources.

e) Planning for safe & accessible services
   - delivering services as close to a patient's home as possible, while preserving the safety, quality and sustainability of health services
   - recognising that different services will be provided at locality, Health Board, regional and national levels to preserve the safety, quality and sustainability of health services.

f) Planning for needs of specific groups
   - considering cultural diversity in communities and the health needs of specific groups
   - reflecting the particular challenges faced in urban and rural communities, including deprivation
   - considering the Welsh language
   - reflecting the different needs of patients along the life course

g) Implementing legislative changes
   - implementing the Wellbeing of Future Generations Act
   - implementing the Social Services and Wellbeing Act, including the requirement for pooled budgets for older persons care accommodation by April 2018

The UHB anticipates that its formal commissioning roles and responsibilities from other providers will continue to include:

1. Specialised Commissioning as a member of WHSSC
2. Specialist CAMHS from Cwm Taf
3. Adult learning disabilities from ABMU
4. Long Term Agreements: Provision of care for Cardiff and Vale patients in neighbouring health boards (Abertawe Bro Morgannwg, Cwm Taf, Aneurin Bevan) and specialist cancer services from Velindre.
5. Reciprocal arrangements for service provision with Cwm Taf and other neighbouring health boards.
6. Collaborative commissioning of WAST
7. Collaborative commissioning of low and medium secure and residential placements for adults with mental health and learning disabilities needs
8. 3rd and independent sector contracts to support prevention and service delivery

9. Integrated commissioning with the local authorities under pooled budgeting arrangements.

As an integrated health board Cardiff and Value UHB expects to provide the majority of care for its residents.

3. Legislative Context

a. Social Services and Wellbeing Act

We are pursuing further integration with our local authority partners. Key priority areas for extending joint working and integration include:

- Older people with complex needs and long term conditions, including dementia;
- People with learning disabilities;
- Carers, including young carers;
- Integrated Family Support Services;
- Children with complex needs due to disability or illness;
- Establishment of pooled funds in relation to family support functions from 2016 and care home accommodation by 2018.

b. Wellbeing of Future Generations Act

We will work to achieve the Wellbeing Goals as we develop, redesign, deliver and commission services. Cardiff and Vale will consider the sustainable development principle when providing and commissioning services. We will:

- Long Term – Balance short-term needs with the need to safeguard the ability to meet long-term needs.
- Prevention – Act to prevent problems occurring or worsening
- Integration – Consider the impact of our own wellbeing goals on other goals and objectives, or on the objectives of other public bodies and partners
- Collaboration – Act in collaboration with patients, carers and partners to meet our wellbeing objectives.
- Involvement – Involve others in the achievement of our wellbeing goals and ensure that the diversity of the population is reflected.

c. Welsh Language Standards

We will consider the Welsh Language Standards when providing and Commissioning Services.

4. Local Context

Locally our priority is to start to deliver the Shaping our Future Wellbeing strategy via the 3 year Integrated Medium Term Plan and to ensure that the local health system continues to provide high quality and responsive services that are sustainable.

The strategic objectives will continue to form the basis of our work programme for 2018-19 – 2020/21.

a) For our population – we will:
   i. Reduce health inequalities
   ii. Deliver outcomes that matter to people
   iii. All take responsibility for improving our health and wellbeing
b) Our service priorities – we will:
   iv. Offer services that deliver the population health our citizens are entitled to expect
   v. Deliver care closer to home where reasonable and practical
c) Sustainability – we will:
   vi. Have an unplanned (emergency) care system that provides the right care, in the right place, first time
   vii. Have a planned care system where demand and capacity are in balance
   viii. Reduce harm, waste and variation sustainably making best use of the resources available to us
d) Culture – we will
   ix. Be a great place to work and learn
   x. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology
   xi. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives

These will be underpinned by our organisational values: care; trust; respect; personal responsibility; integrity; kindness.

During 2017/18 we have introduced our **Turning the Curve to Transformation Programme** and these are designed to deliver against our strategic objectives and to balance increased levels of activity and reducing resources. We aim to address issues of harm waste and variation and develop new models of care on a system-wide basis to respond to this challenge and to deliver sustainable services. Clinical /Service Boards and Corporate Departments will be expected to contribute to transformation over and above CRP savings.

We have adopted a set of **Transformation Principles** to govern this work.

Turning the Curve to Transformation will:

- Not compromise patient safety
- Deliver financial benefits
- Have clear measurable outcomes
- Clearly articulate expectations of staff
- Focus upon cultural and behavioural change

Turning the Curve to Transformation is reliant upon:

- Clinical leadership
- Creating capacity in Clinical Boards
- Using the skills and experience of our own staff

Turning the Curve to Transformation will have:

- Robust governance
- Clear communication and engagement
- A programme and project management approach

The transformation programme is split into three areas:

Locality Working

- Increase number of people choosing healthy behaviours
- Sustain General Practice and Primary ad Community Care
- Increase the number and capacity of services meeting stable (low or high) health need in the community

Planned Care

- Reduce number pf people invited to hospital-based outpatient appointments
- Optimising planned care pathways (including theatres)
- Reduce elective length of stay

Unscheduled Care

- Reduce number of people attending EU
- Achieve national emergency care targets
- Reduce emergency length of stay

5. Recent Achievements

- Cardiff and Vale UHB has consistently improved its referral to treatment time for 10 consecutive quarters, seeing a 52% reduction on 36 week waits over the last 30 months.
- The UHB has treated 167 more patients with cancer and seen a 14% improvement in cancer results for urgent suspected cancer.
- The use of off-contract nursing agency has reduced from approximately 490 to zero.
- The UHB regularly treats 350-450 patients in the Emergency Unit.
- The All-Wales Medical Genetics service developed one of the first non-invasive diagnostic services for the testing of non-small cell lung cancer patients in the UK.
- The corporate values were revised and these have been translated into behaviours.
- Community Resource Teams supported 457 patients over weekends after extending the service to 7 days.
- The Emergency Unit has reduced the time that frequent attenders spend in the unit by 91% with an associated 95% cost saving.
- The Mental Health REACT service (Response Enhanced Assessment Crisis and Treatment) received 1057 referrals which saved £5.9m in admission avoidance
- The new Front Door Crisis Occupational Therapy Team practices a culture of home first and screened 3034 vulnerable older patients.
- There has been a pilot in East Cardiff to provide healthcare and support closer to home for patients with long term lung conditions
- The uptake of the seasonal flue3 vaccination exceeded 50% for the first time.
- Dr Sunil Dolwani performed a live colonoscopy on Channel 4
- The UHB was the first in the UK to meet the Visibly Better Standard in radiology.
- Audiology and Ear, Nose and Throat clinics were transferred into the community
- A new Medical Ambulatory Care Unit was opened
- The UHB's Slippers for Christmas campaign reached 100, 00o people on social media
- The newly refurbished restaurant Y Gegin was opened on the UHW site
- A therapy garden was opened at the Noah's Ark Children's Hospital for Wales
- The UHB held a Research, Development and Innovation Conference showcasing world-class excellence.
- 3D multi-view anatomy software for teaching was trialed with Panasonic
- New park and ride service for patients and staff was implemented
- The UHB celebrated 45 years at the University Hospital of Wales
- The first patients used a new scanner at UHL
- We welcomed 5948 babies

10

- The UHB managed one of the biggest sporting events in the world, the UEFA Champions League final and messages about the use of services reached over £1m people on social media
- The UHB filmed The Greatest Gift with the BBC to highlight the impact of presumed consent on organ donation
- Highlighted the issues that cause pressures on A&E as part of a mannequin challenge with the BBC

6. Quality and Patient Experience

The UHB has developed a Patient Quality, Safety and Improvement (QSI) Framework for 2017-2020, which sets out how the UHB will endeavour to ensure that high quality, safe care is always provided and that people experience better care from the services they receive. This is supported by the Patient Experience Framework which will aim to ensure that we hear and actively listen to the voices of our service users and can demonstrate our response to their feedback.

The UHB wishes to ensure the provision of equitable services across Cardiff and the Vale which meet the needs of the population. The challenge is to ensure that its residents have equitable access to health care which is effective and of a proven quality. The UHB must ensure that patients and their carers are involved in decisions about their own health and have the information available to enable them, to make an informed choice.

An increasing number of the services provided to the population of Cardiff and Vale are delivered in partnership with the Local Authorities and third sector organisations. It is important therefore that the planning of services involves a multi-agency approach and also involves patients, service users and carers to plan services in a way that reflects the needs to the local population. As an integrated healthcare provider, our focus on quality, safety and the patient experience must extend across all settings where healthcare is provided. We cannot focus on secondary care, recognising 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.

The UHB reviews clinical quality and outcomes on a regular basis via the Quality, Safety and Experience Committee and via monthly Professional Performance Reviews and Executive Clinical Board performance reviews. Each Clinical Board has well embedded QSE groups, responsible for monitoring the quality and safety of

services and for considering the experiences of patients accessing their services. Indicators that are assessed include patient safety issues; complaints; serious/ untoward incidents; indicators of quality improvement and service quality such as patient falls; incidence of pressure damage; infection prevention and control incidents. The health board aims for early identification of failing services and specialities and mechanisms for early identification of issues, for escalation via the governance structures to the Board.

The UHB will adhere to the NHS Wales Health and Care Standards and produce an Annual Quality Statement to report progress against the QSI and Patient Experience Frameworks.

The UHB board is committed to leading and delivering the quality and patient safety agenda. Improving patient safety requires the cooperation of primary, community, secondary and tertiary care in partnership with other organisations and with the public.

There is a need to foster trust and a willingness to share good practice, lessons learned from adverse experience, knowledge and skills.

7. Equality and Diversity

Cardiff and Vale University Health Board will support the elimination of all forms of unjustifiable discrimination from all UHB functions and policies and the creation of an environment where diversity is valued, respect for personal dignity and recognition of human rights by and for all employees, patients and the public.

We will undertake Equality and Health Impact Assessments for all service developments and changes and associated policies and procedures.

8. Financial Planning Assumptions

- National guidance will be followed.
- Demographic growth impacts will be modelled using ONS population projection
    - Demand for services other than universal services may not directly correlate to increased population
    - Mapping should include the impact of future population growth and apply these to the impacts of service planning

Savings plans and investments will be agreed and applied on an individual Clinical Board basis, in line with the overall strategic framework of Shaping Our Future Wellbeing and taking into account impacts across the UHB. Priority will be given to any nationally

mandated or legislated investments, after which business cases will need to be made for proposals which demonstrably improve quality, outcomes or value for money and are aligned with our strategic objectives.

The current financial planning assumption is that there will be a 2% uplift and all clinical boards will be required to recover brought forward deficits and make additional 2% savings, there may be some variation to this when final assignments are determined.

The UHB is working to enable fair share population-based resource allocation and full cost recovery of our provider functions.

9. Target Planning

The UHB will work on the improvement trajectories for achieving Welsh Government targets and will ensure that no more patients are waiting more than 36 weeks for treatment than at the end of 2016/17 and that any improvements made in 2017/18 will be maintained and improved.

10. Prudent Healthcare Principles

Cardiff and Vale UHB is committed to operating in the spirit of prudent healthcare principles which are:

- achieve health and wellbeing with the public, patients and professionals as equal partners through co-production
- care for those with the greatest health need first, making the most effective use of all skills and resources
- do only what is needed, no more, no less; and do no harm
- reduce inappropriate variation using evidence based practices consistently and transparently.

11. The Integrated Care Fund

The Integrated Care Fund (ICF) continues to support transformation initiatives in relation to supporting older people to maintain their independence and remain at home, avoiding unnecessary hospital admissions, or inappropriate admission to residential care, as well as preventing delayed discharges from hospital. However, the funding will also be used to develop integrated care and support services for other groups of people, specifically people with learning disabilities and autism, and children with complex needs. The budget for 2017/18 is £6,272,000 revenue and £1,291,000 capital.

The initiatives for 2017/18 include:

- Preventative Interventions

- First Point of Contact / Single Point of Access
- Accommodation Solutions
- Extended Community Reablement
- Integrated Discharge Service
- Integrated Services for People with Learning Disabilities and Children with Complex Needs (Disability Futures Programme)
- Integrated Autism Service
- WCCIS
- Capital developments

12. Welsh Government Primary Care Investment

The Primary Care Investment continues to support schemes that support the health board's aims to deliver care closer to home and these will be built upon into 2018/19. The allocation for 2017/18 is £4.2m, however future funding is dependent upon delivery and funding may be reallocated based on performance outcomes.

13. Working with other Commissioners and Specialised Commissioning

The UHB is working with other Health Boards collectively and collaboratively to coordinate commissioning and deliver outcomes that matter to people in line with the Shaping Our Future Wellbeing 10 year strategy.

- *Specialist* – WHSSC
- *Collective Commissioning* – CAMHS/LD/Velindre/Regional Services
- *Collaborative Commissioning* – Ambulance/specialist mental health and learning disabilities nursing home beds
- *Long Term Agreements* – Contractual agreements with neighbouring health boards for provision of services to Cardiff and Vale patients.
- *Reciprocal Arrangements* - Development of cost neutral reciprocal arrangements for service provision with Cwm Taf and other neighbouring health boards.

14. Reference sources

These commissioning intentions have been informed by:

- The Partnership Needs Assessments of the two local authority areas
- Primary Care Cluster Plans
- NHS Outcomes Framework
- National Service Delivery Plans
- Local strategy
- National guidance and legislation

Appendix 1 – Detailed Commissioning Intentions for 2017-20

Immediate Priority

Deliver Outcomes that Matter to People: • **Reduce health inequalities** • **Deliver outcomes that matter to people** • **All take responsibility for improving our health and wellbeing**	
Description	Health Board Area Impacted
1. **Health Improvement - The UHB will continue to:** a. Offering staff support to have and maintain a healthy weight b. Supporting and improving the mental health of staff c. Improving the physical activity environment of the organisation	Public Health All Clinical Boards and providers
2. **Reduce Health Inequalities** a. Deliver against the Strategic Equality Plan b. Embed and deliver against Primary Care Cluster plans c. Improve access to NHS dentists	Public Health All Clinical Boards and providers
Prevention 3. **Immunisation** a. Increase uptake of seasonal flu vaccine in staff and 'at risk' groups. All Clinical Boards to exceed 60% uptake by frontline staff. 4. **Tobacco** a. Increase the number of primary care and community staff trained in undertaking brief intervention techniques and brief advice such as 'Making Every Contact Count' 5. **Alcohol** a. Work with secondary care, voluntary and third sector organisations, and community health services to reduce alcohol related admissions including an increased focus on working with primary and community health to manage alcohol use in chronic illness. 6. **Obesity** a. Implement a childhood level 2 & 3 obesity service b. Optimise the adult Level 3 obesity services to reduce waiting time	PCIC Children & Women Medicine Public Health Local Authorities All other clinical boards and providers
7. **Learning disabilities** a. Develop and implement revised transition arrangements for young people moving into adulthood.	Women's and Children's PCIC ABMU Cardiff Council Vale of Glamorgan Council

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8. **Ensure compliance with the Welsh Language Act** a. Embed a systematic approach to Welsh language services as an integral element of service planning and delivery b. Increase the capability of the workforce to provide Welsh language services in priority areas	All clinical boards, divisions, providers and Local Authorities
9. **Improve identification and support for Carers, in line with the Social Services and Wellbeing Act.** a. Provide accurate, appropriate and up to date information to carers b. Consult carers in a timely way and respect their knowledge of the cared for person	All clinical boards, divisions, providers and Local Authorities

Service Priorities • Offer services that deliver the population health our citizens are entitled to expect	
Description	Health Board Area Impacted
1. **Cancer** a. **Develop shared care and primary care support arrangements for cancer patients. Increasing focus on:** i. Early diagnosis, including advice and guidance for GPs ii. Cancer survivorship, support after treatment and long term follow up arrangements iii. Acute oncology admissions	Medicine Surgery Specialist Dental PCIC CD&T Velindre
2. **Stroke** a. Improve outcomes of stroke patients, by reducing the levels of death and disability following a stroke b. Reduce length of stay of stroke patients in bed-based services.	PCIC Medicine CD&T
Long Term Conditions 3. **Supporting self-care/management in relation to long term conditions where there is evidence of effective self-care approaches e.g. diabetes, cardiovascular disease and MSK. A number of approaches will be developed:** a. Inclusion of self-care/management activities as appropriate, specifically diabetes and other long term conditions, frail elderly, MSK b. Promotion of and embed self-care approaches within encounters between providers and patients/clients c. Inclusion of delivery of public health and self-care activity in staff job descriptions d. Inclusion of public health and self-care activity in staff appraisals 4. **Diabetes** a. Strengthen ThinkGlucose and extend to cover UHL b. Strengthen the system of diabetes education and support/self care	All Clinical Boards and providers

c. Implement diabetes care bundle/indicator monitoring set	
Dementia **5. Development of integrated pathways** a. Implement dementia care bundle in hospital and community settings b. Develop integrated hospital and community pathways to ensure patients with dementia are on the correct care pathway and to facilitate timely discharge	PCIC Medicine Mental Health CD&T
Mental Health (all ages) 6. **Develop and implement system wide operational resilience plans with capacity and management systems supporting flow across the whole of the urgent care system.** a. Ensure new mental health liaison investment into Mental Health Services Older Persons liaison service is implemented according to the multi-disciplinary team RAID model to reduce average length of stay and increase admission avoidance and flow in general hospital care for patients with cognitive impairment. 7. **Child and Adolescent Mental Health Services** a. Embed neurodevelopment services within Community Child Health and develop integrated pathways with CAMHS	Mental Health PCIC Women's and Children's Local Authorities Cwm Taf (CAMHS) Commissioning CD&T
8. **Early Years and Maternal Health** a. Implement the obesity pathway for pregnant women b. Increase uptake of childhood immunisations c. Improve smoking cessation rates in maternity	Women's and Children's PCIC Public Health
9. **'Home First'.** a. Managing Ambulatory Care Sensitive Conditions to reduce bed days, specifically pathways around: Atrial Fibrillation; Chronic Heart Failure; Chronic Obstructive Pulmonary Disease as part of the All Wales Pacesetters programme b. Move early stages of pathways into primary and community care, specifically: Diabetes; Gastroenterology; Dermatology; Urology c. Develop model for 'discharge to assess' in the community	PCIC; Medicine; Specialist CD&T
10. **Delivery** a. Deliver improvement plans against the national waiting time standards	All Clinical Boards and providers

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Sustainability • **Have an unplanned (emergency) care system that provides the right care, in the right place, first time** • **Have a planned care system where demand and capacity are in balance** • **Reduce harm, waste and variation sustainably making best use of the resources available to us**	
Description	Health Board Area Impacted
Planned Care 1. All Clinical Boards and Corporate Departments to identify one or more priority projects for implementation during 2018-19 which demonstrate the ways of working, and contribute to the goals identified, under the Wellbeing of Future Generations legislation 2. **Frail Elderly:** a. Increase integration of health and social care and consider whole systems partnerships, agreeing and implementing pooled budgets for residential care for older people b. Sustain the reduction in the number of admissions from nursing homes and further reduce length of stay following admissions from a nursing home c. Work with our partners to publish an Market position statement and integrated commissioning strategy for care and support services for Older People 3. Transform outpatient services, moving 30% of appointments away from acute hospital sites 4. Reduce DNA rates 5. Reduce percentage of patients with more than 1 cancelled procedure and increase number of new dates offered within 14 days	PCIC Medicine Specialist Surgery CD&T
Unplanned Care a. Develop ambulatory emergency care model 6. **Highly responsive urgent care services outside hospitals** a. GPs and primary care b. Community services e.g. MH and community nurses 7. **Admission avoidance (e.g. Support to residential homes)** a. Decrease emergency readmissions in the 30 days following discharge 8. **Develop urgent and emergency care networks** a. Develop broader emergency care networks that connect all urgent and emergency care services together 9. **Stroke services (See service priorities section)**	PCIC Medicine WAST/EASC Dental Mental Health Women's and Children's Cwm Taf (CAMHS) ABMU (LD) CD&T
10. **Accessibility of Primary Care** a. Address GP sustainability issues both in and out of hours	PCIC CD&T Medicine

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b. Increase number of dentists and optometrists with extended hours c. Improve performance of OOH service d. Improve availability of GP referred direct access to diagnostics over increased hours	
11. Increase Locality Working a. Develop pathway and service plans for the operation of integrated community health and wellbeing centres **b.** Improve integrated community working with primary, community care and partnership working	All Clinical Boards Cardiff Council Vale of Glamorgan Council Partners
12. **End of Life care** a. Ensure all end of life patients have advanced care plans in place and do not attempt CPR (DNACPR) orders in place	All Clinical Boards
10. Patient Quality, Safety and Experience **a. Support delivery of the Quality, Safety and Improvement Framework 2017-2020, with specific focus on:** a. Improving compliance with the investigation and timely closure of Serious Incidents and Never Events, within prescribed WG timescales b. Reduction in the number of falls that cause serious harm to patients c. Full implementation of the revised Sepsis pathway d. Reduction in the rates of healthcare acquired infections in line with WG targets e. Reduction in the numbers of healthcare acquired pressure ulcers f. Development of an annual risk based local clinical audit plan g. Demonstrate improvement in all of the Health and Care Standards h. Work towards full compliance with all NPSA alerts and NHS Wales Patient Safety Solutions – specifically SPN 24 –Standardising wristbands **b.**	All Clinical Boards and providers Corporate nursing team
Finance **11. Ensure that Long Term agreements are appropriate** a. Ensure that new developments are not subsumed into existing LTAs **12. Allocation expectations** a. Plan for a 2% uplift, recovery of brought forward deficits and make 3% savings. **13. Continuing healthcare and funded nursing care**	All Clinical Boards and providers

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a. Introduce new nursing homes framework b. Restructure FNC and reflect recommendations from the high court ruling	
Estates 11. **Deliver against estates plans:** a. Develop estates plans to support the delivery of the South East Wales Regional Planning Forum i. NICU development ii. Obstetrics expansion iii. Develop strategic service and capital blueprint for integrated community health and wellbeing centres and wider integrated community infrastructure	Planning Mental Health Public Health Nursing PCIC Women's and Children's
Regional Planning 12. **Deliver Cardiff and Vale elements of South Wales Programme** i.e. Deliver the changes to service configuration to implement the enhanced neonatal network capacity and support the changes to obstetrics and paediatric flows arising from changes to inpatient service provision at Royal Glamorgan Hospital 13. Develop and implement the recommendations of the regional projects to improve the collaborative provision of: a. Orthopaedics b. Ophthalmology c. Diagnostics **d.** Other collaborative service improvements that are agreed through the Regional Planning Forum	All Clinical Boards

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Culture • **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**	
Description	Health Board Area Impacted
1. **Great place to work and learn** a. Reduce sickness levels to below 4.2%, improve staff wellbeing, and embed absence management b. Embed workforce development and implementation plans to support the WOD strategy: Engaged, sustainable, efficient, transforming, capable c. Improve workforce efficiency – ensure an affordable workforce plan is in place which is aligned to service and financial requirements. Make in-year improvements and the necessary recurrent workforce savings.	All Clinical Boards and Divisions Partners

d. Increase sustainability of the workforce – ensure right people in right roles, in right place at the right time e. Ensure all staff have an up to date Performance Appraisal and Development Review to improve performance and accountability f. Within PADR, ensure all staff have completed the Statutory and Mandatory Training Core Modules g. Develop and maintain systems for clinical revalidation	
2. **Working better with partners** a. Improve interoperability between Clinical Boards, Local Authorities, 3rd/independent sector providers i. Develop interoperability between different areas of the health board and local authorities and 3rd/independent sector providers that enables service transformation through the sharing of patient information. ii. Support tactical patient information-sharing initiatives that are aligned with the broader strategic objective of seeing accurate, timely and relevant patient information available to practitioners to support patient care b. Work with local authority and other partners through the C&V Regional Partnership Board to develop an Area Plan to address the findings of the Social Services and Wellbeing Act population needs assessment for the region c. Work with partners in the Cardiff Public Services Board and Vale Public Services Board to prepare Wellbeing plans to address the findings of the Wellbeing Assessment for the two areas carried out for the Wellbeing of Future Generations Act	All Clinical Boards Cardiff Council Vale of Glamorgan Council Partners
3. **Excel at teaching, research, innovation and improvement** a. **Information Technology and Information** i. Implement strategic plans outlined in Shaping our Future Wellbeing ii. Develop IM&T plans and governance for the Primary Care Cluster new models of care	All Clinical Boards and Divisions Partners
4. **Deliver in line with our values:** a. Kind and caring; respectful; trust and integrity; personal responsibility b. Equality and Diversity i. Support the elimination of all forms of unjustifiable discrimination from all UHB functions and policies. ii. Support the creation of an environment where diversity is valued.	All Clinical Boards and Divisions Partners

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iii. Ensure respect for personal dignity and recognition of human rights by and for all employees, patients and the public iv. Implement and embed the Strategic Equality Plan	

Appendix 2 – Detailed Commissioning Intentions for 2017-20

Medium-Term Priority

Deliver Outcomes that Matter to People: • **Reduce health inequalities** • **Deliver outcomes that matter to people** • **All take responsibility for improving our health and wellbeing**	
Description	Health Board Area Impacted
1. Continue to work to identify those practices with populations with poorer health outcomes that have potential to benefit from a focus on primary and secondary prevention initiatives	PCIC Public Health Other Clinical Boards
2. **Health Improvement - The UHB will continue to:** a. Improve the availability of healthy food for staff, visitors and patients; cutting access to unhealthy food and beverage products on the premises b. Ensuring that night staff have access to healthy food options c. Supporting 'active travel' schemes for staff and visitors d. Helping staff, visitors and patients quit smoking e. Supporting staff with alcohol issues f. Developing workforce capability to deliver public health activity and appropriately support lifestyle behaviour change with the people they meet	Public Health All Clinical Boards and providers
3. **Reduce Health Inequalities** a. Expand the School Holiday Enrichment Programme (SHEP) b. Asylum seekers i. Review demand and capacity modelling and ensure appropriate capability and capacity in service provision. ii. Develop and implement specific pathways as appropriate.	Public Health All Clinical Boards and providers
Prevention 4. **Immunisation** b. Expand Fluenz programme in primary schools c. Implement, subject to an agreed business case, a schools-based immunisation team to deliver routine and missing immunisations, targeting areas of low uptake d. Implement a comprehensive cycle of data cleansing and performance management at a GP practice and primary care cluster level for immunisation e. Introduce and embed new vaccination programmes 5. **Tobacco**	PCIC Children & Women Medicine Public Health Local Authorities All other clinical boards and providers

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a. All Clinical Boards to record smoking status of inpatients on admission and refer all smokers to the UHBs in-house smoking cessation service, or record offer declined 6. **Increase social prescribing** a. Review and recommend options for social prescribing, specifically physical activity and weight management on referral 7. **Alcohol** a. Improving the early identification of alcohol related risk through standardising alcohol screening in 'mainstream' health settings such as primary care, secondary care, sexual health clinics and mental health services. b. Building the primary care base for treating alcohol use disorders and improving access to treatment within all general practices 8. **Obesity** a. Each Clinical Board to develop robust action plans to tackle obesity, including raising issues through Making Every Contact Count (MECC), routine weighing/measuring and referral to dietetics where appropriate. 9. Embed prevention at every level of the organisation and across all stages of pathways, including rolling out the Optimising Outcomes Prior to Surgery (OOPS) pathway over 2017-20 and adopting MECC, with all Clinical Boards developing and implementing a plan for embedding health improvement and prevention within at least one clinical team. **10.** 10% of staff within relevant clinical areas to have completed MECC Level 1 e-learning by end of 2018-19	
11. **Learning disabilities** a. Continue joint working with local providers to support people to move from registered care to supported living arrangements b. Continue joint working with local authorities (children's/housing) to accurately scope and demand forecast need for appropriate housing, enabling people to live in their own home. c. Developed pooled budget arrangements with Local Authorities for adults with Learning Disabilities d. Continued delivery of the Partnership's Disability Futures Programme	Women's and Children's PCIC ABMU Cardiff Council Vale of Glamorgan Council
12. **Ensure compliance with the Welsh Language Act** a. Set out actions required to deliver services through the medium of Welsh in response to the Population Needs Assessment	All clinical boards, divisions, providers and Local Authorities

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13. **Improve identification and support for Carers, in line with the Social Services and Wellbeing Act.** a. Supporting carers to recognise themselves in that role and helping staff to spot carers b. Recognise the long-term support needs of carers	All clinical boards, divisions, providers and Local Authorities

Service Priorities • Offer services that deliver the population health our citizens are entitled to expect	
Description	Health Board Area Impacted
1. **Cancer** a. Development of standardised pathways with Velindre and other specialist providers	Medicine Surgery Specialist Dental PCIC CD&T Velindre
2. **Stroke** a. Improve primary prevention	PCIC Medicine CD&T
Long Term Conditions 3. **Supporting self-care/management in relation to long term conditions where there is evidence of effective self-care approaches e.g. diabetes, cardiovascular disease and MSK. A number of approaches will be developed:** a. Skilling up health and social care staff to 'Make Every Contact Count'; supporting patients to make behaviour changes for health gain; enabling staff to use appropriate contacts with patients/clients to help maintain or improve their mental and physical health and wellbeing, whatever their specialism or the purpose of that contact b. Promotion of self-care through patient/client resources 4. **Diabetes** a. Implement the diabetes community workforce plan	All Clinical Boards and providers
Dementia **5. Development of integrated pathways** a. Identify and implement technological solutions to improve cognitive functioning, and to support people with dementia remaining independent for as long as possible. b. Work with all relevant clinical boards to implement a sustainable solution to reducing and sustaining waiting times for a dementia	PCIC Medicine Mental Health CD&T

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diagnosis to within the national target of 4 weeks c. Deliver against the actions for Year 2 of the Dementia Strategy (2017-2027) 6. **Improving the capacity of the organisation to respond to the needs of those with a dementia diagnosis, their carers and family members** a. Enhance the delivery of dementia awareness training in order to meet the Welsh Government target of 75% of frontline staff trained across the UHB b. Ensure that all health professionals take an active 'Making Every Contact Count' approach to prevention of dementia and other chronic illnesses through discussion of lifestyle risk factors	
Mental Health (all ages) 7. **Develop and implement system wide operational resilience plans with capacity and management systems supporting flow across the whole of the urgent care system.** a. Develop and implement parity of esteem initiatives, including workforce development plans to show how teams can change their skill mix; support training for staff (on methods to assess someone's mental health and how to provide psychological support); ensure physical health assessment and support is routinely included in the care planning of people in mental health services; mainstreaming prevention, promotion and self-management b. Develop integration of health and social care service provision across sectors and continue to work with partners to enhance the services that are provided 7 days a week, built around the Primary Care clusters, to enable response to health and wellbeing needs close to home. 8. **Child and Adolescent Mental Health Services** a. Embed and integrate commissioned young people's emotional wellbeing service with primary mental health b. AMH / CAMHS service to extend First Episode Psychosis Early Intervention transitional team across the 14 – 24 year old age range. c. Develop transition from child to adult services including joint work with children's social services 9. **Primary Secondary care interface** a. Work with Primary Care to improve support for decision making closer to General Practice for	Mental Health PCIC Women's and Children's Local Authorities Cwm Taf (CAMHS) Commissioning CD&T

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Mental Health Care and Treatment. Enabling work of demand capacity analysis of current referrals and whole systems integrated Community Mental Health Team review of Adult and Mental Health Services Older Persons services, to be followed by service redesign to support GP Liaison and develop services through an intervention focus instead of service or team boundary focus. b. Develop further shared care protocols with Primary Care on the prescribing of antipsychotics and other areas of prescribing 10. **Other** a. Ensure new Psychological Therapies investment is targeted at waiting list reductions in primary care and facilitate the delivery of psychologically minded care and treatment across non specialist professional groups and other clinical boards. b. Ensure new perinatal investment improves early detection of mental health problems around childbirth across all clinical boards. c. Develop interagency practice guidelines for those facing people who are suicidal and/or self-harming. d. Work with substance misuse partnership commissioning structures to address the waiting list for addiction prescribing services.	
11. **Early Years and Maternal Health** a. Develop integrated patient-centred care to provide individual care plans	Women's and Children's PCIC Public Health

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Sustainability • **Have an unplanned (emergency) care system that provides the right care, in the right place, first time** • **Have a planned care system where demand and capacity are in balance** • **Reduce harm, waste and variation sustainably making best use of the resources available to us**	
Description	Health Board Area Impacted
Planned Care **13. All Clinical Boards and Corporate Departments to provide a brief case study and evaluation of the WFG project implemented during 2018-19; and identify additional project(s) for implementation during 2019-20 which contribute to the Wellbeing of Future Generations goals and ways of working** 14. **Review and implement efficient, effective whole systems pathways, specifically:** a. Ophthalmology b. Dermatology c. Gastroenterology d. Urology 15. **Expand and implement new telehealth/assisted technology** 16. **Reduce number of follow up appointments delayed past their target date** 17. **Deliver NHS Outcomes Framework targets or develop action plans and improvement trajectories as appropriate.**	PCIC Medicine Specialist Surgery CD&T
Unplanned Care 18. **Access to care in the right place and the right time** a. Review and develop an integrated plan for medicine i. Consider role of Llandough and community hospitals ii. Develop reciprocal arrangements with Cwm Taf and other neighbouring health boards b. Work with 111 project to ensure meets need; input to accurate Directory of Services for Cardiff and Vale to ensure residents are signposted to appropriate services 19. **Develop urgent and emergency care networks** b. Evaluate the 2015/16 and 2016/17 winter pressure schemes and commission/implement these on a substantive basis 20. **Stroke services (See service priorities section)** 21. **Ambulance services** a. Improve productivity b. Decrease conveyance rates c. Increase proportion of direct admissions (not via A&E)	PCIC Medicine WAST/EASC Dental Mental Health Women's and Children's Cwm Taf (CAMHS) ABMU (LD) CD&T

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d. Increase proportion of patients for Hear and treat/See and treat to ensure a reduction in ambulance responses e. WAST and health board to embed and improve the agreed process to ensure that frequent service users are managed consistently and equally f. Fewer than 15% of patient transport bookings to be made on the day journey is required	
22. Deliver NHS Outcomes Framework targets or develop action plans and improvement trajectories as appropriate. 23. Utilise information collected through the Patient Reported Outcome/Experience Measures (PROMs/PREMs) to redesign services and pathways to deliver improved outcomes and patient experience	All Clinical Boards Cwm Taf (CAMHS) ABMU (LD) Local Authorities Third Sector Partners
24. **Accessibility of Primary Care** a. Review and consider increased opening hours of Barry MIU	PCIC CD&T Medicine
25. **End of Life care** a. Decrease the number of people who die in hospital b. Develop End of Life planning processes to support patients to choose where to die c. Include End of Life protocols and support within the winter pressures schemes	All Clinical Boards
20. Patient Quality, Safety and Experience **a. Support delivery of the Patient Experience Framework with specific focus on:** ➢ Improving performance against the 30 day working response time; ➢ 60% of concerns to be resolved via the informal route ➢ Development of suitable environments which meet the needs of patients with sensory impairment especially those with impaired sight or hearing ➢ Development of a workforce/volunteer network with advanced skills to meet the specific needs of those with sight and hearing loss ➢ Being able to seek the views of patients and carers and the patient experience across all areas of the UHB ➢ Increasing the number and utilisation of patient stories ➢ The actions being taken on the themes emerging from 'what it is like to be a patient in the UHB' (You said/we did)	All Clinical Boards and providers

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Finance 14. **Benchmarking** a. Identify one specific care pathway for each directorate in which benchmarking and/or clinical evidence base suggests over-treatment is occurring 15. **Decommissioning** a. Implement Royal College of Radiology guidelines on reducing procedures with lack of clinical/cost effectiveness b. Identify any procedures undertaken that are included on the NICE 'not to do' list and develop plan to decommission c. Review processes where there is little evidence for efficacy or the benefit does not outweigh the cost	All Clinical Boards and providers
Estates 16. **Deliver against estates plans:** a. Deliver full business case to re-provide Rookwood Hospital services at Llandough	Planning Mental Health Public Health Nursing PCIC Women's and Children's

Culture • **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**	
Description	Health Board Area Impacted
2. **Great place to work and learn** a. Improve workforce capability – deliver quality training and development to meet learning and leadership skills b. Transform the workforce to enable quality productivity and continuous improvement c. Improve succession planning and manage implications of an ageing workforce d. Ensure adequate and timely planning of workforce resource requirements and address staffing difficulties e. Continuous improvement of local management actions to recruit and retain staff f. Embed education and development within the organisation g. Increase apprenticeship opportunities h. Move away from traditional ways of working in Primary Care, developing new workforce roles and innovative practice	All Clinical Boards and Divisions Partners

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5. **Excel at teaching, research, innovation and improvement** a. Innovation i. Develop and implement knowledge portal and academy b. Research and development i. Increase the number of research studies by 10% ii. Increase the number of patients entering trials by 10% c. Education i. Adherence to new GMC Medical Education standards to deliver improved patient outcomes through high quality medical training	All Clinical Boards and Divisions Partners
6. **Deliver in line with our values:** a. Develop corporate level defined set of desired behaviours and embed at Clinical Board and divisional level with all employees b. Demonstrate evidence of values being embedded internally through workforce processes such as Recruitment, PADR, Induction, Training and Education	All Clinical Boards and Divisions Partners

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Appendix 3 – Detailed Commissioning Intentions for 2017-20

Longer-term Priorities

Deliver Outcomes that Matter to People: • **Reduce health inequalities** • **Deliver outcomes that matter to people** • **All take responsibility for improving our health and wellbeing**	
Description	Health Board Area Impacted
1. **Health Improvement - The UHB will continue to:** a. Promoting recognised national wellbeing charters/initiatives b. Supporting staff to act as health ambassadors in their local communities c. Developing partnerships with local communities to improve health d. Improving access to healthy and affordable food in Cardiff and the Vale	Public Health All Clinical Boards and providers
2. **Reduce Health Inequalities** a. Each directorate to analyse equity of access for one additional care pathway and implement changes based on findings	Public Health All Clinical Boards and providers
Prevention 3. **Tobacco** a. Implementation of the of the software tool to allow automatic GP read code reports to improve Tier 1 data collection b. Implementation and monitoring of the smoking cessation service intranet hub to GP software to allow patients to be referred automatically to the most appropriate smoking cessation provider	PCIC Children & Women Medicine Public Health Local Authorities All other clinical boards and providers

Service Priorities • Offer services that deliver the population health our citizens are entitled to expect	
Description	Health Board Area Impacted
1. **Stroke** a. **Social care staff better supported to care for stroke survivors**	PCIC Medicine CD&T
Long Term Conditions 2. **Supporting self-care/management in relation to long term conditions where there is evidence of effective self-care approaches e.g. diabetes, cardiovascular disease and MSK. A number of approaches will be developed:**	All Clinical Boards and providers

a. Identification of opportunities for inclusion of health promotion and self-care initiatives through contacts with partners, for e.g. local authorities and third/independent sector b. Provision of evidence-based self-care/management programmes or piloting innovative approaches where evidence is not available c. Improve availability of near patient testing and agree offset of costs where appropriate	
Dementia **3. Development of integrated pathways** a. Explore all resource opportunities to reinstate and sustain GP dementia diagnostic clinics b. Consolidate and promote the support available to residential care homes to deliver better outcomes for people in their care with dementia c. Increase the dementia diagnosis rate across the UHB d. Comply with all expectations outlined in the national dementia strategy 4. **Improving the capacity of the organisation to respond to the needs of those with a dementia diagnosis, their carers and family members** a. Promote dementia prevention awareness campaign using Welsh Government's Act Now materials b. Support employees to adopt healthy lifestyles both in and outside of work that contributes to the reduced risk of cognitive impairment.	PCIC Medicine Mental Health CD&T
Mental Health (all ages) 5. **Develop and implement system wide operational resilience plans with capacity and management systems supporting flow across the whole of the urgent care system.** a. Continue to maximise opportunities for working with the local authorities and improve the regular reporting of social care activity, quality and outcomes 6. **Primary Secondary care interface** a. Pilot a community secondary care discharge peer support model in one locality/cluster arrangement to act as navigator for vulnerable service users stepping down from community secondary care services. 7. **Develop realistic and relevant service user focussed outcomes in mental health at the earliest stage possible time and through a service user lens.**	Mental Health PCIC Women's and Children's Local Authorities Cwm Taf (CAMHS) Commissioning CD&T

10

a. This is in the context of the most disabling impact of mental illness including loss of social networks, employment, and housing. 8. **Other** a. Develop and implement the requirement for a Dual Diagnosis delivery plan for Cardiff and the Vale (substance misuse)	
Oral and Eye Health 9. **Oral Health** a. Increase percentage of resident population with access to NHS dentists b. Implementation of integrated pathways agreed by C&V Oral Health Action Group (OHAG) c. Deliver Local Oral Health Plan **10. Eye Health** a. Optometrists and GPs to work together to ensure patients are seen in the most appropriate setting b. Implement Together for Health – Eye Heath Care Delivery Plan	PCIC Dental Ophthalmology
11. **'Home First'.** a. Managing Ambulatory Care Sensitive Conditions to reduce bed days, specifically pathways around: Atrial Fibrillation; Chronic Heart Failure; Chronic Obstructive Pulmonary Disease as part of the All Wales Pacesetters programme b. Move early stages of pathways into primary and community care, specifically: Diabetes; Gastroenterology; Dermatology; Urology c. Develop model for 'discharge to assess' in the community	PCIC; Medicine; Specialist CD&T
12. **Delivery** a. Deliver against the disease specific NHS Delivery Plans	All Clinical Boards and providers

10

Sustainability • **Have an unplanned (emergency) care system that provides the right care, in the right place, first time** • **Have a planned care system where demand and capacity are in balance** • **Reduce harm, waste and variation sustainably making best use of the resources available to us**	
Description	Health Board Area Impacted
Planned Care 1. GPs and secondary care clinicians to develop multidisciplinary care and access to specialist services within clusters around pathways of care 2. Ensure INNU, Prior Approval and IPFR policies are understood by primary care and all Clinical Boards 3. Ensure that the INNU intervention list is fully implemented by Clinical Boards 4. All Clinical Boards to understand the cost effectiveness of interventions and work to remove variation between services and locations. 5. Aim to reduce cost per Quality Adjusted Life Year (QALY) across services.	PCIC Medicine Specialist Surgery CD&T
Unplanned Care 6. **Improve inter-practice referrals in Primary Care to reduce the number of secondary care referrals** a. E.g. sexual health/contraception	PCIC
Finance 7. **Ensure that Long Term agreements are appropriate** a. Reduce tertiary activity carried out under secondary care agreements 8. **Cost of tests and support services** a. Ensure that all referrers are aware of the cost of tests and other diagnostics b. Further develop internal trading frameworks 9. **Decommissioning** a. Each Clinical Board to review the Interventions Not Normally Undertaken (INNU) and ensure compliance with policy	All Clinical Boards and providers

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Culture • **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**	
Description	Health Board Area Impacted
3. **Great place to work and learn** a. Increase workforce engagement by creating conditions to unleash capability, potential and commitment to goals and values of the organisation b. Development and embedding of different service models which drive change in the workforce model and skill mix	All Clinical Boards and Divisions Partners
7. **Excel at teaching, research, innovation and improvement** a. **Research and development** i. Use R and D to benefit patient care by providing new diagnostic and prognostic testing, more stratified medicine and more innovative therapies to our patients.	All Clinical Boards and Divisions Partners

10

Appendix 4 – WHSSC Draft Commissioning Intentions 2018-21

To be update once issued by WHSSC

FINANCE REPORT FOR THE PERIOD ENDED 31st AUGUST 2017	
Name of Meeting : Board Meeting	**Date:** 28th September 2017

Executive Lead : Executive Director of Finance
Author : Deputy Director of Finance 02920 743555
Caring for People, Keeping People Well: This report details performance against the draft annual financial plan supporting the UHB to deliver service priorities, maximise patient outcomes whilst maintaining the sustainability of services.
Financial impact: The UHB financial position at the end of August 2017 is a deficit of £12.805m comprised of the following: • £nil variance against the UHBs savings target; • (£0.070m) favourable budget management variance; • £12.875m planned deficit (5/12th of £30.900m).
Quality, Safety, Patient Experience impact: This report details financial performance against the unapproved one year operational plan which supports improvements in quality, safety and patient / carer experience.
Health and Care Standard Number 1
CRAF Reference Number 6.7
Equality Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The work that has been undertaken to develop the 2017/18 draft operational plan;
- The scrutiny of Financial Performance undertaken by the Finance Committee;
- The month 5 position which is broadly on line with the profiled deficit within the draft operational plan.

The Board is asked to:

- **NOTE** that the UHB has an unapproved draft one year operational plan that has a planned deficit of £30.900m for the year;
- **NOTE** the £12.805m deficit at month 5 which includes a planning deficit of £12.875m and budget underspends of (£0.070m);
- **NOTE** the risks that need to be managed especially the identification of £8.8m further savings required to deliver a £30.9m deficit plan.

SITUATION

This report details the financial position of the UHB for the 5 months period ended 31st August 2017.

The UHB remains on target to meet the £30.9m planned deficit which includes a £35.0m savings plan. At the end of August the UHB had confirmed £26.2m of savings schemes. The UHB is continuing to progress work to bridge the remaining savings gap of £8.8m which is currently profiled into months 7-12.

BACKGROUND

The UHB considered a draft financial plan at its January 2017 meeting as part of its consideration of the Integrated Medium Term Plan for 2017/18 – 2019/20. The scale of the financial challenge and the size of the net deficit was such that the Board was not in a position to submit to Welsh Government a plan for approval as it was significantly away from being financially balanced.

Welsh Government requested the UHB to restate its plan and to resubmit it for consideration by the 10th March 2017. There was an expectation by Welsh Government that significant progress would be made in reducing the forecast deficit for 2017/18, which stood at £69.685m. The UHB submitted a revised financial plan to Welsh Government on the 10th March 2017 which had a reduced deficit of £45.873m. This draft plan was presented to the Board at its 30th March 2017 meeting and its adoption was endorsed, recognizing that it was not yet complete and very much work in progress. Further to this the plan was reconsidered by the UHB at its Board meeting on the 25th May 2017 where it was agreed to deliver a position no worse than the £30.9m forecast position in 2016/17. This report has been prepared against this planned deficit. A summary of this plan is provided in table 1.

Table 1: Revised Operational Plan 2017/18 @ August 2017

	Financial Plan
	£'000
Draft Financial Plan @ Jan 2017	**-69,685**
Risk Adjustments and Transformation Opportunities	23,812
Risk Adjusted Plan @ March 2017	**-45,873**
Additional In Year Identified Savings	6,163
Further Savings (yet to be identified) to deliver Stretch Plan	8,810
Financial Plan with Stretch Target	**-30,900**

ASSESSMENT AND ASSURANCE

The Finance Dashboard outlined by Table 2 reports actual and forecast financial performance against key financial performance measures.

Table 2: Finance Dashboard @ August 2017

Finance Dashboard						
Finance Indicators	Standard	Performance		In Month	Year to Date	Month 5 Full Year Forecast
		In Month	Year to Date	RAG Rating		
Remain within revenue resource limit - Variance Adv/(Fav)	£0	£2.515m	£12.805m			
Variance against unapproved 2017/18 £30.9m deficit plan	£0	(£0.060m)	(£0.070m)			
Pay expenditure (actual versus Plan)	£0	(£0.155m)	(£0.729m)			
Non-Pay Expenditure (Actual versus Plan)	£0	(£0.038m)	£0.825m			
Income (actual versus Plan)	£0	£0.133m	(£0.166m)			
Remain with CAPEX resource limit	£0	n/a	(£1.573m)			
Creditor payments compliance 30 day Non NHS	95%	88.50%	89.90%			
CRP Green / Amber status - Delegated Targets @ wc Aug 31st	80% green/20% amber		92% / 16%			

Month 5 Cumulative Financial Position

The UHB reported a deficit of £12.805m at month 5 as follows:

- Nil variance against the UHBs savings target;
- (£0.070m) favourable budget management variance;
- £12.875m planned deficit (5/12th of £30.900m).

Table 3 analyses the operating variance between income, pay, non pay and planned deficit.

Table 3: Summary Financial Position for the period ended 31st August 2017

Income/Pay/Non Pay	In Month			Year to Date			Full Year		
	Budget	Actual	Variance (Fav)/Adv	Budget	Actual	Variance (Fav)/Adv	Budget	Forecast	Variance (Fav)/Adv
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	(104.677)	(104.544)	0.133	(511.450)	(511.615)	(0.166)	(1,282.575)	(1,282.575)	0.000
Pay	49.171	49.015	(0.155)	243.357	242.628	(0.729)	582.962	582.962	0.000
Non Pay	58.082	58.044	(0.038)	280.968	281.792	0.825	730.513	730.513	0.000
Variance to Draft Plan £m	2.575	2.515	(0.060)	12.875	12.805	(0.070)	30.900	30.900	0.000
Planned Deficit	(2.575)	0.000	2.575	(12.875)	0.000	12.875	(30.900)	0.000	30.900
Total £m	0.000	2.515	2.515	(0.000)	12.805	12.805	(0.000)	30.900	30.900

Income

The year to date and in month financial position for income is shown in table 4.

Table 4: Income Variance @ August 2017

Income	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Revenue Resource Limit	(71.206)	(71.206)	0.000	(341.665)	(341.665)	0.000
Non Cash Limited Expenditure	(1.689)	(1.689)	0.000	(8.041)	(8.041)	0.000
Accomodation & Catering	(0.043)	(0.043)	(0.000)	(0.874)	(0.927)	(0.053)
Education & Training	(3.208)	(3.246)	(0.038)	(15.805)	(15.878)	(0.073)
Injury Cost Recovery Scheme (CRU)	(0.214)	(0.150)	0.064	(1.069)	(1.263)	(0.194)
NHS Patient Related Income	(23.146)	(23.111)	0.036	(113.107)	(113.309)	(0.201)
Other Operating Income	(4.334)	(4.399)	(0.065)	(26.544)	(26.558)	(0.015)
Overseas Patient Income	(0.010)	(0.019)	(0.009)	0.167	0.130	(0.037)
Private Patient Income	(0.115)	(0.055)	0.059	(0.561)	(0.361)	0.199
Research & Development	(0.712)	(0.626)	0.086	(3.950)	(3.742)	0.208
Total £m	(104.677)	(104.544)	0.133	(511.450)	(511.615)	(0.166)

An in month deficit of £0.133m and a cumulative surplus of £0.166m is reported against income budgets.

The reported cumulative deficit against R & D income is primarily due to the reduction in Welsh Government funding. In addition in month commercial R & D performance was less than plan.

Income from the Compensations Recovery Unit has slowed over the last 2 months due to a reduction in recorded new clams. Cumulative income remains ahead of plan for the year to date.

The majority of the cumulative deficit reported against private patients relates to Specialist Services.

Pay

An in month underspend of £0.155m is reported against pay budgets continuing the trend established in the second half of 2016/17.

Table 5 identifies that a cumulative month 5 budget underspend of £0.729m in 2017/18 compared to month 5 overspend of £1.203m in 2016/17.

Table 5: Analysis of fixed and variable pay costs

	2016/17 Total Spend £m	2016/17 Month 1 to Month 4 £m	2017/18 Month 1 to Month 4 £m	2016/17 Month 5 £m	2017/18 Month 5 £m	2016/17 Cum. to Month 5 £m	2017/18 Cum. to Month 5 £m
Basic	502.093	164.203	168.924	41.117	42.466	205.320	211.391
Enhancements	23.635	7.578	8.205	1.747	2.154	9.324	10.359
Maternity	4.136	1.369	1.417	0.353	0.372	1.722	1.790
Protection	0.743	0.257	0.223	0.061	0.048	0.318	0.272
Total Fixed Pay	**530.607**	**173.406**	**178.770**	**43.278**	**45.041**	**216.684**	**223.811**
Agency (mainly registered Nursing)	9.017	3.213	2.689	0.670	0.819	3.883	3.508
Nursing Bank (mainly Nursing)	14.249	4.286	4.586	1.207	1.253	5.493	5.839
Internal locum (Medical & Dental)	2.105	0.760	1.433	0.142	0.339	0.902	1.772
External locum (Medical & Dental)	9.547	3.378	2.130	0.790	0.548	4.168	2.678
On Call	2.154	0.712	0.684	0.154	0.207	0.867	0.891
Overtime	6.072	2.086	1.933	0.469	0.433	2.555	2.366
WLI's & extra sessions (Medical)	3.549	1.093	1.388	0.437	0.374	1.530	1.762
Total Variable Pay	**46.693**	**15.528**	**14.842**	**3.869**	**3.974**	**19.398**	**18.817**
Total Pay	**577.301**	**188.935**	**193.613**	**47.148**	**49.015**	**236.082**	**242.628**
Pay Budget	**576.692**	**187.729**	**194.186**	**47.150**	**49.171**	**234.879**	**243.357**
Budget Variance (Fav)/Adv £m	**0.609**	**1.206**	**(0.574)**	**(0.003)**	**(0.155)**	**1.203**	**(0.729)**

The increase in 2017/18 pay levels is mainly due to the cost of the annual pay award, the apprenticeship levy and funded developments.

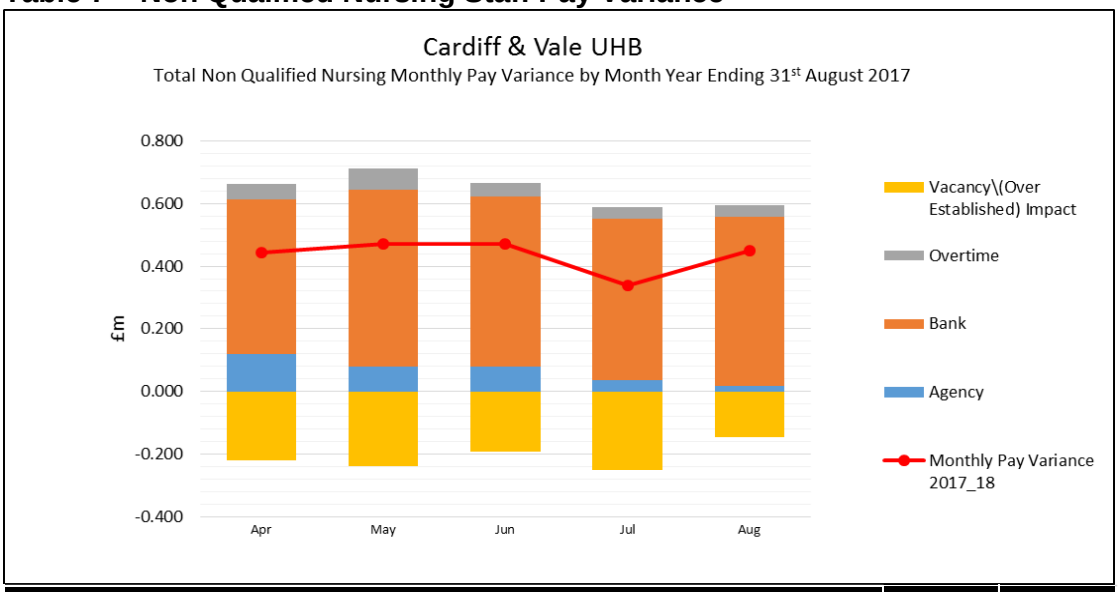
An analysis of pay expenditure by staff group is shown in Table 6.

Table 6: Analysis of pay expenditure by staff group @ August 2017

Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Additional clinical services	1.991	1.947	(0.044)	10.118	9.829	(0.290)
Management, admin & clerical	5.557	5.738	0.181	28.534	28.135	(0.399)
Medical and Dental	12.675	12.563	(0.112)	62.617	62.224	(0.394)
Nursing (registered)	14.704	14.627	(0.077)	73.212	72.133	(1.079)
Nursing (unregistered)	3.765	4.214	0.449	18.643	20.816	2.173
Other staff groups	7.727	7.254	(0.474)	36.372	36.424	0.053
Scientific, prof & technical	2.752	2.673	(0.079)	13.861	13.067	(0.793)
Total £m	49.171	49.015	(0.155)	243.357	242.628	(0.729)

Performance against pay budgets is broadly in line with the trend established in the first four months of the year. An underspend of £0.155m is reported against pay budgets within the month. At month 4 a £0.5m year to date savings target was levied in Corporate Executive Directors pay budgets and shown under 'other staff groups'. The in month movement reported against 'management, admin and clerical' and 'other staff groups' follows the realignment of this savings target to the more appropriate staff categories to reflect expected underspends. The year to date position by staff group is therefore now reflective of performance against the additional savings requirement.

Table 7 – Non Qualified Nursing Staff Pay Variance

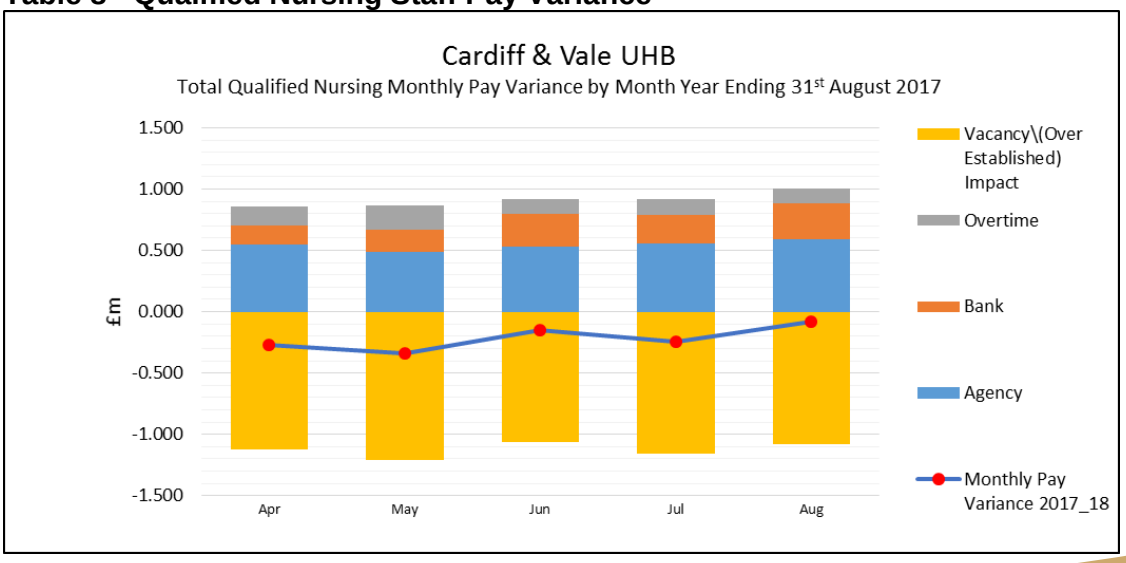


Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.016	0.333
Bank	0.541	2.655
Overtime	0.038	0.234
Adverse Impact	0.595	3.222
Vacancy\(Over Established) Impact	(0.145)	(1.049)
Total Pay Variance - Unqualified Nursing (Fav)/Adv £m	0.449	2.173

Table 7 illustrates that the majority of adverse variance against non-qualified nursing assistants is due to an overspend of £2.655m on bank staff which is partly offset by an underspend against established posts.

11

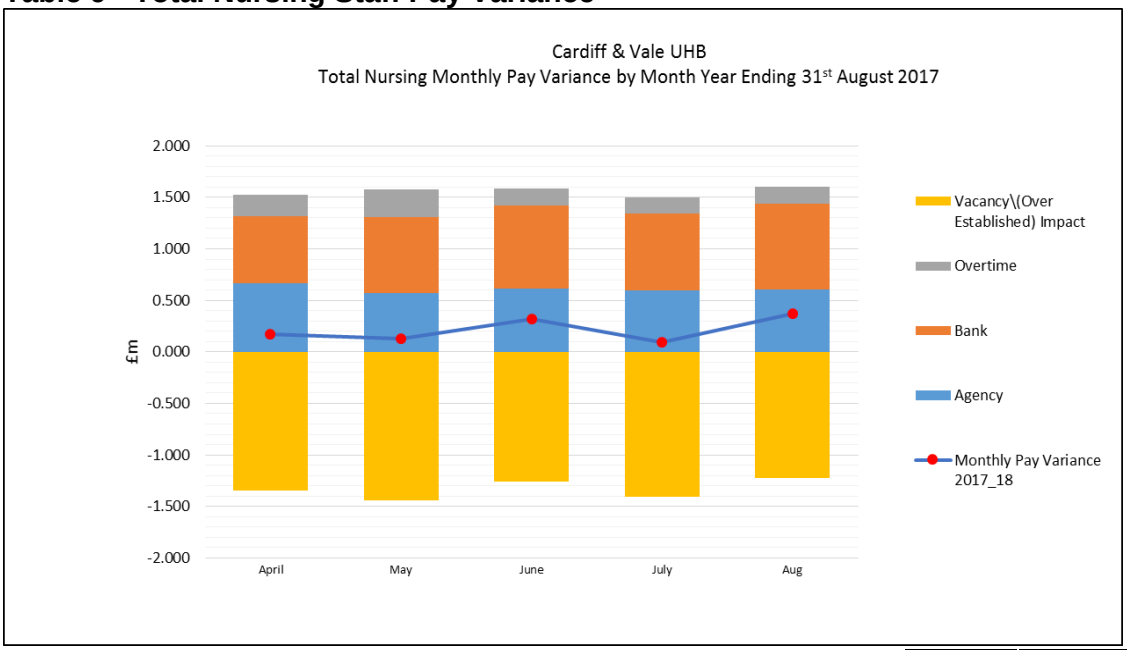
Table 8 - Qualified Nursing Staff Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.590	2.718
Bank	0.295	1.129
Overtime	0.119	0.709
Adverse Impact	1.004	4.557
Vacancy\(Over Established) Impact	(1.081)	(5.636)
Total Pay Variance - Qualified Nursing (Fav)/Adv £m	(0.077)	(1.079)

The information in Table 8 indicates that expenditure on established posts is significantly less than budget. The in month underspend continues the trend set in the second half of the last financial year.

Table 9 - Total Nursing Staff Pay Variance

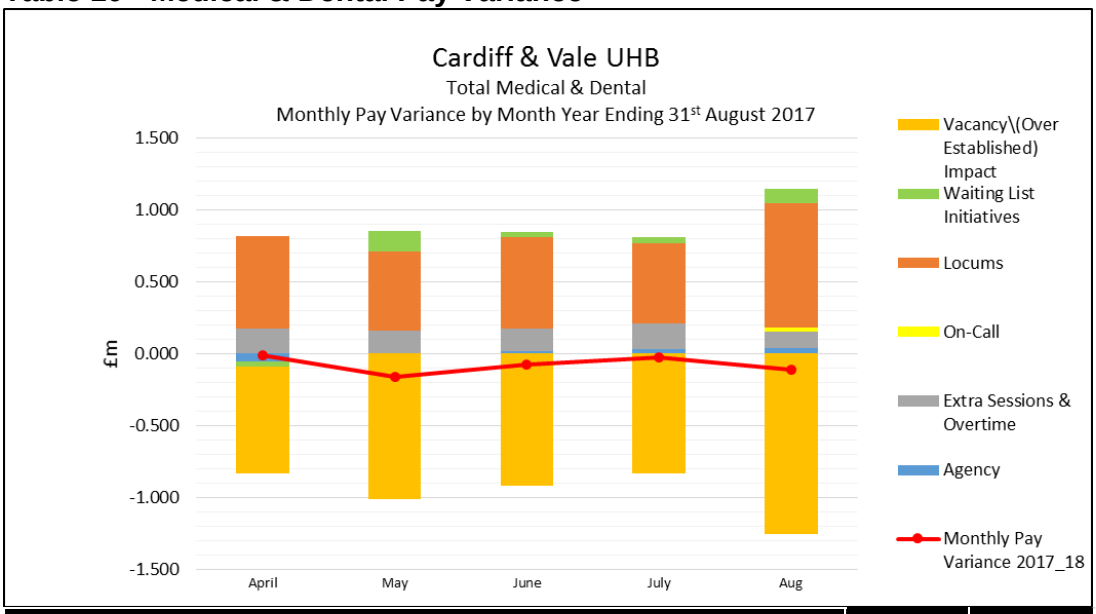


Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.606	3.052
Bank	0.835	3.784
Overtime	0.157	0.943
Adverse Impact	1.599	7.779
Vacancy\(Over Established) Impact	(1.226)	(6.685)
Total Pay Variance - (Fav)/Adv £m	0.372	1.094

Table 9 confirms that expenditure against substantive nursing posts for the year to date is less than budget. However the combined overspend on agency, bank and overtime is greater than the underspend against vacant posts leading to an overall overspend against nursing budgets.

Table 10 shows financial performance against medical and dental pay budgets. This identifies that the favourable variance against established posts is partially offset by expenditure on locums, waiting list initiatives and extra sessions leaving a favourable variance of £0.394m at month 5.

Table 10 - Medical & Dental Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.034	0.022
Extra Sessions & Overtime	0.117	0.789
On-Call	0.031	0.028
Locums	0.858	3.247
Waiting List Initiatives	0.102	0.275
Adverse Impact	1.142	4.362
Vacancy\(Over Established) Impact	(1.254)	(4.755)
Total Pay Variance - Medical & Dental (Fav)/Adv £m	(0.112)	(0.394)

Non Pay

Table 11 shows the financial performance against non pay budgets.

Table 11: Non Pay Variance @ August 2017

Non Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Clinical services & supplies	7.864	7.843	(0.021)	38.227	38.336	0.109
Commissioned Services	14.128	14.076	(0.051)	67.677	67.800	0.122
Continuing healthcare	5.020	5.100	0.080	24.605	24.785	0.180
Drugs / Prescribing	12.837	12.799	(0.039)	60.999	61.085	0.086
Establishment expenses	0.830	0.983	0.153	4.310	4.203	(0.107)
General supplies & services	0.668	0.639	(0.029)	3.105	3.299	0.194
Other non pay	3.097	3.113	0.016	12.107	12.594	0.486
Premises & fixed plant	3.058	2.970	(0.088)	14.432	14.159	(0.273)
Primary Care Contractors	10.582	10.522	(0.060)	55.505	55.532	0.027
Total £m	58.082	58.044	(0.038)	280.968	281.792	0.825

Table 11 highlights a £0.825m overspend against non pay budgets for the year to date.

NCSO price concessions have resulted in the UHB incurring an additional £1.2m of prescribing costs for the year to date. The pressure has been managed to date through the application of growth funding, reduced prescribing volumes, category M savings and an earlier than anticipated patent expiry. It is uncertain whether the additional cost can continue to be managed if the price concession continues in the long run.

Similarly the recent court judgement in respect of NHS funded nursing fees is expected to lead to a pressure between £1m to £4m (dependent upon rate increase and backdating). This pressure is not reflected in the UHB's forecast and is highlighted as a new risk.

The overspend in other non-pay is driven by pressures in Surgery, Lab Medicines and additional costs resulting from the outsourcing of the neuro-interventional radiology service. The UHB has already engaged WHSCC in discussions around the coverage of the additional cost arising from the outsourcing of the neuro-interventional radiology service

Financial Performance of Clinical Boards

Budgets are set to ensure that there is sufficient resource available to deliver the UHB's plan. Financial performance for 5 months to 31st August 2017 by Clinical Board is shown in Table 12.

Table 12: Financial Performance for the period ended 31st August 2017

Clinical Board	M4 Budget Variance £m	M5 Budget Variance £m	In Month Variance £m	Cumulative % Variance
Clinical Diagnostics & Therapies	0.128	0.087	(0.041)	0.20%
Chidren & Women	0.257	0.345	0.088	0.85%
Capital Estates & Facilities	(0.008)	0.006	0.014	0.02%
Dental	(0.012)	(0.038)	(0.026)	(0.23%)
Executives	(0.508)	(0.083)	0.424	(0.50%)
Medicine	0.439	0.434	(0.004)	0.95%
Mental Health	(0.064)	(0.074)	(0.010)	(0.25%)
PCIC	(0.427)	(0.659)	(0.233)	(0.54%)
Specialist	(0.321)	(0.454)	(0.133)	(0.72%)
Surgery	0.246	0.238	(0.008)	0.45%
Central Budgets	0.261	0.128	(0.133)	0.20%
SubTotal	**(0.009)**	**(0.070)**	**(0.061)**	**(0.01%)**
Planned Deficit	10.300	12.875	2.575	2.51%
Total	**10.291**	**12.805**	**2.514**	**2.50%**

The majority of Clinical Boards have broadly balanced month 5 expenditure within existing resources and budgets. The key exceptions are the Medicine, Children and Women, Surgery and the CD & T Clinical Boards.

The Medicine Clinical Board is overspent on its nursing budgets with pressures due to bank and agency cover of vacancies, sickness and specialling. Underperformance in PICU and NICU alongside premium costs of medical cover are pressures in the Children and Women Clinical Board. The deficit reported by the Surgery Clinical Board is primarily due to the early recognition of underperformance in orthopaedics and overspends on Wet AMD. The majority of overspend reported by the CD & T Clinical Board relates to additional costs arising from the outsourcing of the neuro-interventional radiology service.

All Clinical Boards have completed a review of 2017/18 financial forecasts and those Clinical Boards with a forecast year end overspend have been asked to produce recovery plans in order to achieve a balanced year end outturn. This includes CD&T, Children and Women, Dental and Medicine Clinical Boards. The expectation is that all Clinical Boards will deliver the lower of their forecast position or a break even position.

Savings Programme

The UHB agreed a 1.5% recurrent savings target of £13m and a further non recurrent savings target of £4.333m for delegated budget holders. In addition the UHB targeted £2.695m savings through the delivery of UHB wide transformation. Further to this the UHB agreed a £14.973 stretch plan leading to an overall savings target of £35.001m

The development and delivery of delegated schemes is monitored through weekly reporting of individual schemes and the risk to delivery is measured by a traffic light system.

At the time of reporting the UHB has identified £26.191m of savings schemes and this is summarised in Table 13 and is detailed by Clinical Board in **Appendix 1**.

Table 13: Progress against the 2017/18 Savings Programme at Month 5

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Unidentified) £m
Total £m	35.001	26.191	(8.810)

Further work continues to identify additional savings to deliver the plan. At the end of August the UHB needs to identify a further £8.8m of savings schemes as outlined in Table 13. Any shortfall against this will be phased into the position from month 7 onwards. The profiling of identified and unidentified savings is shown in **Appendix 2**.

For the year to date £9.567m of savings are profiled into the position, against which the UHB has delivered £9.567m leading to a balanced performance against programmed savings targets for the year to date. It should be noted that a number of identified corporate schemes are profiled into the last 6 months of the year.

Balance Sheet

The Balance sheet is shown in **Appendix 3** and the opening balances reflect the Audited Accounts approved by the Board on 1st June 2017.

The decrease in the carrying value of property, plant and equipment since the start of the year is largely due to depreciation.

The main reason for the increase in trade debtors is the increase in amounts due from the Welsh Risk Pool following the change to the discount rate announced by the Lord Chancellor on 27th February 2017. This is mirrored by a similar increase in the value of provisions held since 1st April 2017.

The reduction in trade and other payables shown within current liabilities is primarily due to the decrease in capital creditors, where the majority of the significant year end balances have now been settled.

Cash Flow Forecast

The cash flow forecast is contained in **Appendix 4**. The UHB is currently forecasting the requirement for £7.034m cash assistance in respect of working balance movements and £30.9m Strategic Cash Assistance to cover the planned deficit. The UHB will seek this support from Welsh Government later in the financial year.

A reconciliation of the reported opening and closing cash position is shown in Table 14 below:

Table 14: Reconciliation of opening and forecast closing cash position

Description	£m
Opening Cash balance	0.881
Working balances arising	(7.034)
Forecast Deficit	(30.900)
Forecast Cash Deficit £m	(37.053)

Public Sector Payment Compliance

Performance of 89.9% to the end of August is less than the 95% target. The poor performance is partly related to the transition to the All Wales Nursing Contract and an additional backlog in payments to a transport provider. The UHB expects performance in relation to the All Wales Nursing Contract to gradually improve with the 1st August 2017 roll out of an automated ordering & receipting process that currently works well in respect of one supplier. A new authorisation process has been put in place with the transport provider which should prevent the backlog in payments re-occurring. In addition, the UHB has now agreed to implement a "No purchase order, No Pay" policy with the long term intention of improving the efficiency of invoice payments.

Capital Resource Limit (CRL)

Progress against the CRL for the period to the end of August 2017 is detailed in **Appendix 5** and summarised in Table 15.

Table 15: Progress against Capital Resource Limit @ August 2017

	£m
Planned Capital Expenditure at month 5	8.835
Actual net expenditure against CRL at month 5	7.262
Variance against planned Capital Expenditure at month 5	(1.573)

Capital progress to date has been slow. The reported net spend to the end of August is however skewed by the two significant asset sales where the net book value will provide a source of capital funds for the full year and not just the first five months.

Financial Risks

The UHB remains on track to deliver the agreed £30.9m deficit subject to the final outcome of the two risks outlined below:

- The delivery of the savings target which will require the identification and delivery of a further £8.8m of savings schemes.
- A £1m to £4m increase in NHS Funded Nursing Care Fees following the Supreme Court judgement in respect of weekly fees. The extent of additional liability is dependent on the length of backdated payments and revised rate of payment. This risk is not currently included in the UHB's forecast outturn.

Key Concerns & Recovery Actions

At month 5, the key concerns and challenges are set out below:

1. Concern- Agreeing an operational plan with Welsh Government.

   Action - The UHB continues to work with Welsh Government to ensure good financial management processes remain in place and to explore further options to support financial sustainability.

2. Concern - Budget overspends at month 5;

   Action – All Clinical Boards have confirmed expected year end outturn through the monthly forecasting framework. Clinical Boards with forecast year end overspends are required to determine recovery actions as part of the Clinical Board Performance Escalation Process which is at Chief Executive level.

3. Concern - Against the £35.0m savings programme, £26.2m green and amber schemes are in place, leaving a gap of circa £8.8m to be identified.

   Action - The UHB is undertaking further work to identify the residual £8.8m savings gap and this includes a detailed review of budgets and forecasts and consideration of a number of corporate schemes. Any shortfall against the residual savings gap will be phased into the position from month 7 onwards.

4. Concern – Increase in Funded Nursing care Fees.

   Action – The risk is being assessed across Wales in terms of consistency of interpretation, liability and cost. This has not yet been concluded. If this is not funded by Welsh Government, it may impact up the UHBs ability to deliver its current forecast position.

CONCLUSION

The UHB is committed to achieving in year and recurrent financial balance as soon as possible without adversely affecting patient safety and service delivery.

The UHB currently has a draft financial plan for 2017/18 which requires the delivery of £35m financial savings to achieve a £30.9m deficit. Satisfactory progress has been made to date after the identification of £26.2m savings with a further £8.8m savings to be identified. A number of options and further opportunities have been identified to mitigate against this financial risk and these are being evaluated. In this context the UHB will continue to work closely with Welsh Government and share progress being made at its Targeted Intervention meetings. The UHB will also ensure good financial management processes remain in place to explore further options to support longer term financial sustainability.

The reported financial position for the five months to the end of August is a deficit of £12.805m. This is made up of a budget plan deficit of £12.875m and a favourable variance against plan of £0.070m.

Appendix 1

2017-18 Weekly Summary week commencing 21st August 2017-18 PYE

Clinical Board	17-18 Target 1.5% Recurrent / 0.5% Non Recurrent	Granular Identified Green	Shortfall vs Green	Clinical Board Amber	Clinical Board Pipeline Red	Total Green & Amber	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000	%	£'000
Corporate Execs	681	955	-274	106	72	1,060	3	-379
Specialist Services	2,400	2,057	343	859	324	2,916	2.43	-516
Capital Estates and Facilities	1,244	1,255	-11	110	0	1,365	2.19	-121
PCIC	3,323	3,327	-4	226	450	3,553	2.14	-230
Surgery	2,357	2,013	344	446	35	2,459	2.09	-102
Children & Women	1,775	1,438	337	373	456	1,812	2.04	-37
Mental Health	1,395	1,406	-11	0	45	1,406	2.02	-11
Medicine	1,878	1,604	274	275	94	1,879	2.00	-1
CD&T	1,880	1,499	381	384	125	1,883	2.00	-3
Dental	400	343	57	0	10	343	1.71	57
Non Delegated Schemes	17,668	400	17,268	8,458		7,516		10,152
Total	**35,001**	**16,297**	18,704	**11,236**	**1,610**	**26,191**		8,810

2017-18 Weekly Summary week commencing 21st August 2017-18 FYE

Clinical Board	17-18 Target 1.5% Recurrent	Granular Identified Green	Shortfall vs Green	Clinical Board Amber	Clinical Board Pipeline Red	Total Green & Amber	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000	%	£'000
PCIC	2,493	3,239	-746	275	160	3,514	2.11	-1,021
Mental Health	1,047	1,031	16	0	45	1,031	1.48	16
CD&T	1,382	771	611	378	125	1,149	1.25	233
Dental	300	57	243	0	20	57	0.29	243
Surgery	1,768	1,451	317	525	147	1,976	1.68	-208
Capital Estates and Facilities	933	431	502	320	400	751	1.21	182
Children & Women	1,331	635	696	391	795	1,026	1.16	305
Medicine	1,408	1,562	-154	140	977	1,702	1.81	-294
Specialist Services	1,800	1,141	659	637	324	1,778	1.48	22
Corporate Execs	501	609	-108	87	16	696	2.08	-195
Non Delegated Schemes	17,668	400	17,268	2,250	0	2,650		15,018
Total	**30,631**	**11,326**	19,305	**5,003**	**3,008**	**16,329**		14,302

Appendix 2

Cardiff and Vale UHB Financial Plan 2017/18 - Monthly Run Rates

	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Forecast Year end Position £'000
Gross costs	**103,244**	**101,554**	**110,313**	**109,081**	**110,590**	**110,961**	**111,588**	**112,308**	**112,261**	**113,571**	**112,392**	**139,183**	**1,347,045**
Identified savings	-618	-1,481	-2,972	-1,757	-2,739	-1,793	-2,433	-2,086	-2,150	-2,120	-2,107	-3,936	-26,191
Unidentified savings required for stretch target							-979	-979	-1,468	-1,468	-1,958	-1,958	-8,810
Total savings required	**-618**	**-1,481**	**-2,972**	**-1,757**	**-2,739**	**-1,793**	**-3,412**	**-3,065**	**-3,619**	**-3,588**	**-4,065**	**-5,894**	**-35,001**
Net costs	**102,626**	**100,073**	**107,341**	**107,324**	**107,851**	**109,168**	**108,176**	**109,243**	**108,642**	**109,983**	**108,327**	**133,289**	**1,312,043**
Income (phased as per budget plan)	98,952	98,579	104,814	104,728	105,337	106,583	105,591	106,658	106,057	107,398	105,742	130,704	1,281,143
Net surplus/ (deficit)	**-3,674**	**-1,494**	**-2,527**	**-2,596**	**-2,514**	**-2,585**	**-2,585**	**-2,585**	**-2,585**	**-2,585**	**-2,585**	**-2,585**	**-30,900**

Notes

Unidentified savings to deliver the stretch target have been phased in from month 7 and are stepped up every two months

April gross costs are lower than average in part due to the monthly 1 budget setting process and the unwinding and confirmation of previous year estimates.

Gross costs in May are abated by the 7.3m profit on disposal arising from the sale of CRI West Wing and sale of the former petrol station at Llandough

Monthly gross costs will vary due to demand side seasonal care and prescribing pressures; the implementation of in year plans; the timing of weekly pay runs and the payment of pay enhancements

The spike in month 12 gross costs is primarily due to the additional £23.3m of AME Donated Depreciation\Impairments profiled into month 12 and the expected settlement of LTAs

Appendix 3

BALANCE SHEET AS AT 31ST AUGUST 2017

	Opening Balance 1st April 2017	Closing Balance 31st August 2017
Non-Current Assets	**£'000**	**£'000**
Property, plant and equipment	628,042	631,571
Intangible assets	1,601	1,327
Trade and other receivables	42,437	41,263
Other financial assets		
Non-Current Assets sub total	**672,080**	**674,161**
Current Assets		
Inventories	15,129	16,518
Trade and other receivables	137,493	202,272
Other financial assets	0	0
Cash and cash equivalents	881	5,133
Non-current assets classified as held for sale	1,815	0
Current Assets sub total	**155,318**	**223,923**
TOTAL ASSETS	**827,398**	**898,084**
Current Liabilities		
Trade and other payables	157,516	144,550
Other financial liabilities	0	0
Provisions	102,277	168,824
Current Liabilities sub total	**259,793**	**313,374**
NET ASSETS LESS CURRENT LIABILITIES	**567,605**	**584,710**
Non-Current Liabilities		
Trade and other payables	10,207	9,985
Other financial liabilities	0	0
Provisions	44,615	37,860
Non-Current Liabilities sub total	**54,822**	**47,845**
TOTAL ASSETS EMPLOYED	**512,783**	**536,865**
FINANCED BY: **Taxpayers' Equity**		
General Fund	399,057	423,139
Revaluation Reserve	113,726	113,726
Total Taxpayers' Equity	**512,783**	**536,865**

11

Appendix 4

CASH FLOW FORECAST AS AT 31st AUGUST 2017

	April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
RECEIPTS													
WG Revenue Funding - Cash Limit (excluding NCL)	77,340	60,358	90,378	66,386	67,086	77,642	69,092	75,182	84,642	68,722	79,582	27,328	843,738
WG Revenue Funding - Non Cash Limited (NCL)	1,830	1,830	1,150	1,410	1,610	1,815	1,375	1,610	1,610	1,610	1,610	2,107	19,567
WG Revenue Funding - Other (e.g. invoices)	2,360	2,360	2,506	2,361	2,361	2,331	2,331	2,331	2,331	2,331	2,331	7,164	33,098
WG Capital Funding - Cash Limit	9,000	2,000	1,000	2,100	3,900	2,950	1,900	3,900	3,800	1,822	1,722	2,092	36,186
Sale of Assets	0	9,152	0	0	0	0	0	0	0	0	0	0	9,152
Income from other Welsh NHS Organisations	47,076	17,644	41,554	29,101	31,459	41,803	24,666	31,648	38,514	26,497	30,543	35,297	395,802
Other - (Specify in narrative)	11,438	3,599	7,579	5,630	8,324	6,391	6,104	5,775	5,463	5,811	4,977	8,269	79,360
TOTAL RECEIPTS	**149,044**	**96,943**	**144,167**	**106,988**	**114,740**	**132,932**	**105,468**	**120,446**	**136,360**	**106,793**	**120,765**	**82,257**	**1,416,903**
PAYMENTS													
Primary Care Services : General Medical Services	5,249	4,042	8,318	3,992	3,986	5,416	4,035	4,035	5,447	4,035	4,035	5,447	58,037
Primary Care Services : Pharmacy Services	153	124	144	112	125	135	135	135	135	540	270	270	2,278
Primary Care Services : Prescribed Drugs & Appliances	15,528	2	15,095	4	7,945	15,712	0	7,760	15,520	0	7,760	7,760	93,086
Primary Care Services : General Dental Services	1,734	1,877	1,908	1,936	1,720	1,806	1,830	1,830	1,830	1,830	1,830	1,830	21,961
Non Cash Limited Payments	1,986	2,196	1,910	2,173	2,105	2,135	2,120	2,120	2,120	2,120	2,120	2,120	25,225
Salaries and Wages	45,715	47,104	47,578	46,857	46,825	46,788	46,794	47,001	46,665	46,788	47,227	47,322	562,664
Non Pay Expenditure	41,188	43,621	48,892	44,051	45,352	43,640	43,466	44,606	44,715	44,859	44,663	46,443	535,496
Capital Payment	9,738	1,925	1,323	1,802	3,587	2,974	3,256	3,912	3,811	3,760	3,848	2,066	42,002
Other items (Specify in narrative)	15,801	2,891	17,084	2,836	9,095	16,394	2,880	8,965	16,191	2,880	8,965	10,106	114,088
TOTAL PAYMENTS	**137,092**	**103,782**	**142,252**	**103,763**	**120,740**	**135,000**	**104,516**	**120,364**	**136,434**	**106,812**	**120,718**	**123,364**	**1,454,837**
Net cash inflow/outflow	11,952	(6,839)	1,915	3,225	(6,000)	(2,068)	952	82	(74)	(19)	47	(41,107)	
Balance b/f	881	12,833	5,994	7,909	11,134	5,134	3,066	4,018	4,100	4,026	4,007	4,054	
Balance c/f	12,833	5,994	7,909	11,134	5,134	3,066	4,018	4,100	4,026	4,007	4,054	(37,053)	

11

Appendix 5

PROGRESS AGAINST CRL AS AT 31st AUGUST 2017

Approved CRL issued July 20 2017 £'000s	36,186

Performance against CRL	Year To Date			Forecast		
	Plan £'000	Actual £'000	Var. £'000	Plan £'000	F'cast £'000	Var. £'000
All Wales Capital Programme:						
Replacement Cardiac Catheter Labs UHW	2	2	0	3	3	0
Rookwood Emergency Works	655	15	(640)	1,445	1,445	0
Relocation of Central Processing Unit	0	0	0	0	0	0
Neonatal Phase 2	5,606	5,627	21	15,935	15,935	0
Primary Care Fees	0	0	0	125	125	0
Gamma Cameras	81	(15)	(96)	672	672	0
Anti Ligature Works	0	0	0	987	987	0
CRI Wards 14 and 14(a)	396	7	(389)	2,148	2,148	0
Sub Total	**6,740**	**5,636**	**(1,104)**	**21,315**	**21,315**	**0**
Discretionary:						
I.T.	395	79	(316)	1,162	1,162	0
Equipment	289	44	(245)	2,023	2,023	0
Statutory Compliance	711	619	(92)	2,800	2,800	0
Estates	8,019	8,203	184	16,750	16,750	0
Sub Total	**9,414**	**8,945**	**(469)**	**22,735**	**22,735**	**0**
Donations:						
Ronald McDonald House, Oakgrove Foundation & Endowments	5,503	5,503	0	6,048	6,048	0
Sub Total	**5,503**	**5,503**	**0**	**6,048**	**6,048**	**0**
Asset Disposals:						0
West Wing	1,806	1,806	0	1,806	1,806	0
The Former Filling Station at Llandough	10	10	0	10	10	0
Sub Total	**1,816**	**1,816**	**0**	**1,816**	**1,816**	**0**
CHARGE AGAINST CRL	**8,835**	**7,262**	**(1,573)**	**36,186**	**36,186**	**0**
PERFORMANCE AGAINST CRL (Under)/Over £'000s		**(28,924)**			**0**	

11

PERFORMANCE REPORT
Name of Meeting : Board Meeting **Date of Meeting :** 28 September 2017
Executive Lead : Director of Public Health
Authors : Members of the Performance and Information Department (tel 029 20745602)
Caring for People, Keeping People Well: This report underpins the integrity value of the Health Board's Strategy, providing transparency on our progress in delivering our duties to our resident population and patients and clients who rely on us to provide clinically and cost effective care.
Financial impact: The achievement of the efficiency and productivity targets will deliver savings to support the financial position
Quality, Safety, Patient Experience impact : The performance report outlines performance over the domains of quality and safety and patient experience, and outlines areas and actions for improvement
Health and Care Standard 1 – Governance Leadership and Accountability **CRAF Reference No 6** - Resources
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- the fact that the UHB is making progress in delivering our Operational Delivery Plan for 2017/8 by achieving compliance with 18 of its 60 performance measures.

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

12

SITUATION

The full Performance Report sets out the UHB's performance against Welsh Government (WG) Delivery Framework and other priority targets up to August 2017 and provides more detail on actions being taken to improve performance in areas of concern.

BACKGROUND

The UHB is presently compliant with 18 of its 60 performance measures (July =17/60, March = 23/58) and is making satisfactory progress towards delivering a further 24 (July = 23, March =13).

The Welsh Government's Delivery Framework continues to be revised for 2017/18, with new measures or revisions to existing measures having been adopted. A review

of the performance reporting considering these changes and the views of board members will commence in October.

Since the last report two measures have improved to green:

#23 – The proportion of patients on an urgent suspected cancer pathway and with a confirmed diagnosis of cancer treated within 62 days improved from 92% to 95%

#47 – The proportion of secondary mental health service users with a care and treatment plan increased to above 90%, the Welsh Government's expected level of performance.

Two measures have improved to amber:

56 – The proportion of medical staff undertaking performance appraisal within the past 15 months has increased to over 81%, the highest level recorded but marginally below the Welsh Government's standard of 85%.

#61 – The proportion of handovers between the Welsh Ambulance service and the Emergency Unit being completed in 15 and 60 minutes improved to 62% and 96% respectively. The Welsh Government's expected standards are 60% and 100%/

One measure showed a deterioration:

#32 – The proportion of patients receiving a nutritional assessment and related care plan within 24 hours of admission reduced from 96% to 93%.

Consequently there are now 18 measures where performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale.

This is summarised in the table below:

Policy Objective	Green	Amber	Red	Score
Delivering for our population	7	9	4	11.5/20
Delivering our service priorities	3	2	1	4/6
Delivering sustainably	7	7	11	10.5/25
Improving culture	1	6	2	4/9
Total	**18**	**24**	**18**	**30/60**

ASSESSMENT

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

- Mental Health Measures
- Unscheduled care report incorporating Emergency Department and ambulance response and handover times, delayed transfers of care, and chronic condition emergency admission rates
- GP Out of Hours services
- Stroke
- Cancer
- Elective access including dementia and diagnostic waiting times and postponed admissions
- Healthcare Acquired Infection
- Interventions Not Normally Undertaken

Commentary and assessment on the latest finance and quality and safety indicators is provided in separate reports from the Directors of Finance and Nursing respectively.

Cardiff and Vale University Health Board - Performance Dashboard - September 2017

Purpose	Strategic Objectives	Measure	n	Status report: Mar 14	Mar 15	Mar 16	RAG rating	Mar 17	RAG rating	Jul 17	RAG rating	Sep 17	RAG rating	Latest Trend	Target	Time period	Exception Report
Caring for people and keeping them well	For Our Population	Uptake of influenza vaccination among high risk groups	1	>65: 69%, @risk 52%, pregnant women: 44%	>65: 70%, @risk 53%, pregnant women: 49%	>65: 68.5%, @risk 47.7%, pregnant women: n/a	R	>65: 68.5%, @risk: 48.1%, staff 52.9%	A	>65: 69.0%, @risk: 48.4%, staff 52.9%	A	>65: 69.0%, @risk: 48.4%, staff 52.9%	A	↔	Green: Community: 75%, staff 50%; Amber (improvement on 15/16)	Mar-17	
		95% vaccination of all children to age 4 with all scheduled vaccines	2	84.6%	84.0%	83.7%	A	81.2%	R	82.9%	R	82.9%	R	↔	Target: 95%, amber = improvement (15/16 = 83.7%)	Q4 16/17	
		Proportion of adults obese or overweight	3	55% (12/13)	54% (13/14)	54%	G	54%	G	52%, Age std 54%	G	52%, Age std 54%	G	↔	reduction on previous year (54% 2012/13, 2013/14)	NSW 2015/16	
	All take responsibility for improving our health and wellbeing	% of adults consuming > 14 units of alcohol p. Wk (New measure)	4	44% (12/13)	44% (13/14)	44%	A	42%	G	23%		23%			New measure - previous results relates to consumption above recommended units	NSW 2015/16	
		Proportion of adults meeting physical activity guidelines	5	26% (12/13)	27% (13/14)	27%	G	60%		60%	A	60%	A	↔	Target continuous reduction in % of adults who reported being physically active for more than 150 mins in the previous week	NSW 2015/16	
		% of C&V resident smokers who make a quit attempt via smoking cessation services - target 1%	6	not available	0.6%	1.1%	R	0.7% to Q2	R	1.3% to Q4	R	1.3% to Q4	R	↔	SIG target 5% by 2017/18, UHB milestone 2% over 4 Qtrs by year end (15/16 = 1.6%)	Q4 16/17	
		% C&V residents who are CO validated as successfully quitting at 4 weeks - measured annually - target 40%	7	not available	36.9%	46.0%	G	67.0%	G	56.0%	G	56.0%	G	↔	For 1 target 40%, Amber indicates improving (15/16 46%)	Q4 16/17	
		Rate of conceptions among females under 18	8	Cardiff 36 per 1000, Vale 28.4 per 1000	Cardiff 30 per 1000, Vale 29 per 1000	Cardiff 30.4 per 1000, Vale 19.4 per 1000	G	Cardiff 27.5 per 1000, Vale 15.8 per 1000	G	Cardiff 27.5 per 1000, Vale 19 per 1000	A	Cardiff 27.5 per 1000, Vale 19 per 1000	A	↔	reduction on previous year	2015 (Annual)	
	Deliver outcomes that matter to people	Crude Hospital Mortality Rate for people aged less than 75	9	94	103	0.60%	G	0.60%	G	0.60%	G	0.62%	G	↔	12 Month Reduction Target	12 months to Jul 17	
		Emergency crude mortality rate (12 mth)	10	3.15%	3.27%	2.94%	G	3.05%	G	3.04%	G	3.04%	G	↔	Reduction in CMR (Aug 2015 to Jul 2016 = 2.9%)	12 months to Jul 17	
		Demonstrable reduction in the mortality rate for stroke, heart attack and fractured neck of femur patients (30 day post event, 12 mth)	11	stroke 14.6%, heart attack 3.7%, #NOF 8.9%	stroke 12.8%, heart attack 3.2%, #NOF 6.9% (Feb)	stroke 10.1%, heart attack 3.7%, #NOF 5.9%	G	stroke 11.2%, heart attack 3.7%, #NOF 6.1%	A	stroke 11.1%, heart attack 4.0%, #NOF 6.7%	A	stroke 12.5%, heart attack 3.4%, #NOF 6.8%	A	↓	Demonstrable reduction in rolling 12 month rate (Feb 15 to Jan 16: 10.0%, 4.3%, 6.7%)	12 months to May 17	
		% Universal mortality reviews undertaken within 28 days of a death (New measure)	12	25%			G			70%		77%		↑	NEW MEASURE from April 17 - Target is 95%, Amber is improvement from 70% baseline	In June-17	
		Patient experience monitored through "Fundamentals of Care" audit and national surveys	13	Operational score 84% (4/12 >85%), User Experience score 89% (2/13 >85%)	Operational score (6/12 >85%), User Experience score 89% (23/26 >85%)	Operational score (15/18 >85%), User Experience score 89.7% (23/26 >85%)	A	87%	A	87%	A	87%	A	↔	% of pts responding who rated overall experience of care as 8/10 or above (Green 90%)	National report Sept-16	
		"Two minutes of your Time patient feedback scores"	14	0/11 >90%	7/11 >90%	6/11 >90%, 7/11 >85%	R	6/11 >90%, 7/11 >85%	R	6/11 >90%, 7/11 >85%	R	7/11 >90%, 7/11 >85%	R	↑	Green: 90% for each of the 11 questions. Amber: >85%	Monthly snapshot for Aug-17	In Nursing director's report
		Proportion of formal complaints responded to within 30 working days	15	45%	43%	55%	R	43%	R	61%	R	62%	R	↔	85%	Complaints received to July-17	In Nursing director's report
	Reduce health inequalities	Life expectancy at birth	16	80.5 2009/11	80.8 2011/13	80.8	G	80.8	G	Cdff F: 82.6, M 78.3, V: F: 83.2, M: 79.1	G	Cdff F: 82.6, M 78.3, V: F: 83.2, M: 79.1	G	↔	Continuous Improvement	2013/15	
		Reduce infant mortality for population	17	4.1 per 1,000 live births (2012)	4.3 per 1,000 live births (2013)	4.3 per 1,000 live births	A	3.9 per 1,000 live births	G	3.9 per 1,000 live births	G	3.9 per 1,000 live births	G	↔	reduction on 2012 rate (4.1)	ONS (2015)	
		% live births with a birth weight of less than 2500g	18	7.3% (provider)	6.7% (provider)	5.6% (provider)	G	5.90%	G	6.00%	G	6.30%	G	↔	12 mth cumulative reduction on previous year (7.7%)	Upto Aug-17	
		Rate of hospital admissions with any mention of intentional self harm for children and young people per 1000 popn (New measure)	19			433		387		387	A	3.87	A	↔	Annual reduction from 4.33 in 14/15	Year 15/16	
		Reduction in the number of emergency hospital admissions for basket of 8 chronic conditions per 100k popn	20	1157	1048	1020	G	1089	A	1108	A	1061	A	↔	reduction against same 12 month period of previous year (1078)	Upto May-17	
		Reduction in the number of emergency hospital readmissions within a year for basket of 8 chronic conditions	21	223	196	192	G	196	A	200	A	198	A	↔	reduction against same 12 month period of previous year (198)	Upto May-17	
		Emergency admission for hip fractures (age-standardised, 65+ per 100,000 people) (Revised Populations applied)	22	727.5 (Mar-Feb14)	633.9 (Mar- Feb 15)	499	G	554.8	G	578.7	A	565.1	A	↔	reduction on previous year (576 per 100,000 conf limit=+48)	June-May 2017	
	Our Service Provides	Delivery of the 31 day (Non- USC) and 62 day (USC) cancer access standards	23	96% NUSC, 83% USC	96.4% NUSC, 82% USC	100% NUSC, 74.2% USC	R	57% NUSC, 83% USC	R	99% NUSC, 92% USC	A	100% NUSC, 96% USC	G	↑	98 % NUSC, 95% USC	Monthly snapshot for July-17	
		Primary care contractor professionals assurance status	24	Satisfactory	Satisfactory	Satisfactory	G	Satisfactory	G	Managerial Intervention Required	A	Managerial Intervention Required	A	↔	CMS Core Service Sustainability Issues for 6 Practices within the UHB, with all receiving support to ensure viability	as at 11/09/2017	
		Offer services that deliver the population health our citizens are entitled to expect	% GP Practices open during daily core hours or within 1 hour of daily core hours	25	76% (2013)	83% (2014)	83% (2015)	G	88%	G	88%	G	88%	G	↔	Improvement target (2015 - 96%)	Jul-17	
		Dementia Bundle: Diagnosis rates, Access & training	26	97%	Diagnosis: 54% Access: 84% Training: 42%	Diagnosis: 55% Access: 71% Training: 33%	R	Diagnosis: 58% Access: 56% Training: 30%	G	Diagnosis: 58% Access: 97% Training: 35%	G	Diagnosis: 58% Access: 100% Training: 30%	G	↔	Target: Diagnosis improvement in proportion >65years diagnosed with dementia, Access attain 95% memory patients seen within 14 weeks, Trainingimprovement in %CP practices that completed MH DES in dementia care	Diagnosis Yr 15/16, Access Aug 17, Training Year 15/16	✓
		% of people over 65 who are discharged from hospital and referred to a care home and not their usual place of residence	27	2.77%	2.77%	2.60%	G	3.00%	R	3.10%	R	3.20%	R	↔	Demonstrable reduction in rolling 12 month rate (Sep-Aug 16:2.7%)	12 months to Aug-17	
		Sustained compliance against four acute stroke bundles	28	1: 96%, 2: 44%, 3: 77%, 4: 91%	1: 98%, 2: 89%, 3: 94%, 4: 96%	1: 35%, 2: 100%, 3: 57%, 4: 67%	R	1: 40%, 2: 96%, 3: 64%, 4: 79%	R	1: 60%, 2: 98%, 3: 67%, 4: 76%	A	1: 45%, 2: 100%, 3: 68%, 4: 90%	A	↔	Continuous improvement against all 4 NHS Wales Quality Improvement Metrics (NEW)	Monthly performance in July-17	✓
	Sustainability	Reduce harm, waste and variation sustainably making best use of the resources available to us	Number of new serious incidents & % assured within agreed timescale (NEW MEASURE)	29	102	97 serious incidents, 47 no surprises	219 serious incidents, 21 no surprises	R	206 serious incidents, 39 no surprises	A	41 Sis, 6 no surprises - 74% assured in timescale	A	76 Sis, 12 no surprises - 58% assured in timescale	A	↔	No. of SIs: reduction in year (219 Sis in15/16, 226 16/17) ; Timeliness for assurance : 95%	No. of SIs: Aug-17, Timeliness: July-51	In Nursing director's report
			% 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	30	Bundle 6: 84% compliant	Bundle 6: 86.7% compliant	Bundle 6: 90.6% compliant	A	64.9%	A	68%	A	64%	A	↔	NEW MEASURE FROM AUGUST: Continuous improvement target (Q1 16/17 = 48.1%, Q2 = 62%, Q3=64.9%, Q4 = 57%)	M4-17/18	
			Reduction in number of patients who had a potentially preventable Hospital Acquired Thrombosis (VTE) up to 90 days post discharge	31	41.0%	35.0%	156		161	A	21		21			NEW Definition FOR 2016/17: rolling 12 mth reduction in preventable HATs post level 2 Root Cause Analysis	12 mths to Mar-17	
			% of nutrition score completed and appropriate action taken within 24 hours of admission	32	92%	94%	95%	G	94%	A	96%	G	93%	A	↓	Green: 95%, Amber 90%	Monthly snapshot for July-17	
			Patient environment: Credits 4 cleaning scores for high risk areas	33	Very high risk: 93%, High risk: 92%, Significant risk: 89%	Very high risk: 93%, High risk: 93%, Significant risk: 92%	Very high risk: 94.7%, High risk: 94.4%, Significant risk: 91.3%	R	Very high risk: 98.1%, High risk 97.0%, Significant risk: 96.7%	G	Very high risk: 98.6%, High risk: 97.3%, Significant risk: 96.2%	G	Very high risk: 98.4%, High risk: 97.0%, Significant risk: 96.6%	G	↔	Very high risk: 98% High risk: 95% Significant risk: 85%	Monthly snapshot for July-17	
			% compliance with Hand Hygiene (WHO 5 moments)	34	91%	91%	94%	R	94%	R	92%	R	94%	R	↔	Green: 100%, Amber >95%	Monthly snapshot for July-17	
			Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA), working towards a zero tolerance	35	263 C difficile cases, 31 MRSA cases	172 C difficile cases, 44 MRSA cases	11 C difficile cases, 11 S. aurea cases	A	13.7 C difficile cases, 10.6 S. aurea cases	R	11 C difficile cases, 12.3 S. aurea cases; 39.7 E. coli cases	R	27 C difficile cases, 34 S. aurea cases; 72 E. coli cases	R	↔	Target is average monthly rate of no more than 10 C difficile, 8 S. aurea and 24 E. coli cases for Apr 17 to Mar 18 period	4mths. Apr 17 to July-17	✓
			Reduction in the number of healthcare acquired pressure ulcers	36	Mthly average = 38	Monthly average = 31 (372 14/15)	M12 = 413, avg = 34.4	G	M10 = 577 MA(12) = 55	R	M2 = 179 MA(12) = 71	R	M4 = 316 MA(12) = 77	R	↓	10% reduction on previous year (2015/16 avg = 34.4, target = mthly average of 31) [source:POC]	M4 - to July 2017	
			Financial balance: remain within revenue resource limits	36	£19.177m deficit at M12	£21.364m Deficit at M12	£0.268m surplus at M12, (£13.3m favourable variance from plan)	G	£29.717m deficit at M11	R	£7.695m deficit at M3	R	£12.8m deficit at M5	R	↔	2017/18 Draft Planned Deficit £30.9m	M5 - 2017/18	In Finance Report
			Remain within capital resource limits.	37	Actual spend at M 12= £59.7m	Actual spend at M 12= £64.6m	Actual spend at M12= £41.6m	G	Actual spend at M11= £26.216m	G	Actual spend at M3= £9.178m	G	Actual spend at M6= £7.262m	G	↔	Approved planned year end spend as at July 2017 = £36.186m	M3 - 2017/18	
			Show reductions in annual total pay spend.	38	£521.9m to M12	£529.5m to M12	£545.781m to m 12	R	£545.113m to m 3 2016/17	R	£145.113m to m 3 2017/18	R	£242.6m to m 5 2017/18	R	↔	Reduction on £236.1m to mth 5 2016/17	M5 - 2017/18	
		Have a planned care system where demand and capacity are in balance	Number of procedures undertaken that are on the UHB's "interventions not normally undertaken" list for procedures of limited clinical effectiveness	39			5315		5528	A	5478	A	5453	A	↔	12 month rolling reduction (May-Apr16 : 5451)	July-June 17	✓
			Reducing outpatient did not attend rates for New and Follow Up appointments	40		N 10.8%, FU 12.1%	N 10.5%, FU 11.7%		N 10.2%, 11.8%	A	N 10.2%, FU 12.2%	R	N 10.1%, FU 12.0%	R	↔	12 month rolling reduction: 16/17 New DNA 9.8%, FU 12.2%	M5 - 2017/18	
			Increasing in-session theatre utilisation (adopting Newton measure)	41	Tier 2	79%	79%	A	72%	A	76%	A	77%	A	↔	Newton consulting set standards: green >= 85%, amber 67%-85%, red <=67%	Jul-17	
			Uptake of ERAS across whole HB	42			Programme has stalled	R	Programme has stalled	R	Refresh being planned as part of TTC	R	Refresh being planned as part of TTC	R	↔	Self assessment based on roll out plan agreed with WG	Apr-17	
			Ensure that the data completeness standards are adhered to within 1 month of the episode end date	43	92% in month, 97% past 12 months	95% in month, 96% past 12 months to Feb-15	96.2% in month, 96.6% past 12 month	A	95.8% within 30 days	G	95.8% within 30 days	G	96.9% within 30 days	G	↑	NEW MEASURE FOR 2016/17: 95% within 30 days	Jul-17	
		Have an unplanned (emergency) care system that provides the right care, in the right place, first time	% hospital cancellations rebooked with 14 days	45	52%	36%	56%	R	28%	R	40%	R	43%	R	↔	100%	Monthly snapshot for May-17	✓
			Part 1 Local Primary care Mental Health Support Services (% assessed within 28 days & therapy started within 28days)	46	5.5% (28 days), 73% (56 days)	10.7% (28 days), 90% (56 days)	82.2% (28 days), 92.8% (28 days)	G	70% (assessment), 86% (therapy)	R	80% (assessment), 87% (therapy)	R	71% (assessment), 85% (therapy)	R	↑	80%	Monthly snapshot for July-17	
			Part 2 Coordination of care and treatment Planning for secondary Mental Health Users (% of users with a care and treatment plan)	47	88.3%	91.9%	90.4%	G	91.0%	G	89.0%	A	90.0%	G	↑	90%	Monthly snapshot for July-17	✓
			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 16 days	48	100%	100%	89%	A	100%	G	100%	G	100%	G	↔	100%, Amber: Continuous improvement as new standard	Monthly snapshot for July-17	
			Paid Mental Health Advocacy (Provision of an advocate to all eligible requesting users)	49	100%	100%	100%	G	100%	G	100%	G	100%	G	↔	100%	Monthly snapshot for July-17	
			95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks	50	86.4% <26 weeks, 2088pts > 36 wks	84% <26 weeks, 2396pts > 36 wks	84% <26 weeks, 2523pts > 36 wks	A	83% <26 weeks, 2728pts > 36 wks	A	84% <26 weeks, 1134pts > 36 wks	A	86% <26 weeks, 3512pts > 36 wks	A	↓	95% <26 wks, 0 > 36 wks: Amber: Deliver Mar-17 milestone of 1248	Post at 31-Aug-17	✓
			Attainment of the primary care out of hours service standards	51	7 Green, 1 Amber, 7 Red	7 Green, 8 Red	5 Green, 3 Amber, 9 Red	R	6 Green, 6 Amber, 5 Red	R	6 Green, 6 Amber, 5 Red	R	6 Green, 6 Amber, 5 Red	R	↔	Number of standards where the UHD is compliant (Green 13/17, Amber 10/17)	Monthly performance in Aug 17	✓
			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	52	59%	48%	80%	G	82%	G	67% in June, 84% for 12 mths	G	84% in August, 84% for 12 mths	G	↑	70% n.b. This is a new measure for urgent calls only which commenced on 1st October 2015	Monthly performance in Aug-17	
			76% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge	53	86%	82%	85%	R	84%	R	85%	R	87%	R	↑	95%	Monthly performance in August-17	✓
			Eradication of over 12 hour waits within all hospital emergency care facilities	54	175	101	55	R	59	R	47	A	8	A	↑	0	Monthly performance in Aug-17	
	Culture	Be a great place to work and learn	Percentage of staff (excluding medical) undertaking PADR (Performance Appraisal Development Review)	55	51%	56%	56%	R	58%	R	56%	R	58%	R	↔	Green: >85%, Amber 68-84%, Red <68%	12 months to Aug-17	
			Medical Staff – percentage of staff undertaking Performance Appraisal	56	66%	77%	75.2%	R	74.4%	R	75.1%	R	80.9%	A	↑	Green: 85%, Amber: increase from Mar-15 position of 77%	as at May-17	
			% of staff completing staff survey in the organisation	57	19%	19%	22%	R	26% (f 7000 staff surveyed	R	26% (f 7000 staff surveyed	R	26% (f 7000 staff surveyed	R	↔	Bi-Annual	2016 staff survey	
			Overall measure for organisational climate / engagement	58	Not available	51%	60%	A	3.64/5	A	3.64/5	A	3.64/5	A	↔	Bi-Annual	2016 staff survey	
			Achieve annual local sickness and absence workforce target	59	5.60%	5.54%	5.14%	A	4.86%	G	4.87%	A	4.88%	A	↔	12 month rolling reduction: was 4.9% by end of Mar-17, target: reduce to 4.2% Mar-18	to 31 jul 17	
			Achieve platinum corporate health standard	60	In progress	Achieved	Achieved	G	Achieved	G	Achieved	G	Achieved	G	↔	Achieve standard by March 2014	2013/14	
		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	61	15 mins: 41%, 60 mins: 90%	15 mins: 60%, 60 mins: 92%	15 mins: 58%, 60 mins: 93%	A	15 mins: 49%, 60 mins: 90%	R	15 mins: 57%, 60 mins: 91%	R	15 mins: 62%, 60 mins: 96%	A	↑	15 mins: 60%, 60 mins: 100% (Amber improvement)	Monthly performance in Aug 17	✓
			No. of Delayed transfers of care – mental health (all ages) and non mental health (75 years and over)	62	55 NMH, 15 MH	109 NMH, 24 MH	73 NMH, 21 MH	R	25 NMH, 17 MH	G	46 NMH, 14 MH	A	45 NMH, 9 MH	A	↔	Continuous improvement: March 2017: 29 Non MH, 17 MH	Monthly snapshot for Aug-17	
			Progress in Delivering Strategic Programme	63	Progress on developing high level strategies & relationships with CU	Progress on developing high level strategies & relationships with CU	Blueprint for HEART prepared for board	A	Slippage on aspects due to changing financial posn	A	TTC programme aligned with SOFW objectives	A	TTC programme accelerating	A	↔	Sustained improvement (metrics to be developed)	Assessment at Sep-17	
									Current Performance = 30/60									

12

PERFORMANCE REPORT

SITUATION

This report provides commentary and advises on the actions being taken to drive improvement in the following areas of performance set out by the Welsh Government (WG) which have been prioritised by the Board or which have deteriorated over the period covered by the report. These are:

- Mental Health Measures
- Unscheduled care report incorporating Emergency Department and ambulance response and handover times, delayed transfers of care, and chronic condition emergency admission rates
- GP Out of Hours services
- Stroke
- Cancer
- Elective access including dementia and diagnostic waiting times, postponed admissions and non attendance rates
- Healthcare Acquired Infection
- Interventions Not Normally Undertaken

Details of patient experience measures and the financial position are covered in separate reports to the Board.

BACKGROUND

The UHB is presently compliant with 18 of its 60 performance measures (July = 17/60, May = 23/58, March = 23/58) and is making satisfactory progress towards delivering a further 24 (July = 23, May =16, March =13).

There are now 18 measures (July = 20) where performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale. This is summarised in the table below:

Policy Objective	Green	Amber	Red	Score
Delivering for our population	7	9	4	11.5/20
Delivering our service priorities	3	2	1	4/6
Delivering sustainably	7	7	11	10.5/25
Improving culture	1	6	2	4/9
Total	**18**	**24**	**18**	**30/60**

ASSESSMENT

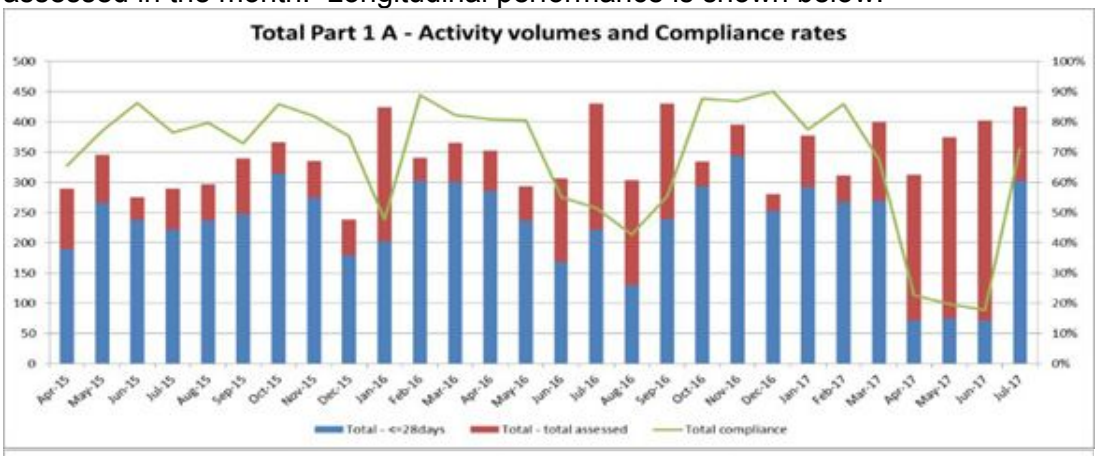
1) MENTAL HEALTH

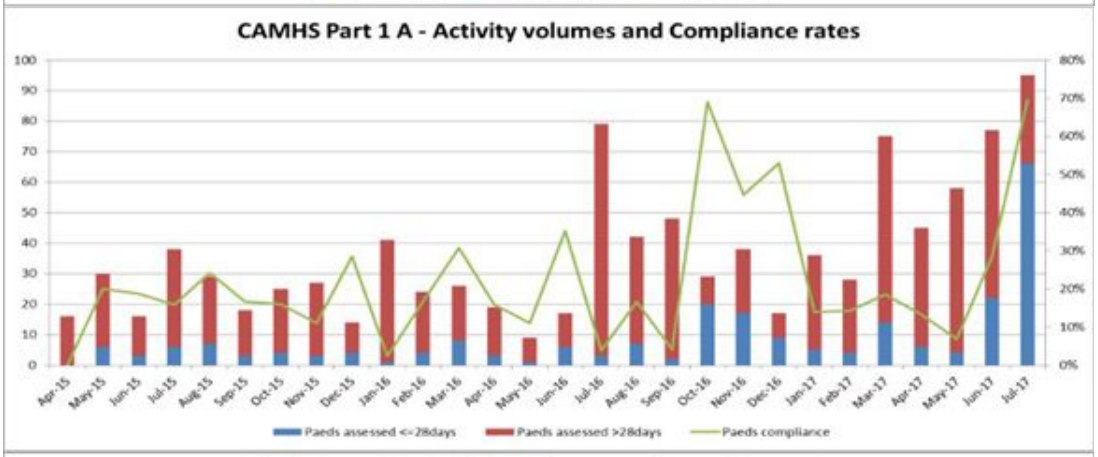
How are we doing?

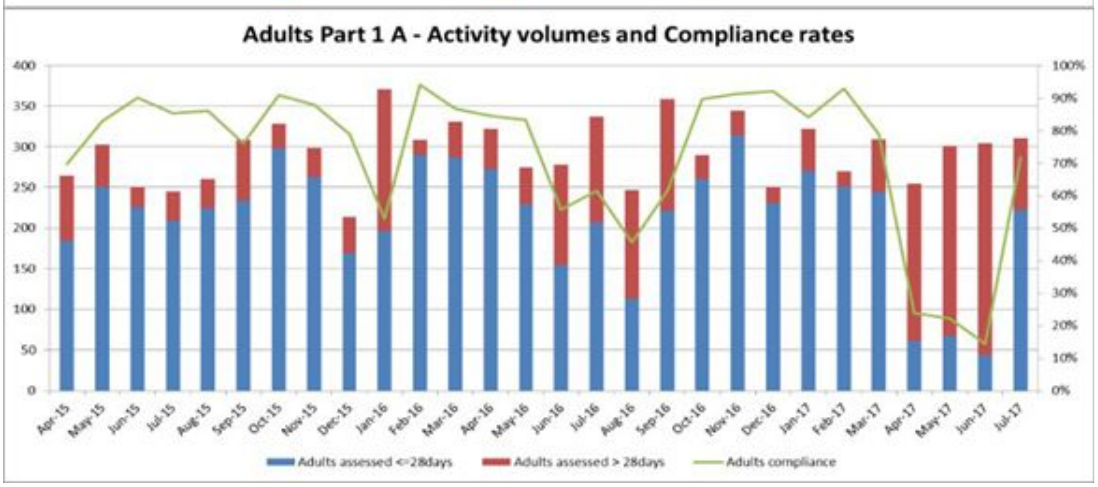
Part 1a: Service users to receive an assessment within 28 days

Overall 71%% of service users seen in July were assessed by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of referral, against the Welsh Government's minimum standard of 80%.

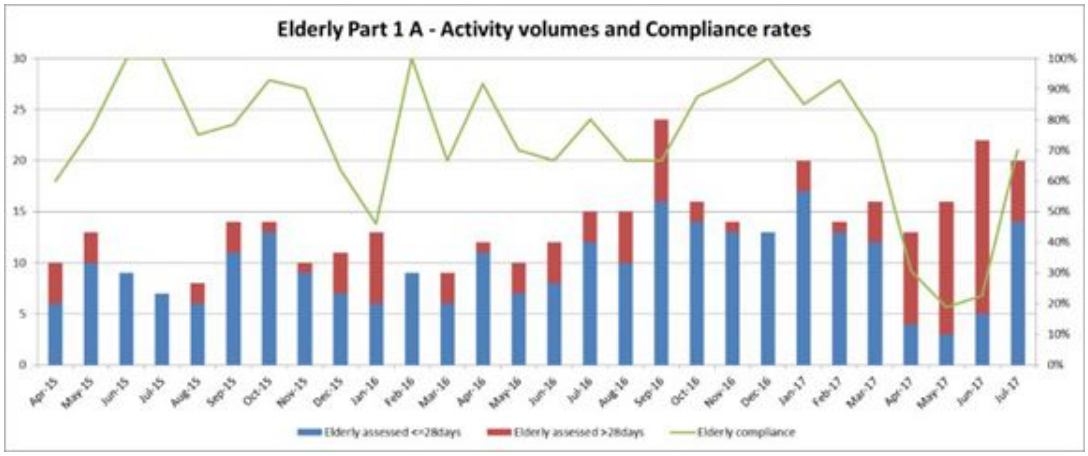
All three services failed to meet the 80% standard, despite 426 users being assessed in the month. Longitudinal performance is shown below:







12



In respect of CAMHS, compliance against Part 1a was 69% in July, this is a significant increase in performance and is attributed to:

- Vacancies filled and more appointments to be made with new staff now operational and delivering Part 1 assessments.
- Electronic referral process introduced, reducing delays.
- Having reduced the backlog, referrals can now be appointed to in month
- Improved data capture and accurate use of PARIS.
- Staff have job plans with allocated assessment /clinic slots.
- Telephone assessment piloted and used in suitable circumstances.

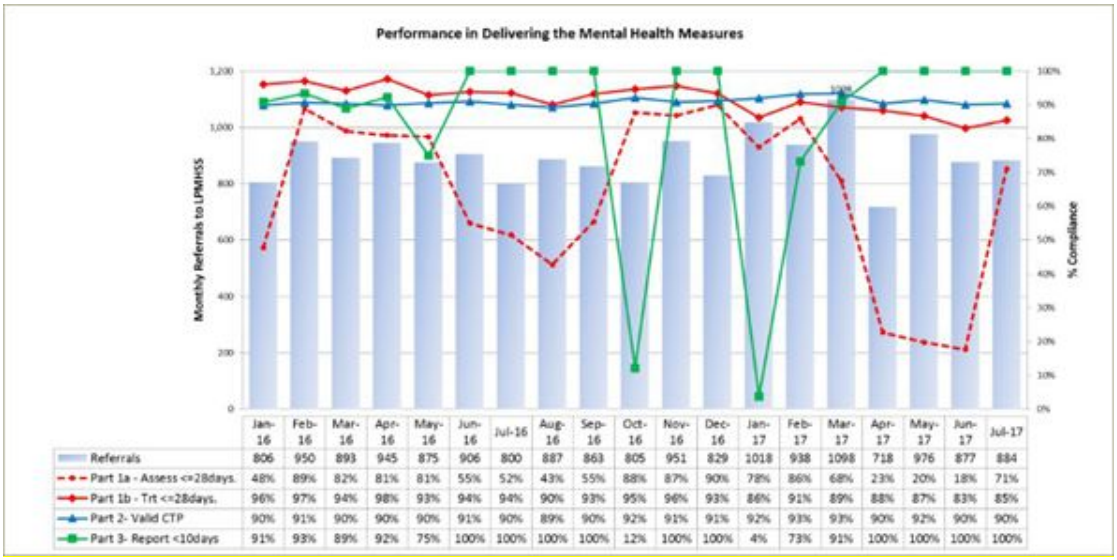
Compliance for Adult and Older Peoples services improved significantly due to staff returning from sickness. In addition, there has been a focus on improving the administration to follow the guidelines for patients who do not attend or cancel their appointments.

Overall referral volumes into adult and older people's services received between April and July 2017 have fallen to an average of 860 per month, down from the levels observed between January to March, at which time the directorate was receiving over 1000 referrals per month.

Part 1b: Overall 85% of service users started a therapeutic intervention following assessment by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of their assessment against a standard of 90%.

Therapy commenced within 28 days	CAMHS	Adults	Elderly	Total
<=28days	3	105	9	112
Total commencing therapy	3	124	9	131
% Compliance	100%	85%	100%	85%

Part 2: Overall 90.4% of LHB residents had a valid Community Treatment Plan completed at the end of July which is above the standard of 90%.



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Referrals	806	950	893	945	875	906	800	887	863	805	951	829	1018	938	1098	718	976	877	884
Part 1a - Assess <=28days.	48%	89%	82%	81%	81%	55%	52%	43%	55%	88%	87%	90%	78%	86%	68%	23%	20%	18%	71%
Part 1b - Trt <=28days.	96%	97%	94%	98%	93%	94%	94%	90%	93%	95%	96%	93%	86%	91%	89%	88%	87%	83%	85%
Part 2- Valid CTP	90%	91%	90%	90%	90%	91%	90%	89%	90%	92%	91%	91%	92%	93%	93%	90%	92%	90%	90%
Part 3- Report <10days	91%	93%	89%	92%	75%	100%	100%	100%	100%	12%	100%	100%	4%	73%	91%	100%	100%	100%	100%

Part 3. 100% of former users assessed under part 3 of the measure were sent their outcome of assessment report within 10 days.

Part 4 of the measure relating to the advocacy service continues to be met.

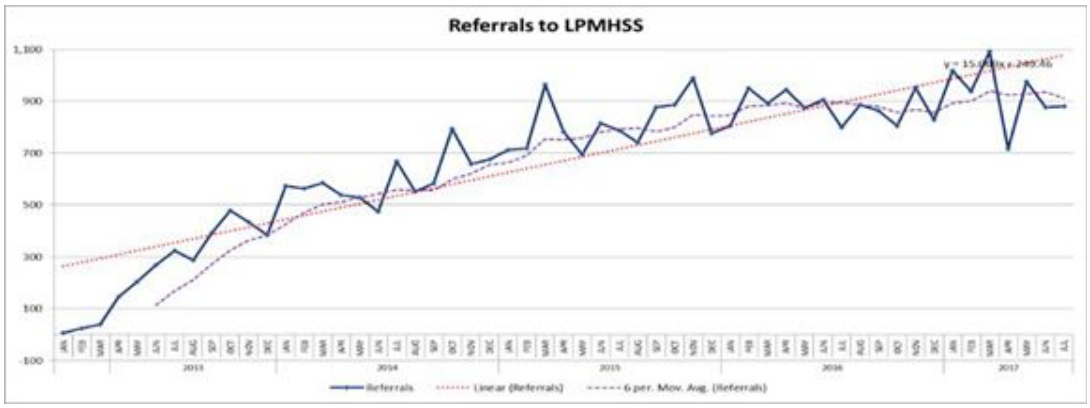
How do we compare with our peers?

Comparison with the performance of other Health Boards in Wales in delivering the mental health measures in the month of June 2017 is shown below:

	Part 1a	Part 1b	Part 2	Part 3
	Part 1a. % of assessments by the LPMHSS undertaken within 28 days from the receipt of the referral	Part 1b. % of Therapeutic Interventions started within 28 days following an assessment by the LPMHSS	% of residents with a valid CTP	% of residents sent their outcome assessment report within 10 days of their assessment.
Wales	75.0%	80.9%	89.3%	100.0%
ABM	60.6%	90.4%	88.6%	100.0%
AB	94.5%	89.2%	90.8%	100.0%
BCU	83.5%	79.9%	89.1%	100.0%
C&V	17.6%	83.0%	87.6%	100.0%
CTaf	89.6%	88.4%	91.0%	100.0%
HDda	81.4%	88.1%	91.9%	100.0%
Powys	78.7%	43.0%	87.4%	100.0%
Rank	7/7	5/7	6/7	-/7

What are the main areas of risk?

The key risk has been the steadily increasing demand on primary mental health services and the inherent variation within the monthly demand. This risk exacerbates a further risk relating to the low level of resilience planned for with regard to the service's capacity to meet the demand, which is often exposed at times of peak demand or unexpected staffing shortages.



What actions are we taking?

Primary Mental Health
Additional funding for the Primary Mental Health service has been approved for all age ranges and continues to be used to underpin our actions.

The child and adolescent mental health service are scoping staffing bank options to provide the supply side flexibility to cope with referral peaks which are common for Children's and Younger People's services.

The Cwm Taf Health Board has developed an action plan to improve the administration of CPT reviews and to increase the clinic capacity by two sessions per month starting from September 2017.

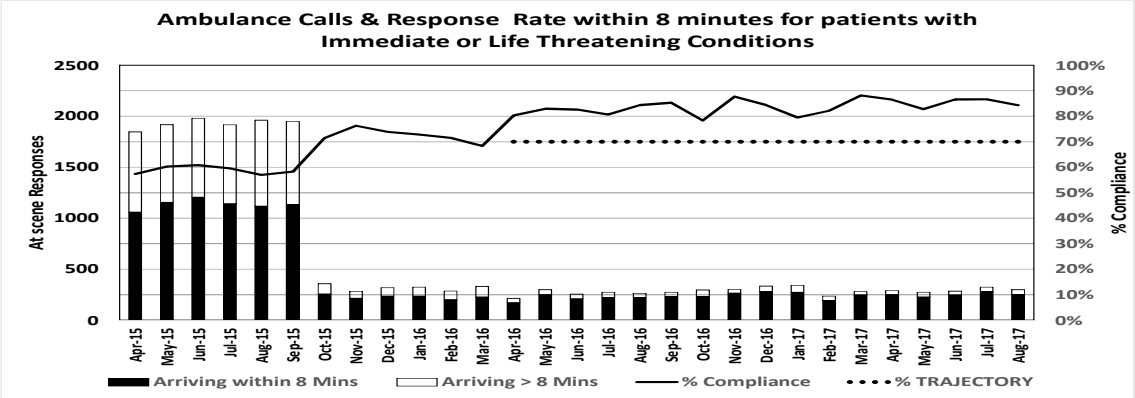
Adult and Older People Services

A reserve list of Bank staff has been identified who are called upon during certain periods in the year. As part of the review of quarter 4 and lessons learnt the service is currently reviewing referral patterns and the trigger levels set to determine when they deploy Bank staff.

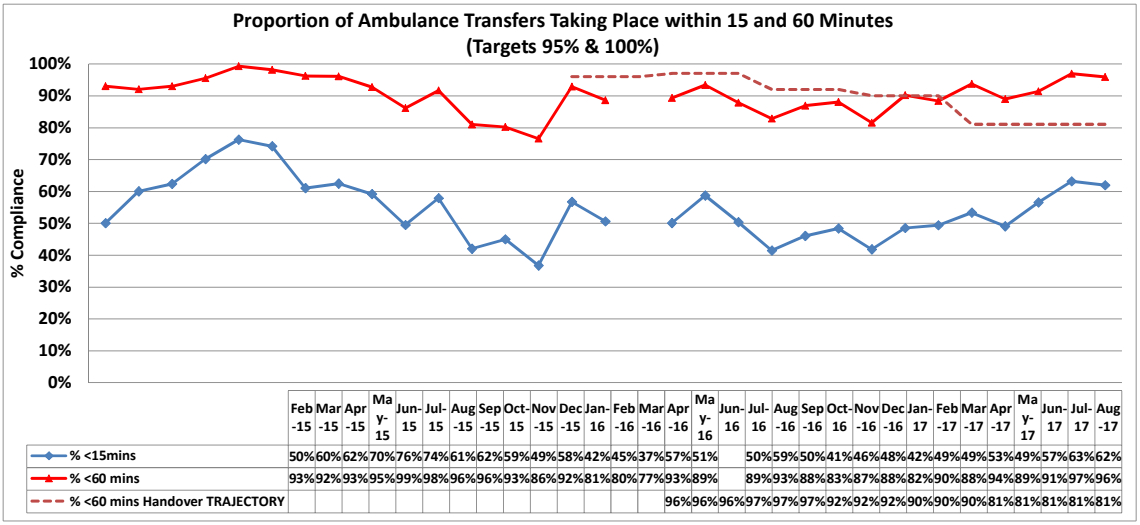
12

2) Unscheduled Care

The Welsh Ambulance Service Trust continues to respond to over 80% of the most urgent calls (Category A) made from within Cardiff and Vale's boundaries within 8 minutes. In August 252 patients out of 299 (84.3%) were responded to within 8 minutes.



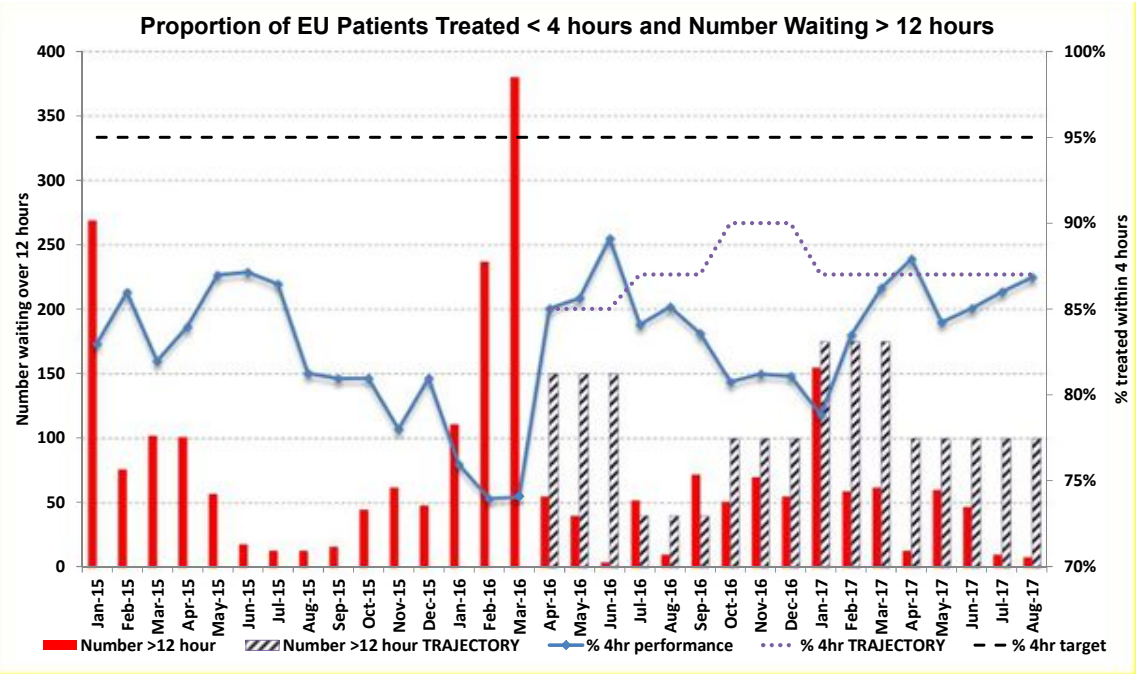
In respect of ambulance handover delays, performance in August was at 62% for patients handed over within 15 minutes and 96% of patients handed over within an hour.



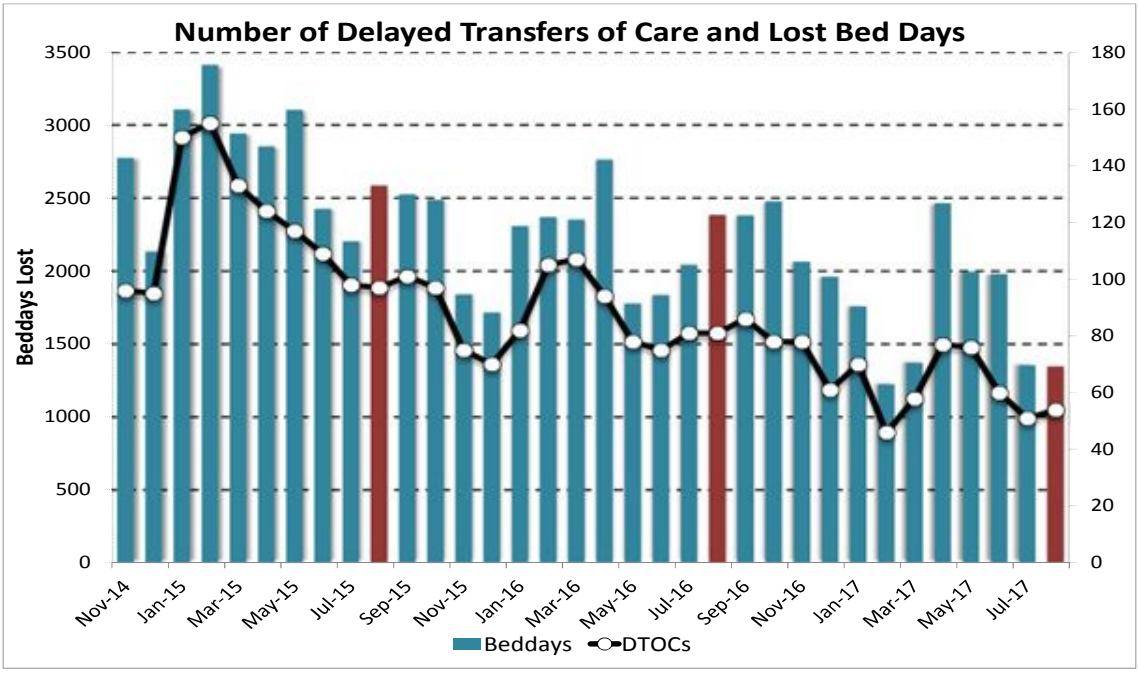
	Feb -15	Mar -15	Apr -15	May- 15	Jun- 15	Jul- 15	Aug -15	Sep -15	Oct- 15	Nov -15	Dec -15	Jan- 16	Feb -16	Mar -16	Apr -16	May- 16	Jun- 16	Jul- 16	Aug -16	Sep -16	Oct- 16	Nov -16	Dec -16	Jan- 17	Feb -17	Mar -17	Apr -17	May- 17	Jun- 17	Jul- 17	Aug -17
% <15mins	50%	60%	62%	70%	76%	74%	61%	62%	59%	49%	58%	42%	45%	37%	57%	51%		50%	59%	50%	41%	46%	48%	42%	49%	49%	53%	49%	57%	63%	62%
% <60 mins	93%	92%	93%	95%	99%	98%	96%	96%	93%	86%	92%	81%	80%	77%	93%	89%		89%	93%	88%	83%	87%	88%	82%	90%	88%	94%	89%	91%	97%	96%
% <60 mins Handover TRAJECTORY															96%	96%	96%	97%	97%	97%	92%	92%	92%	90%	90%	90%	81%	81%	81%	81%	81%

Performance against the Welsh Government's standard requiring 95% of patients to be admitted, discharged or treated within 4 hours of arrival in EU was 87% in August, meeting the performance trajectory agreed in the annual plan, with 8 patients having waited to be admitted for more than 12 hours. These figures exclude patients where there has been clinical justification for the patient requiring extended periods of care and observation within the Emergency Department footprint.

12



At the August 2017 census point, the UHB recorded that 54 patients had their care pathway delayed as per formal WG rules. The lost capacity for the month is 40% less than the corresponding month in 2016.



How do we compare with our peers?

The latest Welsh Government performance data available indicates that C&V was ranked 1st across Wales for two of the four indicators.

12

Month	Jul-17	Jul-17	Jul-17	Jul-17
HB	4 Hour	Patients >12Hrs	Red Call<8 Minutes	Ambulance Waits>1 Hr
ABM	83.2%	296	76.0%	206
AB	81.2%	400	78.4%	199
BCU	77.6%	1,051	76.7%	711
C&V	86.0%	10	86.6%	77
CT	87.2%	133	75.3%	2
HD	89.4%	278	74.8%	37
Wales	83.7%	2,168	78.0%	1,259
C&V Rank	3/6	1/6	1/6	3/6

The UHB has the 5th highest rate of delayed transfers of care of patients aged over 75 years overall in Wales for non-Mental Health, whilst the Mental Health rate is the 6th highest.

July-17		ABM	AB	BCU	C&V	CT	HDda	Powys	C&V Rank
No. of DTOCs per 10,000	Non Mental Health	118.3	157.2	195.4	165.9	140.8	55.8	167.1	5/7
	Mental Health	5.0	2.2	2.1	4.6	2.6	3.7	2.4	6/7

What are the main areas of risk?

Delivery of high quality, safe care in EU requires the availability of sufficiently trained clinical decision makers to meet demand 24 hours a day, 7 days a week and sufficient capacity within the department to assess and treat patients. The ability to recruit staff and for patients to be transferred up to a ward or the assessment units as and when their care requires it, remain the two key risks.

Patients whose care pathways are delayed are not receiving the most effective, safest care. There is an opportunity cost of a bed and its associated resources being used sub optimally, as other patients requiring that capacity are delayed, potentially requiring them to also be treated sub-optimally.

What actions are we taking?

As reported previously, whilst the UHB continues with implementation of the longer term whole systems plan, there are a number of more immediate actions, including:

- Weekend and seasonal planning – including (i) Tactical deployment of additional bed capacity (ii) Early consideration of our approach and planning for Winter 2017/18 – informed by a joint review with our partners of winter last year
- Continued joint working with WAST to develop and implement new EU attendance avoidance pathways
- Consideration of extending paramedic practitioners within Primary Care clusters. An additional 4 paramedic practitioners to be recruited in September subject to evaluation of data
- Improved resilience in our Primary Care GP OOHs service

- Extending and maximising the Ambulatory Emergency Care model, including making the model more inclusive in terms of catchment of patients and co-locating GP OOHs PCC
- A Local Operating Model in UHL has been in place since beginning of June – to manage the site from a Medicine perspective with the same focus as at UHW
- A review of all > 12 hours waits to ensure themes are identified / lessons learnt and a move to interval ('days since') reporting as well as volume
- Launch of '#Endpyjamaparalysis' campaign – to promote independence of patients in hospital and prevent deconditioning
- DTOCs - main issues continue to be Care Home availability and choice. Some of the actions being taken include: Working closely with Local Authority to develop a commissioning framework for Care Homes; Development of a governance framework which includes Discharge Policy , Choice protocol and Standards Operating Procedure for Integrated Discharge Services team; Weekly DToC review meetings at both UHW and UHL, chaired by Head of Integrated Care, to review cases and offers challenge to process, problem solve and escalate constraints

3) GP OUT OF HOURS SERVICES (OOH)

How are we doing?
The UHB monitors the performance of the Out of Hours service using the Welsh Government Quality and Monitoring Standards. The latest update is as follows:

In summary for August, the UHB achieved the following:
- 6 areas were reported as Green (6 reported for June)
- 6 areas were reported as Amber (6 reported for June)
- 5 areas were reported as Red (5 reported for June)

	Demonstrates volumes only		Aug-17			
Standard	**Description**	**Target**	Total	Result	Score	
Telephone Services						
Telephone Calls	No of calls answered within target	95% ans. in 60 secs	**7826**	**7184**	**92%**	
		100% ans. in 120 secs	**7826**	**7459**	**95%**	
Abandoned Calls	No of callers who abandon after 60 secs.	No more than 5%	**7826**	**125**	**2%**	
Handling	% of calls recording correct demographics	100% Correct	**7826**	**7826**	**100%**	
Telephone Triage Services						
Urgent Triage	No of urgent calls, logged & returned	98% triaged within 20 mins	**2117**	**1742**	**82%**	
Routine Triage	No of routine calls, logged & returned	98% triaged within 60 mins	**3589**	**3083**	**86%**	
Immediate Life Threatening (ILT) Conditions						
Referral	No of life threatening conditions identified	100% within 3 mins	**131**	**131**	**100%**	
Home Visiting						
Home Visits	No and percentage of home visits	No target	**7673**	**502**	**7%**	
HV P1 (Emerg)	No of face to face contacts within one hour	75% seen within one hour	**18**	**13**	**72%**	
	No of face to face contacts within two hours	100% seen within two hours	**18**	**18**	**100%**	
HV P2 (Urgent)	No of face to face contacts within two hours	98% seen within two hours	**155**	**126**	**81%**	
HV P6	No of face to face contacts within six hours	98% seen within six hours	**329**	**243**	**74%**	
Primary Care Centre Appointments						
PCC	No and percentage of PCC attendances	No target	**7673**	**2300**	**30%**	
PCC P1 (Emerg)	No of face to face contacts within one hour	75% seen within one hour	**34**	**25**	**74%**	
	No of face to face contacts within two hours	100% seen within two hours	**34**	**33**	**97%**	
PCC P2 (Urgent)	No of face to face contacts within two hours	98% seen within two hours	**316**	**285**	**90%**	
PCC P6	No of face to face contacts within six hours	98% seen within six hours	**1950**	**1936**	**99%**	
Transmissions						
Transmissions	No of reports sent to GP Practice by OOH	100% by 9am	**8888**	**8888**	**100%**	
Other Data						
Rota	No of 1 Hour Shifts Filled	100% of shifts filled	**4178**	**3343**	**80%**	

Non-target indicators are also included, showing that 7% of calls resulted in a home visit (same as June) and 30% resulted in the patient attending a Primary Care Centre appointment (29% in June).

The reported position very similar to June with a reasonable shift fill rate, though 85% and over will be needed to make inroads into the particularly challenging triage targets.

The challenges continue for the UHB in trying to ensure that these clinical shifts are filled as far as is possible, since this holds the key for improved performance.

How do we compare with our peers?

Progress is being made on all Wales data collection for OOH services, though data is not currently available across all LHBs. It will another few months before this data is established to the level required in order to merit being included in this report.

What are the main areas of risk?

The key area of concern continues to be meeting the triage targets, given the ongoing difficulties in rostering to all clinical shifts. Whilst improvements were made in filling shifts in March, it remains below the level needed to both achieve and maintain the very challenging triage targets.

What actions are we taking?

There are a number of actions that are being taken forward to improve the service, which include:

- There is a new bundle payment, whereby GPs have to book 6 hot spot shifts over a 3 month period from July to September 2017.
- Recruitment drive for Clinical/Nurse Practitioners to bolster the level of clinical support within the service.
- A number of IT issues have been affecting the delivery of the service, including delays for clinicians to log in to the application and issues with printing, in particular, prescriptions. Whilst the situation has improved, all issues have not been dealt with as yet.
- The implementation of the 111 service will change the way in which out of hours services are delivered. Whilst implementation within the UHB is not imminent, preparatory work such as migrating from the current version of the software being used to the same hosted version as is used by both Aneurin Bevan and Cwm Taf providing regional working opportunities, is being considered.

4) STROKE

How are we doing?

The expectation on the UHB is to demonstrate continuous improvement over the course of the year with the objective of achieving the SSNAP UK average by the end of the financial year. (SSNAP is the audit tool used throughout the UK to record detailed data on stroke patients treated in hospitals).

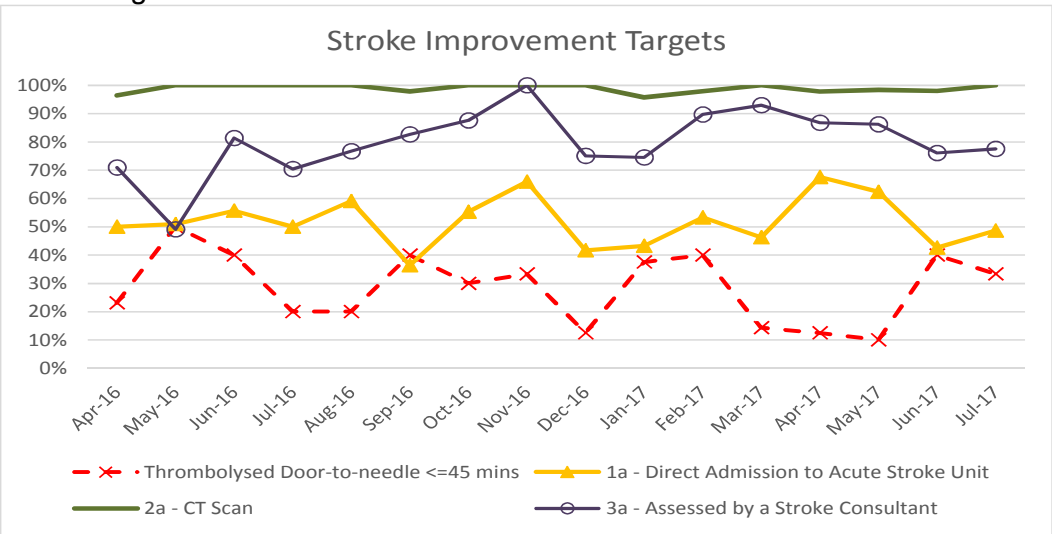
The Welsh Government has chosen four areas within the Quality Improvement Measures (QIMs) to focus on for All-Wales benchmarking. There is a target for three of them, whilst an improvement trend is required for the other. Compliance for both the 4 and 24 hour QIM has deteriorated since May.

WG benchmarking standard		Target	UHB in Jul-17
4 Hour QIM	Direct Admission to Acute Stroke Unit within 4hours	54.8%	48.6%
12 Hour QIM	CT Scan within 12 hours	94.0%	100%
24 Hour QIM	Assessed by a Stroke Consultant within 24 hours	81.1%	77.5%
45 Minute QIM	Thrombolysis Door to Needle within 45 minutes	Improve	33.3%

The following table shows the UHB's performance against all of the QIMs:

Stroke Care Performance Indicators	*Apr-16*	*May-16*	*Jun-16*	*Jul-16*	*Aug-16*	*Sep-16*	*Oct-16*	*Nov-16*	*Dec-16*	*Jan-17*	*Feb-17*	*Mar-17*	*Apr-17*	*May-17*	*Jun-17*	*Jul-17*
Thrombolysed Door-to-needle <=45 mins	23.1%	50.0%	40.0%	20.0%	20.0%	40.0%	30.0%	33.3%	12.5%	37.5%	40.0%	14.3%	12.5%	10.0%	40.0%	33.3%
72 Hour Pathway Care KPIs																
1. Within 4 Hours Care KPI	47.3%	41.8%	56.3%	40.7%	55.8%	39.1%	57.5%	67.4%	46.4%	40.4%	52.1%	47.6%	68.9%	62.1%	40.0%	45.0%
1a - Direct Admission to Acute Stroke Unit	50.0%	50.9%	55.6%	50.0%	59.0%	36.4%	55.3%	65.9%	41.7%	43.2%	53.3%	46.2%	67.5%	62.3%	42.6%	48.6%
1a - TRAJECTORY for above	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%	55.0%	55.0%	55.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%
1b - Swallow Screening	66.7%	54.2%	73.3%	52.1%	61.5%	75.0%	77.8%	80.5%	74.5%	76.7%	74.5%	75.0%	82.9%	81.5%	63.8%	71.1%
2. Within 12 Hours Care KPI	96.4%	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	95.7%	97.9%	100.0%	97.8%	98.3%	98.0%	100.0%
2a - CT Scan	96.4%	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	95.7%	97.9%	100.0%	97.8%	98.3%	98.0%	100.0%
2a - TRAJECTORY for above	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
3. Within 24 Hours Care KPI	49.1%	41.8%	77.1%	59.3%	67.4%	80.4%	85.0%	93.5%	51.8%	63.8%	77.1%	73.8%	71.1%	65.5%	58.0%	67.5%
3a - Assessed by a Stroke Consultant	70.9%	49.1%	81.3%	70.4%	76.7%	82.6%	87.5%	100.0%	75.0%	74.5%	89.6%	92.9%	86.7%	86.2%	76.0%	77.5%
3b - Assessed by a Stroke Nurse	90.9%	96.4%	97.9%	98.1%	90.7%	97.8%	92.5%	95.7%	92.9%	97.9%	89.6%	95.2%	95.6%	93.1%	90.0%	97.5%
3b - TRAJECTORY for above	45.0%	45.0%	45.0%	60.0%	60.0%	60.0%	70.0%	70.0%	70.0%	88.0%	88.0%	88.0%	89.0%	89.0%	89.0%	89.0%
3c - Assessed by One of OT, PT, SALT	67.3%	74.5%	93.8%	83.3%	90.7%	97.8%	100.0%	95.7%	60.7%	72.3%	87.5%	81.0%	84.4%	75.9%	72.0%	85.0%
4. Within 72 Hours Care KPI	67.3%	90.9%	91.7%	94.4%	90.7%	87.0%	100.0%	97.8%	69.6%	78.7%	91.7%	83.3%	95.6%	75.9%	82.0%	90.0%
4a - Formal Swallow Assessment	54.2%	92.3%	94.1%	94.7%	85.7%	87.5%	100.0%	100.0%	68.0%	41.7%	82.4%	76.9%	85.7%	73.7%	65.0%	82.4%
1a - TRAJECTORY for above	80.0%	80.0%	80.0%	82.0%	82.0%	82.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	85.0%	85.0%	85.0%	85.0%
4b - OT Assessment	83.3%	93.9%	95.5%	98.0%	94.7%	97.6%	100.0%	97.6%	84.0%	100.0%	93.3%	90.0%	100.0%	86.3%	94.0%	93.9%
4c - Physiotherapy Assessment	92.6%	100.0%	100.0%	98.0%	97.6%	100.0%	100.0%	100.0%	90.4%	100.0%	97.9%	95.2%	100.0%	94.3%	98.0%	97.3%
4d - SALT Communications Assessment	51.9%	93.8%	96.6%	90.0%	88.9%	77.3%	100.0%	97.1%	71.1%	88.9%	96.7%	90.9%	95.7%	75.0%	76.9%	90.9%
Patients Treated per Month	55	55	48	54	43	46	40	46	56	47	48	42	45	58	50	40

The specific indicators under focus by the Welsh Government are shown in more detail in the following chart:



How do we compare with our peers?

The latest available benchmarking data across Wales is for June 2017:

HB	4 Hours	12 Hours	24 Hours	Door to Needle <= 45 Minutes
ABM	49.1%	90.8%	82.6%	25.0%
AB	55.9%	98.3%	96.6%	18.2%
BCU	49.3%	91.0%	87.2%	16.7%
C&V	41.3%	98.0%	75.5%	40.0%
CT	53.7%	96.4%	81.8%	0.0%
HD	74.2%	98.6%	80.6%	25.0%
Wales	53.7%	94.8%	84.1%	21.1%
C&V Rank	6/6	3/6	6/6	1/6

12

What are the main areas of risk?

These are the latest QIMs which are considered to be significant factors in improving health outcomes when delivered. As such failure to achieve them may have an adverse impact on patient care.

The greater operational challenges to delivery are:

- Inability to transfer patients to the acute stroke unit, where the stroke multi-disciplinary team is based, has a detrimental impact on provision of each of the later bundles, in particular clinical assessment within 24 hours.
- Inability to transfer patients to the Stroke Rehabilitation Centre for continued care, affecting both patient outcomes and the available capacity on the Acute Stroke ward.
- It is also important to note that the challenges faced in sustaining the interventional neuroradiology service, have delayed progress on the regional development of mechanical thrombectomy services.

What actions are we taking?

The main challenge for the UHB remains improving and sustaining compliance against the 4 hour direct admission target. Whilst compliance improved in July (48.6%) in comparison to the previous month (42.6%), it is still below the SNAPP UK average. Key to this is flow into and out of the acute stroke unit in UHW. A number of actions are being taken, including:

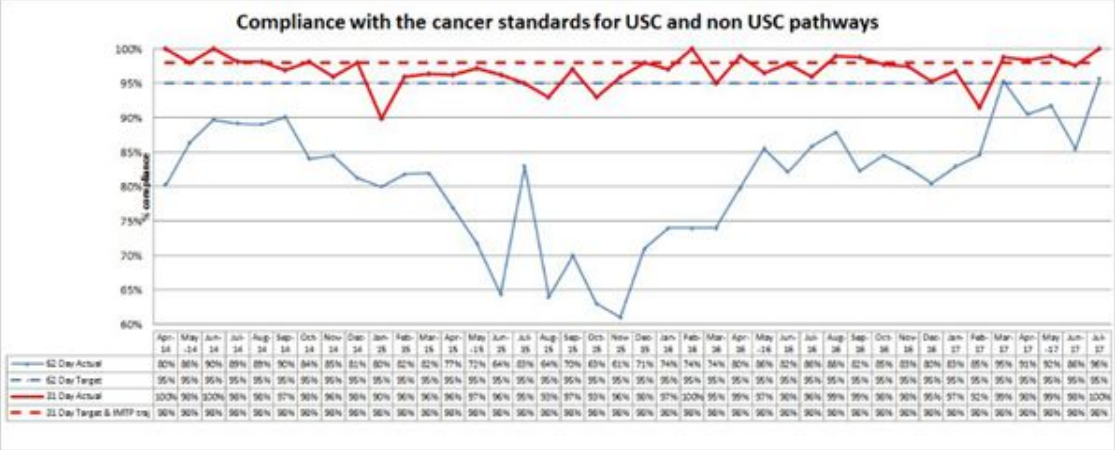
- Breach analysis continues to highlight key constraints and plan corrective measures
- Consideration of the establishment of a 4 bedded mixed gender bay for confirmed stroke patients to receive hyper-acute care for up to the first 72 hours following admission. This would facilitate the flow of stroke patients from EU and AU to A6S.
- Local Operating model in place for SRC, UHL - with the aim of reducing length of stay
- Nursing workforce model revised, with ward teams split into two teams and managing patients in specific groups
- A flow chart for Junior Doctors has been put in place to improve the process of code stroke
- Pilot of automatically generated Clinically Expected Length of Stay (CELOS) on Ward Clinical Workstation to improve discharge planning processes
- Plans to extend the existing therapy service to a 7-day service. Stroke Consultants now provide a 7-day service.

5) CANCER

How are we doing?

Performance in treating cancer patients, who are not on an urgent suspected cancer referral pathway, within 31 days, continues to fluctuate between 95% and 100%, as has been the case for the previous 18 months. The discrete performance for the month of July 2017 was 100% against the standard of 98%.

Performance in commencing treatment for patients referred as urgent with suspected cancer (USC) within 62 days, increased in-month to 95.65% in July 2017, meeting the Welsh Government's target of 95% and above our improvement trajectory of 90%. The number of urgent suspected cancer patients who were treated in July 2017, having waited longer than 62 days, was 3.



The number of urgent suspected cancer patients who had been waiting in excess of 62 days at the end of July and who had not commenced treatment has fallen to 33.

How do we compare with our peers?

In June 2017, the UHB ranked 4rd of the 6 Health Boards for delivery of the 31 day non-USC target and 3rd out of the 6 Health Boards for the 62 day USC target.

Jun-17	ABM	AB	BCU	C&V	CT	HD	Wales	C&V Rank
Non USC	93.1%	96.3%	97.7%	97.6%	96.1%	98.4%	96.4%	4/6
USC	72.7%	82.2%	89.4%	85.1%	91.4%	92.8%	83.8%	3/6

What are the main areas of risk?

The key risks to delivering the required quality and experience standards are:

- Reducing and eliminating backlog of untreated patients on the 62 day pathway. Whilst the backlog of patients waiting > 62 days has reduced in the last week to 64, it remains at too high a level. 83% of the backlog relates to Upper and Lower GI. The main focus of the weekly tracking meeting, chaired by the Assistant Chief Operating Officer, has therefore switched to GI in recent weeks to ensure patients are being expedited and pathways are being validated in a timelier manner.
- In the context of rising referrals, the need to balance waiting time target demands against clinical urgency across all categories of endoscopy i.e. USC, urgent, routine, screening and surveillance. The UHB continues with

implementation of its endoscopy plan to improve patient experience and access to endoscopy services.

- Demand for diagnostic capacity for radiology and pathology also remains high and a challenge. The UHB is also cognisant that the introduction of the single cancer pathway will result in an increase in demand and the speed / timeliness within which diagnostic tests will need to be undertaken and reported.

What actions are we taking?

The UHB remains committed to sustaining the improvements seen. Our approach remains broadly as outlined previously i.e.

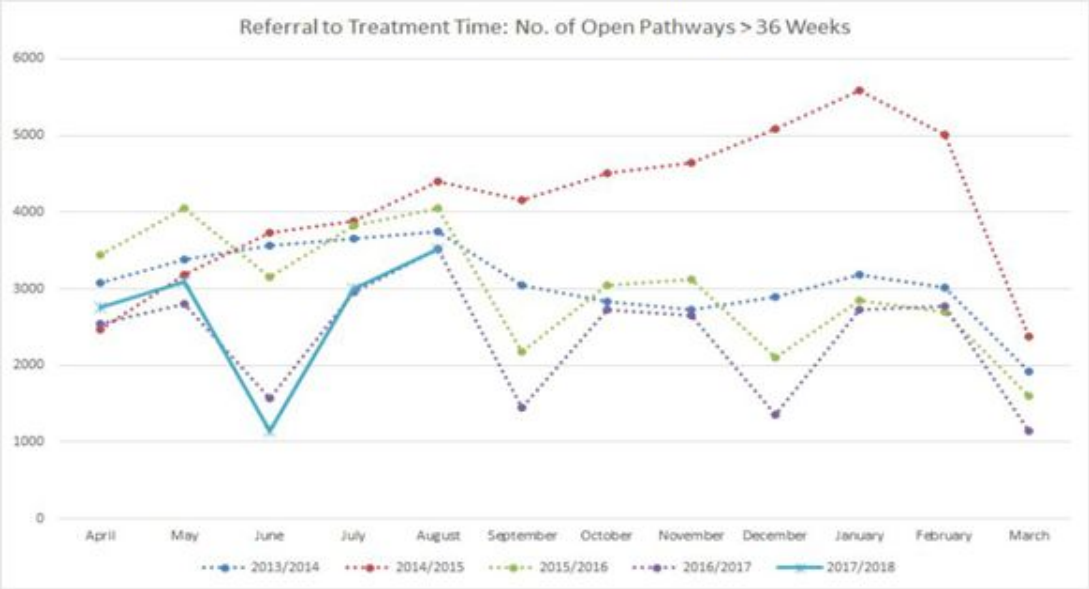
- Led by Medical Director, with the support of the Continuous Service Improvement team, a specific project focusing on lower and upper GI pathway redesign and improvement has been initiated.
- Dedicated breach escalation review process through a monthly Cancer Challenge and Support meetings with Clinical Boards - chaired by the Chief Executive Officer
- Review and standardised monitoring and management process

Patients continue to be tracked at both Directorate and UHB level, with actions escalated as appropriate.

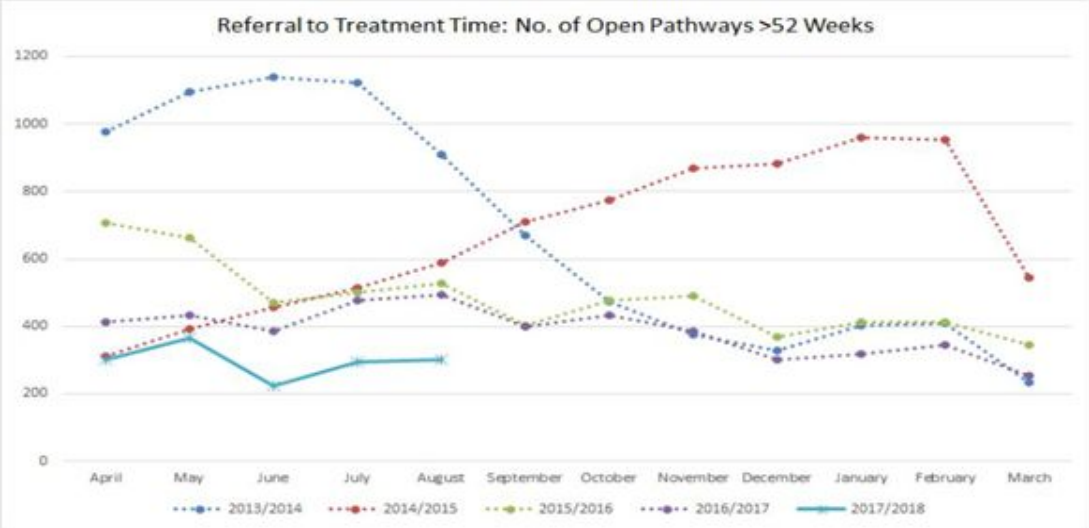
6) ELECTIVE ACCESS

How are we doing?

As at the end of August 2017, 3512 patients had been waiting in excess of 36 weeks for treatment. This represents a significant increase on the end of June position (1138) however this increase mid quarter is characteristic of in quarter trends.



There has been an increase in the volume of longest waiters. At the end of August there were 16 patients (4 at the end of March) waiting in excess of 100 weeks (14 of whom were waiting for Neurosurgery) and 302 patients waiting greater than 52 weeks (222 in June).



There were 14,507 patients waiting in excess of 26 weeks on an elective referral to treatment time pathway at the end of August, equating to 86% of patients

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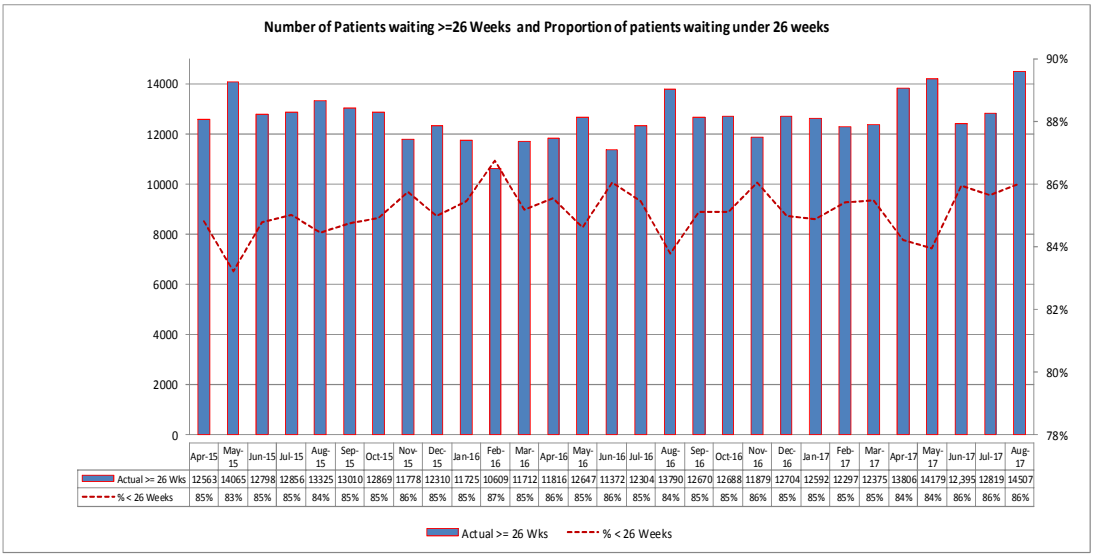
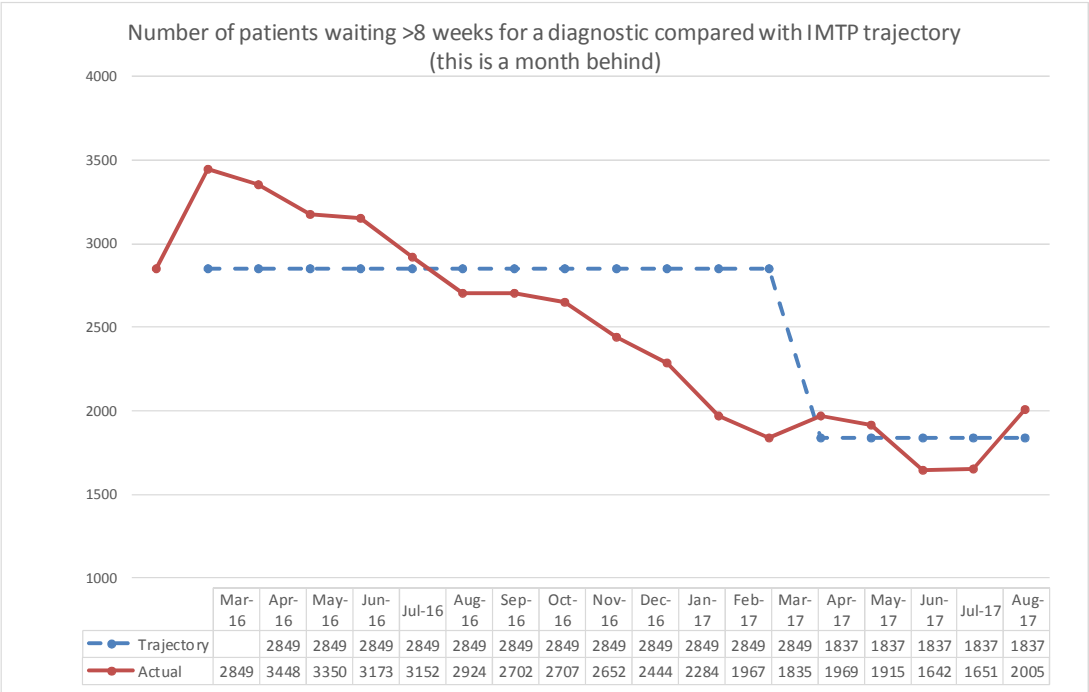
waiting under 26 weeks. This performance is in line with the 86% improvement trajectory submitted in the annual plan.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Actual >= 26 Wks	12563	14065	12798	12856	13325	13010	12869	11778	12310	11725	10609	11712	11816	12647	11372	12304	13790	12670	12688	11879	12704	12592	12297	12375	13806	14179	12,395	12819	14507
% < 26 Weeks	85%	83%	85%	85%	84%	85%	85%	86%	85%	85%	87%	85%	86%	85%	86%	85%	84%	85%	85%	86%	85%	85%	85%	85%	84%	84%	86%	86%	86%

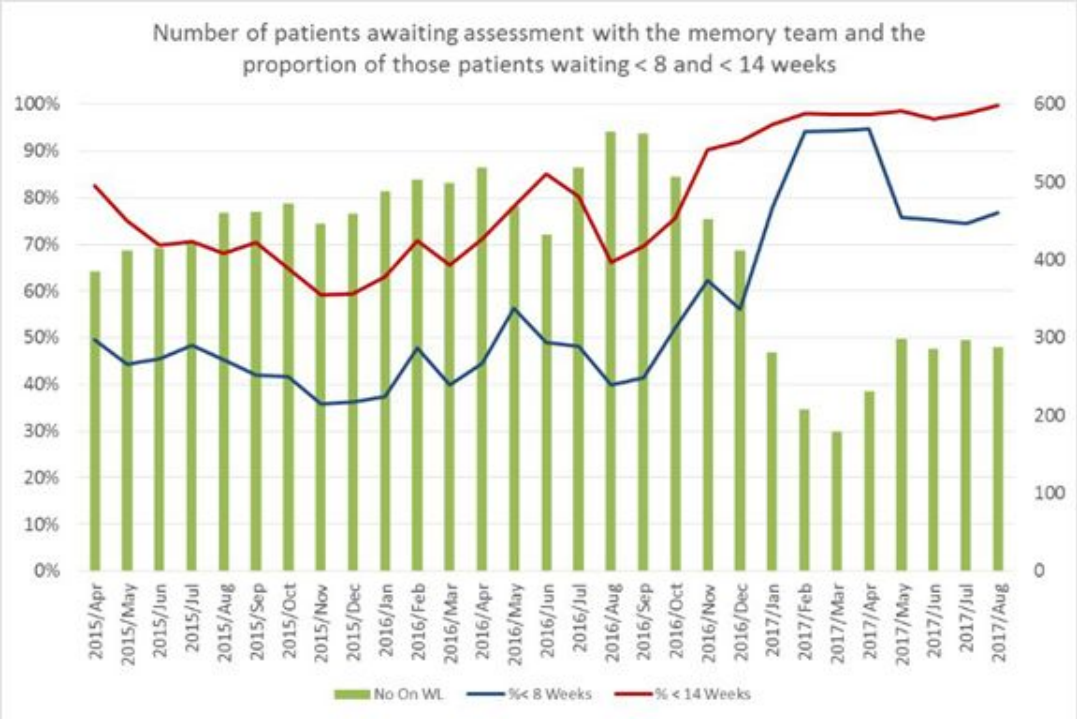
The August 2017 position for the number of patients waiting more than 8 weeks for a diagnostic is 2005, fluctuating marginally above the IMTP trajectory of 1837.



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Trajectory		2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	1837	1837	1837	1837	1837
Actual	2849	3448	3350	3173	3152	2924	2702	2707	2652	2444	2284	1967	1835	1969	1915	1642	1651	2005

At the end of August 2017, 100% of patients requiring a memory assessment were waiting less than 14 weeks against a standard of 95%. There has also been an improvement in the number of patients waiting less than 8 weeks, rising from 75% in July to 77% in August 2017.

12



How do we compare with our peers?

The All-Wales waiting time position at the end of June 2017, shown below, indicates that Cardiff & Vale ranked 4th for the % of patients waiting less than 26 weeks, 2nd for the lowest number of patients waiting in excess of 36 weeks and 5th for the number of patients waiting in excess of 8 weeks for a diagnostic, as shown in the following table.

June 2017	Wales	ABM	AB	BC	C&V	CT	HD	C&V Rank
% < 26 weeks -RTT	86.6%	87.8%	89.5%	84.2%	86.0%	89.3%	84.5%	4/6
No. > 36 weeks - RTT	16665	3966	1314	6570	1134	474	3197	2/6
No. > 8 weeks diagnostic	6860	484	3392	92	1642	1212	35	5/6

What are the main areas of risk?

Whilst there remain a number of risks to the delivery of RTT, the main risk for quarter two and the remainder of the year relates to theatre infrastructure issues in Cardiff and Vale Orthopaedic Centre (CAVOC) at UHL.

Currently no surgical procedures can be undertaken in theatre 5 and no major joint or spinal surgery can be undertaken in theatre 6.

What actions are we taking?

The Orthopaedic Directorate continues to try to mitigate the loss of activity through a range of schemes, including flexible backfill of remaining theatres; three session

days; increased non-arthroplasty activity; increased outpatient activity and additional activity commissioned from external providers.

Welsh Government have approved capital funding for a short term 'modular build' laminar flow unit to reprovide one of the theatres. This is anticipated to be operational in the fourth quarter.

The Welsh Government has indicated that they are making £50m potentially available to support the reduction of waiting times across NHS Wales. The Health Board has taken the opportunity to submit proposals on how this money could be best used to reduce waiting times for Cardiff and Vale residents.

7) HEALTHCARE ACQUIRED INFECTIONS

How are we doing?

Welsh Government Reduction Expectations 2017/18

Welsh Health Circular (WHC/2017/011) issued on 31st March 2017 provides detail on the HCAI reduction expectations for 2017/18. In addition to further reductions expected in *C. difficile* and *Staph.aureus* bacteraemia rates, a new reduction expectation to reduce *E.coli* bacteraemia has been introduced. In summary the requirements for Cardiff and Vale UHB are as follows:

C.difficile: To reduce to 26 cases per 100,000 population by end March 2018.

Staph. aureus bacteraemia: To reduce to 20 cases per 100,000 population by end March 2018.

E.coli bacteraemia: To reduce to 60 cases per 100,000 population by end March 2018.

This target has been agreed with WG and is bespoke to C&V UHB as the rate of *E.coli* bacteraemia seen in the baseline year of 2015/16 (against which the all Wales 10% reduction is required) was at 67 cases per 100,000 population; this is the target rate for all the other HBs in Wales except for AB Health Board and the UHB.

In terms of numbers of cases to achieve these targets over the course of 2017/18 C&V UHB will need to deliver as follows (these may be revised during the year should cases accumulate):

Target Organism	Total Allowable for 2017/18	Average Monthly Number Allowable	Actual Average Apr-Aug 2017
C. difficile	126	10	12
***S. aureus* (Total)**	96	8	14
E. coli	290	24	

Included within the *S. aureus* total were 6 MRSA cases against a target of zero.

Position as at Quarter 1:

C. difficile

The average has increased to 12, following 17 cases in August, remaining above the target.

Staph. aureus* blood stream infections*:

The average has increased to 14, following 17 cases in August, remaining above the target. For the first five months of this year, there have been 8 MRSA cases.

***E.coli* blood stream infections:**

The average has reduced marginally to 30, but remains above the target. This is mainly due to only 22 cases in July, though there were 37 cases in August.

How do we compare with our peers?

C. difficile, S. aureus bacteraemia and *E. coli* bacteraemia monthly commentary, up to Aug 17

Reduction expectation summary (Apr - Aug 17)

Number and rate of *C. difficile*, *S. aureus* bacteraemia and *E. coli* bacteraemia per 100,000 population by health board, Apr - Aug 17

Not on trajectory to achieve expected reduction by Mar 18
On trajectory to achieve expected reduction by Mar 18

	C. difficile		*S. aureus* bacteraemia		*E. coli* bacteraemia	
	Number (*)	Rate**	Number (*)	Rate**	Number (*)	Rate**
ABM UHB	128 (+72)	57.69	77 (+34)	34.71	234 (+88)	105.47
AB UHB	112 (+52)	45.74	71 (+25)	29.00	206 (+59)	84.13
BC UHB	104 (+29)	35.66	83 (+26)	28.46	243 (+50)	83.31
C&V UHB	61 (+9)	29.70	73 (+33)	35.55	152 (+31)	74.01
CT UHB	27 (+3)	21.61	50 (+26)	40.01	109 (+27)	87.23
HD UHB	69 (+28)	42.90	60 (+29)	37.30	194 (+88)	120.61
All Wales	518 (+183)	39.69	416 (+158)	31.88	1147 (+282)	87.90

* (difference between current number of cases and number required to be on trajectory to meet the reduction expectation)
** Rate per 100,000 population

What actions are we taking and do we need to take to improve the position and when will they start to take effect?

August has proved to be the worst month for some time in terms of the overall picture of healthcare associated infections. The 17 cases of C. difficile during August has now moved the UHB off target for all the measures.

All clinical boards have now agreed their annual programmes of work at the IPCG and are in the process of implementing them.

12

The key/urgent work that will be taken forward includes:

- Taking forward the UTI pathway improvement work across the whole Health Board System, due to start on 14th September.
- Urgently replacing antimicrobial pharmacist time and implementing the antimicrobial delivery plan.
- Driving down C. difficile in identified hotspots (currently UHL, Medicine Clinical Board and B5, Specialist Clinical Board)
- Implementation of Multi-drug resistant organism procedure.

Actions previously reported to the Board remain in place.

8) INTERVENTIONS NOT NORMALLY UNDERTAKEN
How are we doing?

The Health Board has a comprehensive list of procedures which it considers should not normally be undertaken unless there is clear clinical justification. This list was agreed in 2009/10 and has been added to on a few occasions since. It includes: Dental implants, Caesarean section for non clinical reasons, cholecystectomies, hysterectomy, varicose vein treatment, management of benign skin conditions and Hirsutism.

It is the expectation of the Board that Clinical Boards periodically review the activity being undertaken and ensure that there is justifiable clinical reason. Year to date figures indicate that overall the number of procedures has remained stationary, fluctuating in correlation with the changes in overall elective activity volumes. There are however a few treatments which are steadily increasing, which are shown below:

Calendar year	INNU Procedures undertaken			
	Total	Intrathecal baclofen therapy	Tonsillectomy	Botinum Toxin
2009	5905	32	614	80
2010	5261	22	471	51
2011	5036	100	407	53
2012	5005	181	411	31
2013	5054	262	418	47
2014	4870	292	643	43
2015	5210	320	539	44
2016	5591	314	600	78
M6 - 2017	*2622*	*188*	*284*	*79*
2017-M12 extrapolation	5244	376	568	158

The Welsh Government has recently introduced a measure as part of its delivery framework to monitor the volume of a limited number of procedures being undertaken electively in health boards which the National Institute for Clinical Excellence (NICE) have recommended should not be undertaken. The volume of these procedures undertaken by Cardiff and Vale Health Board appears to have increased in the 1st three months of the financial year above the numbers undertaken in the previous 3 years. This is shown in the table below:

Procedure	2014/15	2015/16	2016/17	Apr- June 2017
Arthroscopic lavage and debridement	25	20	12	5
Blepharoplasty for cosmetic reasons	43	54	50	29
Excision of benign eyelid lesion for non-cosmetic reasons	10	29	20	2
Radiology requests for non-specific lower back pain	16	15	18	10
Rhinoplasty for cosmetic reasons	42	57	36	41
Therapies for non-specific lower back pain	168	324	363	156
Grand Total	**304**	**499**	**499**	**243**

How do we compare with our peers?

Meaningful comparison with other Health Boards is limited. The volume of treatments on the NICE Do Not Do list undertaken by each of the Health Boards, as providers of care, is shown below and would suggest that no Health Board has totally ceased these operations.

Treatments in Apr-June 2017	BC	HD	ABM	C&V	CT	AB	Powys	Total
Arthroscopic lavage and debridement	11	18	5	5	3	14		56
Blepharoplasty for cosmetic reasons	12	13	43	29	1	20	5	123
Excision of benign eyelid lesion for non-cosmetic reasons	26	14	4	2	2	26	4	78
Radiology requests for non-specific lower back pain	8	20	40	10	10	15		103
Rhinoplasty for cosmetic reasons	17	15	47	41	41	11		172
Therapies for non-specific lower back pain	45	98	22	156	5	21		347
Total	**119**	**178**	**161**	**243**	**62**	**107**	**9**	**879**

What are the main areas of risk?

Interventions of limited clinical effectiveness are those which the evidence has suggested are procedures which do not offer good value for money when applied to the population as a whole when considering both the clinical benefit they provide alongside the cost of undertaking the procedure.

Whilst there may always be clinical circumstances where there is exception, ‘high’ or increasing volumes would indicate that there are opportunities for the Health Board to make better use of the finite resources made available for improving the health and care of our population.

What actions are we taking to improve the position and when will they start to take effect?

Renewed focus is being placed in the reported volumes via the monthly fora of Clinical Directors and the organisation's Planned Care Board.

The surgical pathway programme, being developed to reduce waste, harm and variation through the application of standardised effective pathways, will be the key vehicle for minimising the volume of "interventions not normally undertaken" that are undertaken.

RECOMMENDATION:

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

MAJOR TRAUMA NETWORK DEVELOPMENT	
Name of Meeting : Board Meeting	**Date of Meeting** 28 September 2017

Executive Lead : Director of Strategy and Planning
Author : Strategic Partnership and Planning Manager Tel. 029 2184 7730
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : The financial consequences of developing the Network including the Major Trauma Centre will be the subject of business cases that would need to be approved by Boards
Quality, Safety, Patient Experience impact : The development of the Network is designed to improve service quality and patient safety
Health and Care Standard Number 1.1, 2.3, 3.1, 3.2, 3.3, 5.1, 7.1
CRAF Reference Number 1.1, 2.1, 3.1, 4.1, 4.2, 4.3, 5.1, 5.4, 6.2, 6.4, 7.1, 9.3
Equality and Health Impact Assessment Completed: An Equality Impact Assessment has been developed by Health Collaborative

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The NHS Wales Health Collaborative has led on the development of a service model for a major trauma network for South Wales.
- The resulting service model and proposed consultation are based on the advice of the Collaborative Leadership Forum and Major Trauma Project Board

The Board is asked to:

- **CONSIDER AND AGREE** the actions recommended in the Health Collaborative Report attached as Appendix 1

13

SITUATION

The Health Collaborative has produced a report, attached as Appendix 1, which provides an overview of the work which has been undertaken as part of the major trauma project to facilitate the development of a major trauma network for the population of south and west Wales and south Powys. The report puts into context the recommendations of the Independent Clinical Panel regarding the development of the major trauma network, how the network should be led and the preferred location of the major trauma centre for the region.

The report seeks the support of Health Boards for a public consultation that will seek views on the development of the major trauma system for the South Wales region and the implementation of the recommendations of the Independent Panel.

BACKGROUND

Board received a briefing paper in January 2017 providing an update on the process to deliver on making a recommendation for a preferred location of a major trauma centre as part of the development of a network for south Wales, west Wales and south Powys. This described arrangements for an Independent Panel to consider the evidence regarding the establishment of the proposed major trauma centre.

ASSESSMENT AND ASSURANCE

The Independent Panel's recommendations have been reviewed through the Collaborative governance arrangements; the Collaborative Leadership Forum has agreed in principle to support the recommendations of the Independent Panel and to pass it to the constituent Health Boards for consideration.

The report identifies that the key issue for consultation will need to focus on the broader pathway for major trauma patients, from incident through to treatment in a trauma unit, the major trauma centre and ongoing rehabilitation.

The report asks Health Boards to:

- Consider and discuss the content of the report and the associated supporting evidence;
- Accept, in principle, to consult on the recommendations of the Independent Panel as follows:
    - To establish a major trauma network for the south Wales region;
    - For the network to be led by the trauma unit at Morriston Hospital
    - For the Major Trauma Centre to be located at UHW
- Agree to bring back the outcome of the consultation process for decision by Boards, in public. In reaching a final decision, Boards will need also to consider more detailed analysis of the financial and workforce implications of the proposed service model.

GIG CYMRU NHS WALES | Cydweithrediad Iechyd GIG Cymru NHS Wales Health Collaborative	

Health Collaborative Report
MAJOR TRAUMA NETWORK DEVELOPMENT

Executive Lead: Bob Hudson, Director Health Collaborative
Author: Rachel Hennessy, Programme Director, Strategic Planning

Purpose of the Report
This paper provides an overview of the work which has been undertaken as part of the major trauma project to facilitate the development of a major trauma network for the population of South and West Wales and South Powys. The paper puts into context the recommendations made by an Independent Clinical Panel regarding the development of the major trauma network, how the major trauma network should be led and the preferred location of the major trauma centre for the region.

Supporting evidence	Supporting documents are attached as a technical appendix to the report Reference is also made to the following: • Regional Networks for Major Trauma: NHS Clinical Advisory Group (CAG) Report. September 2010 • NHS England Standard Contract for Major Trauma 2013

	• National Audit Office (NAO), Major trauma Care in England February 2010 • Centre for Workforce Intelligence report on Regional Trauma Networks March 2011 • Trauma who cares? A report of the National Confidential Enquiry into Patient Outcome and Death 2007 • SAIL databank https://saildatabank.com/saildata/sail-datasets/emergency-department/

Engagement – Who has been involved in this work?

The work to support the contents of this report commenced in 2014 and has been developed in collaboration with the following organisations:

- Health Boards across South and West Wales and South Powys, namely: Aneurin Bevan UHB; Cardiff & Vale UHB; Cwm Taf UHB; Abertawe Bro Morgannwg UHB; Hywel Dda UHB; Powys tHB;
- Welsh Ambulance Services NHS Trust (WAST);
- Emergency Medical Retrieval and Transfer Service (EMRTS);
- Collaborative Commissioning Team;
- Welsh Health Specialised Services Commission & Emergency Ambulance Service Commission;
- Regular briefings with Community Health Council Chief Officers;
- Third sector – particularly in relation to rehabilitation model;
- Independent clinical specialists.

13

Resolution to:							
APPROVE	X	**ENDORSE**		**DISCUSS**		**NOTE**	

MAJOR TRAUMA NETWORK DEVELOPMENT

1. Purpose of the Report

This paper sets out the work which has been undertaken to develop a service model for a major trauma network for the population of South and West Wales and South Powys (henceforth referred to as the South Wales region).

There is a significant body of evidence that demonstrates that patients who suffer a major trauma and are treated within a major trauma network generally have better outcomes and a greater chance of survival. Examples of the benefits of a major trauma system have been demonstrated recently in the terror attacks in London and Manchester where patients were effectively managed across several major trauma centres (MTC) and trauma units (TU). System knowledge and coordination allowed pre-hospital teams to appropriately triage patients and subsequently minimise the number of patients needing secondary transfer to a major trauma centre for ongoing care. In the major trauma centres and trauma units, clinical teams had the expertise and resources to manage critical injuries. For the London 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 (www.kingsfund.org.uk).

The population of North Wales benefit from Betsi Cadwalader UHB being part of the West Midlands Major Trauma Network that supports the major trauma centre in North Staffordshire. South Wales (including South Powys) is the only region of England and Wales that is not part of a major trauma network; patients do not have access to a designated major trauma centre.

The development of a major trauma network for the region will represent a significant step forward in the provision of emergency care in Wales and will build on the current model of care providing greater expertise and resilience to meet both individual and mass casualty events. The network will lead to enhanced roles for a number of hospitals across the region but particularly for the University Hospital of Wales, Cardiff and Morriston Hospital, Swansea.

2. Background

2.1 Establishment of the Major Trauma Project

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 (A&E) for people living in South Wales. The SWP covered Aneurin Bevan, Cardiff & Vale, Cwm Taf, Abertawe Bro Morgannwg and Powys Health Boards. The Programme did not specifically consider major trauma but as part of the work reviewing A&E services, the clinicians identified the need to develop a major trauma network in South Wales as a priority.

Based on advice and guidance in respect of the ability of a trauma network to improve outcomes for patients, in late 2014, the Health Collaborative was asked by the Chief Executive Officers (CEOs) to develop a service model for a major trauma network for the South Wales region. 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, Welsh Ambulance Services NHS Trust (WAST), Emergency Medical Retrieval and Transfer Service (EMRTS) and Welsh Health Specialist Services Committee (WHSSC). The scope was widened to include Hywel Dda University Health Board, which had not been involved previously in the SWP.

The proposed service model for major trauma services for adults and paediatrics was developed by the clinical reference group (CRG) in line with the standards for major trauma and was approved by the Project Board in May 2015. A detailed model for supporting rehabilitation was also developed through a wider stakeholder group. The standards for major trauma have been set by the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute for Clinical Excellence (NICE) and identify which services should be available for a patient suffering from major trauma - from the response to an accident, transfer to a major trauma centre or trauma units, immediate treatment and urgent surgery, ongoing medical care and further surgery, and rehabilitation. The standards also specify those services which should be available in a major trauma centre, in trauma units, and how the network should work.

3. Developing the case for change and the Service Model

3.1 Definition of Major Trauma

'Major Trauma' is defined as multiple, serious injuries that could result in disability or death. These might include serious head injuries, severe gunshot wounds or multiple injuries caused by road traffic accidents. It is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity (CAG 2010).

Fewer than 0.2% (2/1000 patients) of the people attending their local emergency department will have suffered a major trauma. In 2016 about 750,000 people across the whole of Wales attended a local emergency department (www.saildatabank.com) (this figure is slightly higher than the data used for modelling purposes (see technical appendix) which was based on 2014 TARN data). The data available at this time did not cover all South Wales hospitals and the Emergency Medical Retrieval and Transfer Service (EMRTS) was not in place and therefore is likely to under-represent the true number of major trauma patients in the region.

Major trauma cases by their very nature are complex. Each individual A&E department will only see 1 or 2 cases a week and due to the small number it is a challenge for hospital staff to maintain their highly specialist skills in trauma care.

In summary, this means that about 1,500 patients attending A&E in Wales in any one year are likely to have suffered a major trauma. This equates to about 20 people each week across South Wales and South Powys.

3.2 Case for Change

3.2.1 Benefits of a Major Trauma Network

In recent years, a number of reports have been produced by organisations such as the National Confidential Enquiry into patient Outcome and Death (NCEPOD), National Institute of Clinical Excellence (NICE), the Department of Health Clinical Advisory Group and the National Audit Office, outlining the provision of trauma care across England, Northern Ireland and Wales. The reports consistently identify that better care and outcomes are achieved when properly constituted formal major trauma networks are in place.

Across the South Wales region major trauma cases are currently managed through informal arrangements across the South Wales Health Boards with some more complex cases either admitted directly or transferred to the bigger regional centres - mostly University Hospital of Wales or Morriston Hospital. Whilst this is clearly beneficial to patients, it does not deliver the proven benefits of an established major trauma network.

A **'major trauma network'** comprises a group of hospitals, emergency services and rehabilitation services, that work together to make sure a patient receives the best care for life threatening or life changing injuries; it includes one major trauma centre and several trauma units spread across the region.

A trauma network aims to make sure that seriously injured patients can be treated quickly and efficiently by the specialised services that will have all the necessary equipment to hand; provides an infrastructure that will allow a patient to leave the specialist centre and continue their treatment at a hospital closer to home or in the community as soon as possible. Where there is a major trauma network, it is expected that more patients will survive and make a full recovery.

3.2.2 Quality improvement

Treatment of major trauma patients within a designated trauma network delivers significant quality improvements for patients. The network is designed to ensure patients have the best outcomes possible and receive the best possible care as part of an integrated clinical network irrespective of where in the region they suffer a major trauma. The key benefits of developing a major trauma network are expected to include:

- More people survive: Evidence shows that severely injured patients are 15%-20% more likely to survive their injuries if they are admitted to a major trauma centre.
- Patients receive the best possible care at the most appropriate site from highly specialised teams, providing 24/7 emergency care with access to the required specialist services.
- Patients are less likely to have a long term disability.
- Patients require less long-term NHS care.
- Patients will have an improved ability to return to work and undertake other activities.
- Services meet clinical standards.

- The network enables access to be optimised to services that support patients to return as close to home as soon as possible.
- The NHS is able to better plan for and respond to major incidents, improving the care major trauma patients receive.
- Hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. The major trauma network facilitates the delivery of this, ensuring the best use of resources, making the major trauma centres and trauma units more sustainable.
- Local A&E units are less likely to be disrupted by admission of inappropriate major cases that can affect the ability of the department to manage its more routine workload.

Establishing a major trauma network also has significant benefits for the individual organisations which are part of the network:

- It provides an opportunity to develop the skills and expertise of existing staff at the trauma units and local hospital sites.
- A network with a clearly identified major trauma centre, trauma units and defined response at scene is likely to have a positive impact on recruitment across the network.
- The establishment of a network provides a stronger base to support doctors in training.
- Services are delivered within a clinical network, this means that each of the units in the network understand their role and responsibility.
- Clinical services in South Wales for major trauma align with the rest of the UK and will allow the Welsh NHS to be more effective as part of the national response to major emergencies.

4. Service Model for a Major Trauma Network

A major trauma network has one MTC and a network of hospitals, known as trauma units. Emergency departments that are not trauma units will continue to treat any person who is seriously ill or has an injury which does not need the highly specialist services only available at the major trauma centre or the specialist services only available at the trauma units.

99.8% of people who currently attend their local A&E department will still continue to do so even when the major trauma network is established.

The network model is particularly important in managing patients who are further away from the major trauma centre. Patients are more likely to survive a major trauma in a region where there is a major trauma network, regardless of how far they are away from the major trauma centre.

If a person suffers a major trauma, ambulance crews will make an assessment at the scene using triage tools to ensure that those with major trauma are taken directly to a major trauma centre for urgent treatment. The decision making is supported by the on-call clinician at the major trauma centre and may involve bypassing local hospitals so that patients can quickly receive care with access to highly specialist services and equipment and appropriately trained staff. If the distances are long or patients are identified to have time critical pathology which cannot be managed by ambulance transfer patients may have to be taken to their local trauma unit first for stabilisation before onward transfer to the major trauma centre for treatment.

The very nature of the major trauma centre means that they have on-site access to highly specialist skills and services 24 hours a day seven days a week which are normally time critical when managing a patient with acute

major trauma. Some of these services are likely to only be provided in one place for the whole region.

Across the network, there will be a number of hospitals known as trauma units that will have a higher level of specialist services and care available than a local emergency department so they can support the major trauma centre. The trauma units are important in providing immediate life saving services to those patients further away from a major trauma centre or who need stabilising before being transferred to the major trauma centre.

As soon as a patient is well enough to be discharged from the major trauma centre, they may be moved to a trauma unit in their local region to continue their treatment and recovery. A trauma unit will also be able to recognise patients who are beyond their capability to treat and transfer them rapidly to the major trauma centre.

The trauma network will also develop advice on appropriate transport services (both ambulance and Emergency Medical Retrieval) to facilitate rapid assessment and transfer to the major trauma centre or trauma units 24 hours a day.

4.1 Rehabilitation

Rehabilitation is a key component of the major trauma network and is an essential part of good trauma care and good patient outcomes. Rehabilitation needs will be assessed shortly after a patient is admitted to the major trauma centre and will be delivered during the inpatient phase and be continued in a trauma unit or in the local community. Highly specialist rehabilitation services will continue to be provided across South Wales from Rookwood Hospital in Cardiff and Neath Port Talbot Hospital.

4.2 Pre Hospital Care

A major trauma network will also need to be supported by robust pre admission triage. In 2015, the Emergency Medical Retrieval and Transfer

Service was established in Wales (currently operating 12 hours per day) to support the Welsh Ambulance Service Trust in delivering pre admission triage.

5. Appraising the options

5.1 Phase 1 – Project Board / Clinical Workshop

In June 2015 a workshop led by clinicians considered the options available to support the development of a major trauma network in the South Wales region. The workshop comprised representatives from the six Health Boards (Aneurin Bevan, Abertawe Bro Morgannwg, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys) and WAST. Patient representatives were invited through the third sector support groups and geographical coverage was sought. Community Health Councils (CHC) were also invited in an observer capacity. The workshop incorporated the non-financial option appraisal process and concentrated on the clinical benefits of the different options. The options considered included:

- Do nothing.
- No major trauma centre in South Wales with network arrangement into England (Bristol)
- Single major trauma centre for South Wales based in Morriston Hospital.
- Single major trauma centre for South Wales based at the University Hospital of Wales (UHW), Cardiff.
- Dual site solution based upon both Morriston Hospital and UHW.

The options to do nothing and continue with the South Wales area remaining as the only region not being supported by a major trauma network were quickly eliminated. It was also agreed that to support a population of circa 2 million the network would need to be supported by a major trauma centre located within the region. This ruled out the Bristol option.

The potential for a dual site solution was seriously considered but subsequently eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.

The clinician-led process identified that the preferred option was to develop a major trauma network for the South Wales region that contains a number of trauma units supported by a single site major trauma centre.

Morriston Hospital in Swansea and UHW, Cardiff were the only two hospitals in the region identified as having the potential to meet the necessary clinical outcome criteria and the standards, for a major trauma centre. This is due to the specialist nature of the trauma service itself and the need for co-location with other specialist services.

Following the option appraisal an Equality Impact Assessment was completed to support intended engagement with key stakeholders.

Access to the major trauma centre for individual Health Board populations was also considered through the project and a detailed travel times analysis was undertaken. It is acknowledged that a clear consensus was never reached within the Project Board on the best travel metrics to use but in any event the broad conclusions of the travel times analysis hold good for each option. It is clear that Morriston Hospital is more centrally located within the geography of South Wales minimising overall distance to be travelled and UHW is located closer to the centre of gravity of the population distribution across South Wales minimising travel times for a greater number of people and minimising the potential flow of trauma patients out of Wales to Bristol.

5.2 Independent panel

Building on the work of the Project Board and the outcome of the Clinical Workshop, the NHS Wales Health Collaborative Board agreed with the

recommendation for a trauma network to be established with the major trauma centre located in either UHW or Morriston Hospital.

To facilitate the decision on the preferred location of the site for the major trauma centre, the Collaborative Board 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.

The Independent Panel was chaired by Professor Chris Moran, the National Clinical Director for Trauma to the NHS in England and Professor of Orthopaedic Trauma Surgery at Nottingham University Hospital. With the support of Professor Moran, a group of eight experts were identified to be part of the Independent Panel on the basis of 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. A session was also convened with the panel where representatives from across the health service in the region alongside other key stakeholders were invited to attend. This included: Clinical representatives from Aneurin Bevan, Cwm Taf, Hywel Dda and Powys Health Boards; Public Health Wales; Welsh Government; Community Health Councils; EMRTS; WAST; WHSSC and the Emergency Ambulance Services Committee (EASC).

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 effective management of major trauma is the immediate availability of key specialist services. Most of those specialist services are already provided in both UHW and Morriston. However, specialist neurosurgery is only provided in UHW and burns and plastics services only in Morriston.

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) is a key requirement for the location of the major trauma centre.

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 is imperative that the burns and plastics centre worked very closely with the major trauma centre to make sure patients receive the care they need.

- **Critical mass**

The neurosurgery and burns and plastics services are so specialist they can only be provided from one hospital site for the population of South Wales. The same is true for the establishment of a single major trauma centre for the region.

- **Travel times**

The Panel considered the geography of Wales and made it clear that a major trauma system is expected to improve mortality in all geographical regions of South and West Wales regardless of the transport time to the major trauma centre. It was recognised that irrespective of the location of the major trauma centre at either Morriston Hospital or UHW, some parts of the population in Hywel Dda and Powys will be a considerable distance from the major trauma centre. This is not an unusual situation and most trauma networks in England also support services which are a considerable distance from the major trauma centre. The panel did not believe that either Morriston Hospital or UHW as a major trauma centre

would have any significant advantage over the other in terms of geography.

Working as part of a network, most ambulance services in England operate a bypass system up to one hour. This means that if patients are identified as having suffered major trauma by ambulance personnel they are taken directly to the major trauma centre if it is within one hour travelling time. This can be extended after advice is taken. Patients with more immediate needs will be transported to a trauma unit and stabilised prior to transfer. Only a small proportion of trauma patients require immediate surgery and this is likely to be achieved more rapidly in the major trauma centre mitigating any increase in transport times. The wider network model, (including trauma units, pathways to support direct transfer of a patient to a major trauma centre, EMRTS), has a key role to play in managing patients who may be further away from the major trauma centre.

Taking all three factors into consideration, the Independent Panel produced a report of their findings making the following unanimous recommendations for consideration by the constituent Health Boards:

- **A major trauma network for South and West Wales should be established with the appropriate clinical governance infrastructure.**
- **A clear and realistic timetable for the activation of the trauma network should be set.**
- **The adult and children's MTCs should be co-located on the same site.**
- **The MTC should be located at University Hospital of Wales, Cardiff.**
- **Morriston Hospital should become a large trauma unit and should have the leadership role for the major trauma network.**

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 trauma unit. As a large trauma unit 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 major trauma centre (within agreed protocols) and will continue to be managed within Morriston Hospital. This may be different for other units in the region which do not have such specialist services.

The panel also specified that Morriston Hospital should take the leadership role in the major trauma network. This follows the model in England where the leadership for the network is provided from a hospital other than the hospital where the major trauma centre is located. A lead hospital is necessary to ensure the major trauma network works in a coordinated way and makes sure the patient and the whole patient pathway is the main focus rather than the major trauma centre itself.

6. Financial implications

It is anticipated that there will be additional capital and revenue costs associated with establishing the major trauma network across the region. Whilst some outline modelling has been undertaken, full assessment cannot be made until such time as the designated site is confirmed. Research also suggests that in the longer term the development of an effective trauma network will also deliver wider economic benefits associated with improved clinical and social outcomes.

If Boards approve the development of the network in line with the recommendations of the independent panel, there will need to be an incremental approach to implementation supported by business cases, as appropriate, aligned to IMTPs.

Where networks have been developed in other parts of the UK, such an incremental approach has been successful with initial funding identified for any critical shortfalls and a more phased approach to meeting standards over time.

Any capital requirements will need to be considered in the context of the wider site development plans, interdependencies that exist between trauma services and other clinical services and subject to formal business cases to Welsh Government as appropriate.

WAST has also identified some modest resource implications as a result of the changes to patient flows, the adoption of a new triage model and the anticipated increase in requirements for repatriation. Enhanced training requirements for paramedics and the clinical workforce located outside the major trauma centre/trauma units is also likely to require some additional resourcing which will need to be factored into future years Integrated Medium Term Plans (IMTPs).

7. Next Steps

7.1 Board considerations

The report from the Independent Panel was commissioned to provide advice to support the development of the major trauma network and to recommend a preferred location for the major trauma centre.

The recommendations from the Independent Panel have been reviewed through the Collaborative governance arrangements (Collaborative Executive and Leadership Forum) and the benefits for the population of South Wales associated with developing a major trauma network have been fully considered.

The Collaborative Leadership Forum has agreed in principle to support the recommendations of the Independent Panel and to pass to the constituent Health Boards for consideration.

Health Boards will now need to consider this report and the supporting documents, including the recommendations of the Independent Panel to establish a major trauma network and a major trauma centre for the South Wales region.

In considering this report, Boards are reminded that:

- The evidence is clear that the establishment of a major trauma network (with major trauma units and a major trauma centre) provides better outcomes for patients and saves lives;
- The South Wales region is not currently part of a major trauma network and as such this is a **new service development** for the region;
- The impact on existing hospitals across South Wales is likely to be very small. Based on the data considered as part of this exercise to date the impact on individual A & E departments is likely to be in the order of 1 or 2 patients per week who would, in the proposed new system be treated in the major trauma centre. These will be the most seriously ill or injured patients requiring a very high level of specialist care – many of whom are already transferred to a more specialist centre (often Morriston or UHW) as part of their ongoing care;
- All other patients attending their local A&E will be unaffected by the development of the major trauma centre but will benefit from being part of the network;

It should also be noted that the financial consequences of moving forward with the development of the network and major trauma centre will be subject of business cases that would need to be approved by Boards prior to implementation.

7.2 Consultation

Health Boards in Wales are required to work with their local Community Health Council to consult with the local population on matters of substantial service change.

Given that the proposal to develop a major trauma network is about enhancing services at existing Emergency Departments, it could be viewed that this does not in itself constitute substantial service change requiring public consultation but would certainly require public and stakeholder engagement to ensure a clear understanding of the developments for the future.

However, a major trauma network cannot be established in isolation from the development of a major trauma centre and it is this development that may result in more significant calls for wider consultation. Whilst the evidence cited in this paper has identified that more than 99% of all patients currently attending their local A&E department will continue to do so, even when the major trauma centre is operational, it is important that the public and other stakeholders have a clear understanding of the role of the major trauma centre within the network.

The key issue for consultation will need to focus on the broader pathway for major trauma patients, from incident through to treatment in a trauma unit, the major trauma centre and ongoing rehabilitation.

Any consultation process will be expected to explain how the proposed trauma system will work to the benefit of patients and at the same time help the NHS to best shape pathways to meet patient need.

If Boards accept, in principle, the recommendations of the Independent Expert Panel, immediate discussion will need to take place with the constituent CHCs regarding the mechanism and timescales of any required consultation which would need to commence as soon as possible (Autumn 2017)

Any consultation documentation will be developed by the Health Collaborative team with individual Health Boards engaging with their local Community Health Councils (CHC), to facilitate the local consultation exercise which will seek views on the development of the major trauma system for the South Wales region and the implementation of the recommendations of the Independent Panel.

If, in conjunction with the CHCs, it is agreed that formal public consultation should be undertaken, the consultation questions will need to be framed around the following proposed questions:

- ***We believe there is strong evidence that more lives can be saved and clinical outcomes are improved by establishing a major trauma network – do you agree and are there other considerations you think we should take into account in making the decision to go ahead with this development?***
- ***Based on the recommendations of the expert independent panel, what factors would you want us to take into consideration in the designation of further trauma units and designing the patient pathways between the trauma units and the major trauma centre?***
- ***We believe that rehabilitation as close to home is an important element to an effective major trauma network – do you agree and if so, what key considerations should we take account of in designing such a service?***

It is expected that any consultation will run for between 6 and 12 weeks (to be agreed with the CHCs) with the outcome and subsequent decisions coming to Health Boards for decision, in public, at the end of the calendar year.

8. Conclusion and Recommendations

A considerable amount of work has been undertaken to review the evidence for the establishment of a major trauma network for the South Wales region. This has included significant engagement with key clinicians from constituent Health Boards and independent scrutiny and advice from a panel of UK clinical experts.

This has culminated in a series of recommendations from the Independent Panel **(Appendix 11)** which have been accepted by the Collaborative Leadership Forum.

Health Boards, are asked to:

- **Consider and Discuss** the content of this report and the associated supporting evidence;
- **Accept**, in principle to consult on recommendations of the Independent panel as follows:
    - To establish a major trauma network for the South Wales Region;
    - For the network to be led by the trauma unit at Morriston Hospital
    - For the Major Trauma Centre to be located at UHW
- **Agree** to bring back the outcome of the consultation process for decision by Boards, in public. In reaching a final decision Boards will need also to consider more detailed analysis of the financial and workforce implications of the proposed service model.

Freedom of information status	Open

Health Collaborative Report	
MAJOR TRAUMA NETWORK DEVELOPMENT **TECHNICAL APPENDICES**	
Appendix 1	Major Trauma Network Project Board Terms of Reference
Appendix 2	Service specification
Appendix 3	Service Model
Appendix 4	Rehabilitation service model
Appendix 5	Process for non financial option appraisal
Appendix 6	Outcome report for Non financial option Appraisal
Appendix 7	Financial review of proposed MTC
Appendix 8	Activity modelling
Appendix 9	Isochrones maps
Appendix 10	Independent Panel Terms of reference
Appendix 11	Independent Panel report
Appendix 12	Equality Impact Assessment
Appendix 13	Risk register

13

South Wales Health Collaborative

Major Trauma Project Board

Draft - Terms of Reference

Purpose

The Major Trauma Project Board will oversee the development of, and provide assurance to the South Wales Health Collaborative Board, on the development of the service model and associated business case for a major trauma network and centre for South Wales and South Powys.

Scope and Definition

The major trauma network for South Wales and South Powys will serve the populations of Aneurin Bevan UHB, Abertawe Bro Morgannwg UHB, Cardiff & Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys tHB.

The service model will address the needs of the most severely injured patients, meaning those who have suffered potentially life-threatening or life-changing physical injuries, i.e. all those who could benefit from a regional network.

The model for trauma care across the region will be based on a collaborative approach across all stakeholders to plan, provide and manage the treatment of people injured as a result of major trauma and will cover all aspects of trauma care along the whole patient pathway, from the point of injury to rehabilitation.

The trauma network will be a collaboration of the providers delivering trauma care services across the region. The trauma network should include all providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions and rehabilitation services.

The service model will provide a holistic patient-focussed care package. The service will comply with accepted best clinical practice and standards, provide improved patient outcomes and have robust governance arrangements. Consideration will be given as to how this service interfaces with other developments, e.g. Emergency Medical Retrieval and Transfer Service (EMRTS), and impacts on other services such as diagnostics, critical care etc.

Project Structure

The Project Board will be accountable to the South Wales Health Collaborative Board and be supported by a Steering Group and Clinical Reference Group/Task and Finish Groups.

Project Board Membership
(Nominations to be confirmed)

Executive representation from health boards and WAST (one representative from each board, intention to ensure all executive disciplines represented)
Medical Director, Cardiff & Vale UHB
Medical Director, Abertawe Bro Morgannwg UHB
Unscheduled Care Lead, Welsh Government
Welsh Government representative
EMRTS Project Board representative
Wales Deanery
Workforce representative
Ambulance Commissioner
WHSSC representative
BCU Major Trauma Lead
SWHC Team
External independent advisor

The Project Board will be chaired by the Unscheduled Care Lead, Welsh Government.

Members of the Project Board will be responsible for reporting back to their respective organisation and/or their executive peer group.

Project Board Responsibilities

The Project Board will be responsible for:

- Setting the direction for the project
- Overseeing the project arrangements and ensuring that they are fit for purpose
- Approving the project plan and ensuring that the resources needed are made available to the project when required
- Delivery of the project objectives
- Ensuring that project benefits are identified
- Ensuring that risks to the project are identified and managed
- Delegating authority to the SRO to lead the project on a day to day basis
- Reporting progress to the South Wales Health Collaborative.

The outputs of the project are:

- A clinical model for a major trauma centre and network that:
    - meets accepted best clinical practice and relevant standards
    - describes the clinical pathway from pre-hospital care through the acute phase to in-patient and community rehabilitation
    - identifies the relationship, inter-dependencies and inter-face with other specialities and services
    - consider the options available to deliver the clinical model efficiently and effectively

- A description of the workforce model including workforce movement between sites and trainee requirements
- Projected activity and capacity requirements
- Financial framework that tracks and supports the clinical pathway so that no organisation is financially disadvantaged
- A system of audit and assurance that demonstrates clinical quality and safety, including full participation in TARN reporting and monitoring of patient experience and outcomes
- Performance indicators defined by an agreed set of benchmarks
- The production of a business case, the first stage of which will be preparation of a costed service model

The SRO's role is to:

- design and execute the project plan
- deal with issues and manage risks that might affect progress
- manage communications with stakeholders

Frequency of meetings

The Project Board will meet on a monthly basis, to meet the intention of the preparation of a Strategic Outline Case by December 2014.

Accountability

The Project Board is accountable to the South Wales Health Collaborative.

Drafted: May 2014
Revised: 27 August 2014
Agreed: 27 August 2014
For review: December 2014

Appendix 1

Reports, standards and guidance

Following initial review, the following reports, standards and guidance have been identified. This list will be developed through the Steering Group and Clinical Reference Group:

Major trauma care in England: National Audit Office (February 2010)
http://www.nao.org.uk/wp-content/uploads/2010/02/0910213.pdf

Regional Networks for Major Trauma: NHS Clinical Advisory Groups Report (September 2010)
http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Emergencymedicine/Regionalnetworksformajortrauma.pdf

Standards of practice and guidance for trauma radiology in severely-injured patients: Royal College of Radiologists (2011)

https://www.rcr.ac.uk/docs/radiology/pdf/BFCR(11)3_trauma.pdf

The British Orthopaedic Association Standards for Trauma (BOAST)

http://www.boa.ac.uk/publications/boa-standards-for-trauma-boasts/

Management of People with Spinal Cord Injury: NHS Clinical Advisory Groups Report (August 2011)

http://www.mascip.co.uk/sci-roadmap.aspx

(This report is hosted on the above site – follow link)

Brain Trauma Foundation guidelines for head injury care https://www.braintrauma.org/coma-guidelines/searchable-guidelines/

Triage, assessment, investigation and early management of head injury in children, young people and adults: NICE Guideline - Head injury (CG176)
http://guidance.nice.org.uk/CG176

Rehabilitation after critical illness: NICE Guideline (CG83)

http://publications.nice.org.uk/rehabilitation-after-critical-illness-cg83

Together for Health – A delivery plan for the critically ill: Welsh Government (2013)

http://wales.gov.uk/docs/dhss/publications/130611deliveryen.pdf

Note: NICE is developing five pieces of guidance relating to trauma, with expected publication dates in June and October 2015 (to be confirmed). Each piece of guidance will focus on a different aspect of trauma care.

- Complex fractures: assessment and management of complex fractures (including pelvic fractures and open fractures of limbs)

- Fractures: diagnosis, management and follow up of fractures (excluding head and hip, pelvis, open and spinal)
- Major trauma: assessment and management of airway, breathing and ventilation, circulation, haemorrhage and temperature control.
- Spinal injury assessment: assessment and imaging of patients at high risk of spinal injury
- Trauma services: service delivery of trauma services

Appendix 2 – Service Specification

Major Trauma Quality Indicators

These quality indicators have been commissioned by the National Clinical Director for Major Trauma Chris Moran. They have been developed from the National Service Specification for Major Trauma (NHS England D15/S/a 2013) and the NHS clinical advisory group report on Major Trauma Workforce (CFWI March 2011). They support the NHS England Quality Surveillance programme for major trauma services in England enabling quality improvement both in terms of clinical and patient outcomes. The indicators cover the whole organisation of adult and children's major trauma services including sections for Major Trauma networks, pre-hospital care via ambulance services, Adult Major Trauma centres, Children's Major Trauma centres and Major Trauma units. Three relevant sections of this document have been replicated below – reception and resuscitation, definitive care, and rehabilitation.

Abertawe Bro Morgannwg and Cardiff and Vale UHBs are asked to complete the template on the basis of services currently available for a Major Trauma Centre at either Morriston Hospital, Swansea or University Hospital of Wales, Cardiff. This will be submitted to the Independent Panel in advance of the meeting on 21st February. At the meeting, both health boards may be asked to provide further information/evidence, in support of the responses.

Reception and Resuscitation				
Number	**Indicator**	**Descriptor**	**Yes**	**No**
T16-2B-101/ 201	**Trauma Team Leader**	*There should be a medical consultant trauma team leader with an agreed list of responsibilities who should be leading the trauma team and available 24/7.* *The trauma team leader should be available in 5 minutes of arrival of the patient.*		
T16-2B-102/ 202	**Trauma Team Leader Training**	*All trauma team leaders should have attended trauma team leader training.*		
T16-2B-103/ 203	**Emergency Trauma Nurse/ AHP**	*There should be a nurse/AHP of band 7 or above available for major trauma 24/7 who has successfully attained the adult competency and educational standard of level 2 (as described in the National Major Trauma Nursing Group guidance).* *In units which accept children There should be a paediatric registered nurse/AHP available for paediatric major trauma 24/7 who has successfully attained the paediatric competency and educational standard of level 2 (as described in the National Major Trauma Nursing Group guidance).* *All nursing/AHP staff caring for a trauma patients should have attained*		

		the competency and educational standard of level 1. In centres that accept paediatric major trauma, this should include the paediatric trauma competencies (as described in the National Major Trauma Nursing Group guidance).		
T16-2B-104/ 204	**Trauma Team Activation Protocol**	*There should be a Trauma Team Activation Protocol* *The trauma team should include medical staff with recognised training in paediatrics and paediatric trained nurses with experience in trauma.* *The MTC should agree and implement the network imaging protocol for children.*		
T16-2B-105/ 205	**24/7 Surgical and Resuscitative Thoracotomy Capability**	*There should be a surgical and resuscitative thoracotomy capability within the trauma team and available 24/7*		
T16-2B-106/ 206	**24/7 CT Scanner Facilities and on-site Radiographer**	*There should be CT scanning located in the emergency department and available 24/7.* *There should be an on-site radiographer available 24/7.to prepare the CT scanner for use.*		
T16-2B-107/ 207	**CT Reporting**	*There should be a protocol for trauma CT reporting that specifies:* • *there should be a 'hot' report documented within 5 minutes;* • *there should be detailed radiological report documented within 1 hour from the start of scan;* • *scans should be reported by a consultant radiologist within 24 hours.*		
T16-2B-108/ 208	**24/7 MRI Scanning Facilities**	*MRI scanning should be available 24/7*		
T16-2B-109/ 209	**24/7 Interventional Radiology**	*Interventional radiology should be available 24/7 within 30 minutes of a request* *Interventional radiology should be located within operating theatres or resuscitation areas.* *There should be a protocol for the safe transfer and management of patients which includes the anaesthetics and resuscitation equipment.*		
T16-2B-110/ 210	**24/7 Access to Emergency Theatre and Surgery**	There should be 24/7 access to a fully staffed and equipped emergency theatre. Patients requiring acute intervention for haemorrhage control should be in an operating room or intervention suite within 60 minutes.		

T16-2B-111/ 211	**Damage Control Training for Emergency Trauma Consultant Surgeons**	*All general surgeons who are on the emergency surgery rota should be trained in the principles and techniques of damage control surgery*		
T16-2B-112 ***(adults only)***	**24/7 Access to On-site Surgical Staff**	*The following staff should be available on site 24/7:* • *a general surgeon ST4 or above;* • *a trauma and orthopaedic surgeon ST4 or above;* • *an anaesthetist ST4 or above;* • a neurosurgeon ST2 or above.		
T16-2B-113/ 212	**24/7 Access to Consultant Specialists**	*There following consultants should be available to attend an emergency case within 30 minutes* • *emergency department physicians;* • *a general surgeon; (adults and paediatrics)* • *an anaesthetist; (adults and paediatrics)* • *an intensivist; (adults and paediatrics)* • *a trauma and orthopaedic surgeon;* • *a neurosurgeon; (adults and paediatrics)* • *an interventional radiologist;* • a radiologist; • *a plastic surgeon;* • *a cardiothoracic surgeon;* • *a vascular surgeon;* • *a urology surgeon;* • *a maxillofacial surgeon;* • an ENT surgeon.		
T16-2B-114 ***(adults only)***	**Dedicated Orthopaedic Trauma Operating Theatre**	*There should be dedicated trauma operating theatre lists with appropriate staffing available 7 days a week.* *The lists must be separate from other emergency operating.*		
T16-2B-115/ 213	**Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries**	*There should be specialist surgeons and facilities (theatre/equipment) to provide fixation of pelvic ring injuries within 24 hours.* *There should be cover arrangements in place for holidays and planned absences.*		
T16-2B-116/ 214	**Trauma Management**	*The MTC should agree the network trauma management guidelines as*		

	Guidelines	*specified in T16-1C-107.* *The MTC should include relevant local details.*		
T16-2B-117/ 215	**Critical Care Provision**	*In exceptional circumstances if children are cared for on an adult ITU prior to transfer to a PICU:* *1. there should be guidelines for the temporary management of children that comply with the minimum standards of the paediatric intensive care society;* *2. there should be safe transfer / retrieval pathways;* *3. the unit should be part of a paediatric intensive care network.*		
T16-2B-118/ 216	**24/7 Specialist Acute Pain Service**	There should be a 24/7 specialist acute pain service available for major trauma patients. The MTC should have pain management pathways for: • patients with severe chest injury and rib fractures; • early access to epidural pain management (within 6 hours). The MTC should audit the pain management of major trauma patients including patients with severe chest injuries (AIS3+), who were not ventilated and who received epidural analgesia. There should be a 24/7 specialist paediatric acute pain service for major trauma patients.		
T16-2B-119/ 217	**Administration of Tranexamic Acid**	*Patients with significant haemorrhage should be administered Tranexamic Acid within 3 hours of injury and receive a second dose according to CRASH-2 protocol. (Adults)* *There should be a policy that patients with significant haemorrhage should be administered Tranexamic Acid within 3 hours of injury according to RCPCH guidelines*		

Definitive Care				
Number	**Indicator**	**Descriptor**	**Yes**	**No**
T16-2C-101/ 201	**Major Trauma Centre Lead Clinician**	*There should be a lead clinician for the Major Trauma Centre (MTC) who should be a consultant with managerial responsibility for the service and time specified in their job plan.*		
T16-2C-102 ***(adults only)***	**Major Trauma Service**	There should be a major trauma service led by consultants which takes responsibility for the holistic care and co-ordination of management of		

		every individual major trauma patient on a daily basis.		
T16-2C-103/ 202	**Major Trauma Coordinator Service**	*There should be a major trauma coordinator service available 7 days a week for the coordination of care of major trauma patients.* *The coordinator service should be provided by nurse or allied health professionals of band 7 or above.*		

T16-2C-104/ 203	**Major Trauma MDT Meeting**	*There should be a single daily multi-specialty meeting for the presentation and discussion of all new major trauma patients following admission.*
		The meeting should include:
		• major trauma lead clinician (paediatrics only)
		• *a trauma co-ordinator*
		• a physiotherapist
		• occupational therapist (paediatrics only)
		• speech and language therapist (paediatrics only)
		• youth worker (paediatrics only)
		• play therapist (paediatrics only)
		• psychologist (paediatrics only)
		• *safe-guarding representative as required* (paediatrics only)
		• clinical staff for:
		  ○ major trauma service (adults only)
		  ○ orthopaedics
		  ○ general surgery
		  ○ neurosurgery
		  ○ critical care
		  ○ radiology
		Accommodation for the meeting should include facilities for:
		• Video/teleconferencing
		• PACS		

T16-2C-204 ***(paediatrics only)***	**Identification of Social and Welfare Needs**	*There should be identified members of the team who are trained to assess the social and welfare needs of the child, family and/or carers following a major trauma event whilst they are resident in the MTC. They should have expertise in dealing with complex discharges and be able to*		

		identify and support child protection investigations. They should attend the weekly rehabilitation MDT meetings (T16-2D-202) and should include: • *Rehabilitation co-ordinator* • Safeguarding Team • Family support services • Paediatrician *An appropriate needs assessment and outcome measure tool for children admitted to the MTC should be recorded for all complex patients.*		
T16-2C-105 ***(adults only)***	**Dedicated Major Trauma Ward or Clinical Area**	*There should be a separate major trauma ward or clearly identified clinical area where major trauma patients are managed as a cohort*		
T16-2C-106/ 205	**Formal Tertiary Survey**	*All major trauma patients should have a formal tertiary survey completed to identify missed injuries.* *The survey should be recorded in the patient's notes.* *The major trauma service should audit the implementation of the protocol (paediatrics only).*		
T16-2C-107/ 206	**Management of Neurosurgical Trauma**	*The MTC should have the following neurosurgical provision:* i. *on-site neuroradiology;* ii. *on site neuro critical care;* iii. *a neurosurgical consultant available for advice to the trauma network 24/7;* iv. *a senior neurosurgical trainee of ST4 or above;* v. *all neurosurgical patient referrals should be discussed with a consultant;* vi. *all decisions to perform emergency neurosurgery for trauma are discussed with a consultant;* vii. *facilities available to allow neurosurgical intervention within 1 hour of arrival at the MTC.*		
T16-2C-108/ 207	**Management of Craniofacial Trauma**	*There should be an agreed pathway for patients with craniofacial trauma which includes joint management with neurosurgery.* *Where there are facilities for craniofacial trauma on site they should be co-located with neurosurgery.*		
T16-2C-109/ 208	**Management of Spinal**	*The MTC should agree the network protocol for protecting and assessing*		

	Injuries	*the whole spine in adults and children with major trauma.* *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.* *All patients with spinal cord injury should be entered onto the national SCI database.*		
T16-2C-110/ 209	**Management of Musculoskeletal Trauma**	*There should be trauma orthopaedic surgeons who spend a minimum of 50% of their programmed activities in trauma.* *There should be paediatric orthopaedic surgeons (paediatrics only).* *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 BOAST 4 guidelines.* *All patients with complex musculoskeletal injuries should have a rehabilitation management plan.*		
T16-2C-111/ 210	**Management of Hand Trauma**	*There should be facilities for the management of patients with hand trauma which include:* • *dedicated hand surgery specialists with a combination of plastic and orthopaedic surgeons;* • facilities for microsurgery; • a dedicated hand therapist		
T16-2C-112/ 211	**Management of Complex Peripheral Nerve Injuries**	*There should be facilities and expertise for the management of complex peripheral nerve injuries, including brachial plexus.* *Where these are not on site the MTC should name the tertiary referral centre.*		
T16-2C-113/ 212	**Management of Maxillofacial Trauma**	There should be on site maxillofacial surgeons with access to theatre for the reconstruction of maxillofacial trauma.		
T16-2C-114 ***(adults only)***	**Vascular and Endovascular Surgery**	There should be facilities for open vascular and endovascular surgery, including EVAR, available 24/7.		
T16-2C-115/ 213	**Designated Specialist Burns Care**	*Burns care should be managed through a designated specialist burns network.* *There should be a clinical guideline for the treatment of burns. This should include the referral pathway to the specialist burns centre where*		

		the MTC is not the specialist centre.		
T16-2C-116/ 214	**Patient Transfer**	*The MTC should agree the network protocol for patient transfer T16-1C-104*		
T16-2C-117 ***(adults only)***	**Network Patient Repatriation Policy**	*The MTC should agree the network policy for the repatriation of patients. T16-1C-115*		
T16-2C-118/ 215	**Specialist Dietetic Support**	*There should be a specialist dietician with specified time for the management of major trauma patients.*		
T16-2C-119/ 216	**24/7 Access to Psychiatric Advice**	*There should be 24/7 access to liaison psychiatric assessment services.*		
T16-2C-120/ 217	**Patient Information**	*The patient and or their family/carers should be provided with written information specific to the MTC about the facilities, care and rehabilitation as specified in the NICE guideline – Major Trauma (NG39)*		
T16-2C-121/ 218	**Patient Experience**	*The MTC should participate in the TARN PROMS and PREMS*		
T16-2C-122/ 219	**Discharge summary**	*There should be a discharge summary which includes:* • A list of all injuries • Details of operations (with dates) • *Instructions for next stage rehabilitation for each injury (including specialist equipment such as; wheel chairs, braces and casts)* • *Follow-up clinic appointments* • Contact details for ongoing enquiries.		
T16-2C-220 ***(paediatrics only)***	**Network Patient Repatriation Policy**	*The MTC should agree the network policy for the repatriation of patients. T16-1C-115*		
T16-2C-123 ***(adults only)***	**Rate of Survival**			

Rehabilitation				
Number	**Indicator**	**Descriptor**	**Yes**	**No**
T16-2D-101/ 201	**Clinical Lead for Acute Trauma Rehabilitation Services**	*There should be a named lead clinician for acute trauma rehabilitation services who is a consultant in rehabilitation medicine, and have an agreed list of responsibilities and time specified for the role.*		

T16-2D-102/ 202	**Specialist Rehabilitation Team *(adults only)***	*There should be a multidisciplinary specialist rehabilitation team which should include:* • Consultant in rehabilitation medicine • Physiotherapist • Occupational therapist • *Speech and language therapist* • Dietician • *Clinical psychologist /neuropsychologist* *The team should meet at least weekly to discuss and update rehabilitation management plans and rehabilitation prescriptions.* *There should be specified contacts for the following:* • *pain management specialist* • pharmacist • surgical appliance services • *orthotic services* • prosthetic services • wheelchair services		
	Specialist Rehabilitation Team *(paediatric only)*	There should be a multidisciplinary specialist rehabilitation team which should include: • lead clinician for rehabilitation • rehabilitation co-ordinator • paediatrician • representation from safeguarding team • representation from family support services Where relevant: • play therapist • youth worker • music therapist • physiotherapist • speech and language therapist • dietitian • clinical psychologist / neuropsychologist		

		• neuropsychologist The team should meet at least weekly to discuss and update rehabilitation management plans and rehabilitation prescriptions. There should be specified contacts for the following: • pain management specialist • pharmacist • surgical appliance services • orthotic services • prosthetic services • wheelchair services		
T16-2D-103/ 203	**Rehabilitation Coordinator Post**	*There should be a rehabilitation coordinator who is responsible for coordination and communication regarding the patient's current and future rehabilitation available 7 days a week.* *This rehabilitation coordinator should be a nurse or allied health professional at AFC Band 7 or above with experience in rehabilitation.*		
T16-2D-104/ 204	**Specialist Rehabilitation Pathways**	*There should be referral pathways for patients requiring specialist rehabilitation for;* • *neurological injuries, including t brain injuries* • spinal injuries • complex musculoskeletal injuries • *return to work (vocational rehabilitation)for patients with & without brain injury*		
T16-2D-105/ 205	**Key worker**	*All patients requiring rehabilitation should have an identified key worker to be a point of contact for them, their carer/s or family doctor.* *The key worker should be a health care professional* *The name of the patient's key worker should be recorded in the patient's notes and on their rehabilitation prescription*		
T16-2D-106/ 206	**Rehabilitation Assessment and Prescriptions**	*All patients should receive a rehabilitation assessment including barriers to return to work. All patients should have a Rehabilitation Prescription initiated within 2 calendar days of admission & the first comprehensive Rehabilitation Prescription completed at 4 calendar days following admission*		

		The prescription should be updated weekly at the rehabilitation MDT meeting until transfer into a designated rehabilitation service (T16-2D-102) and prior to discharge and a copy given to the patient *All patients should be reviewed by a Consultant in Rehabilitation Medicine (or an alternative consultant with skills & competencies in rehabilitation eg: elderly care for elderly patients with multiple co-morbidities) within 3 calendar days of admission* *Patients who have Category A or B rehabilitation needs (using the Patient Categorisation Tool) should have a "specialist rehabilitation prescription" completed by a Consultant in Rehabilitation Medicine or their designated deputy. (1)The specialist RP must accompany the patient on discharge from the MTC, with network arrangements to ensure appropriate referral to specialist rehabilitation services* *All patients should receive a rehabilitation assessment. Where a prescription is required this should be completed within 72 hours.*		
T16-2D-107/ 207	**Rehabilitation for Traumatic Amputation**	*There should be a rehabilitation program for patients with a traumatic amputation which includes:* • *a linked prosthetics centre which provides an out-reach service to see patients with amputation;* • pain management of acute amputation, including phantom limb pain; • specialist paediatric psychological services for patients who suffer acute, traumatic amputation. (paediatrics only)		
T16-2D-108/ 208	**Referral Guidelines to Rehabilitation Services**	*The MTC should agree the network referral guidelines for access to rehabilitation services T16-1C-113*		
T16-2D-109/ 209	**Clinical Psychologist for Trauma Rehabilitation**	*The trauma rehabilitation service should include a clinical psychologist for the assessment and treatment of major trauma patients.* *Inpatient and outpatient clinical psychology services should be available.*		
T16-2D-110	**BSRM Core Standards for Specialist Rehabilitation in the Trauma Pathway**	*For patients identified as having category A or B needs, & so potentially requiring specialist (Level 1 or 2) rehabilitation, the following datasets should be completed as part of the "Specialist Rehabilitation Prescription", & should be completed by a Consultant in Rehabilitation Medicine or their designated deputy:-*		

		• Patient Categorisation Tool or Complex Need Checklist- • *RCS-E or RCS-ET (dependent on MTC & Network arrangements)* • Northwick Park dependency Score • Neurological & Trauma Impairment Set *Where specialist rehabilitation is not provided at the MTC, & patients are transferred to TUs or other hospitals, the Specialist RP must be updated at the point of discharge from the MTC* *The MTC should also participate in the National Clinical Audit of Specialist Rehabilitation for Patients Following Major Injury.*		

Appendix 3– Service Model

SOUTH WALES HEALTH COLLABORATIVE
SERVICE MODEL OVERVIEW
MAJOR TRAUMA NETWORK

Version history

Version	Date Issued	Status	Owner
1.0	21.05.15	Final – issued for non-financial option appraisal exercise	RF

CONTENTS

	Page
1. Introduction	2
2. Context	
2.1 Scope, vision, planning principles, service aims and objectives	3
2.2 Clinical standards	5
3. Service Model	7
3.1 Service overview	
3.2 Clinical service interdependencies	
3.3 Key characteristics of the major trauma network	
3.4 Service models at each level of care	
3.5 Pathways of care	
3.6 Key risks	
4. Workforce	15
5. Specialised, tertiary & networked services	16
6. Key performance Indicators	16
7. References	16

Appendix 3– Service Model

SERVICE MODEL – MAJOR TRAUMA

1. Introduction

This paper describes the proposed service model for a major trauma network to serve South Wales, South Powys and West Wales.

The service model is being developed by the Major Trauma Network Clinical Reference Group, which reports to the Major Trauma Network Project Board, and has clinical representation from all participating health boards and the Welsh Ambulance Services Trust (WAST). The service model's main reference points are the NHS Clinical Advisory Group Report (September 2010): Regional Networks for Major Trauma, the NHS England Standard Contract for Major Trauma (2013), and the Centre for Workforce Intelligence report on Regional Trauma Networks (March 2011) and takes account of other published clinical standards. The process for developing service models is iterative and the model will need to be reviewed on a regular basis.

This service model should be considered in conjunction with service models for emergency medicine, emergency surgery and the Emergency Medical Retrieval and Transfer Service (EMRTS).

This service model is accompanied by, and should be read in the context of, the 'Standards and Guidance for the development of a Major Trauma Network for South Wales' document.

2. The scope, vision, planning principles, service objectives

2.1. Details of the scope, vision, planning principles, service objectives used in developing the service model are provided in this section.

Scope	The major trauma network for South Wales, South Powys and West Wales will serve the populations of Aneurin Bevan UHB, Abertawe Bro Morgannwg UHB, Cardiff & Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys tHB. The service model will address the needs of the most severely injured patients, adults and children, meaning those who have suffered potentially life-threatening or life-changing physical injuries, i.e. all those who could benefit from a regional network. The model for trauma care across the region will be based on a collaborative approach across all stakeholders to plan, provide and manage the treatment of people injured as a result of major trauma and will cover all aspects of trauma care, along the whole patient pathway from the point of injury to rehabilitation. The trauma network will be a collaboration of the providers delivering trauma care services across the region. The trauma network should include all providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions and rehabilitation services. The service model will provide a holistic patient-focussed care package. The service will comply with accepted best clinical practice and standards, provide improved patient outcomes and have robust governance arrangements. Consideration will be given as to how this service interfaces with other relevant developments and impacts on other clinical and support services.

Vision	To ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable major trauma services at all points along their care pathway from the point of injury to rehabilitation, in line with best practice standard requirements, evidenced by key performance indicators (KPI).

Planning Principles	Some key principles underpin the ongoing planning processes and require that the new service model should describe a system that will deliver: • Safe, effective, compassionate and equitable care • High quality, sustainable major trauma treatment and care from the point of injury to rehabilitation – the four key areas are pre-hospital care, acute care, acute on-going care, and rehabililtation

Appendix 3– Service Model

	• Timely access for patients to the 'definitive place of treatment' to avoid delays in the patient pathway • Services that meet national clinical and workforce standards • Access to senior medical advice and treatment 24/7 for major trauma patients • Service models underpinned by realistic and deliverable workforce models • Stable medical teams that deliver high-quality patient care in an effective environment in which to train and educate the next generation of doctors • Integration of care and effective relationships with other health professions • An appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs • Early access to rehabilitation assessments and to ensure that patients are moved through the system appropriately

Service Aims & Objectives	**To improve the quality and safety of care for patients by:** • Providing a comprehensive system of specialist care for people who have suffered serious injury (major trauma) through the delivery of a regional trauma network • 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 • Tailoring services to meet the needs of individual patients, including vulnerable patients • 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 the sustainability of services to patients by: • Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate. • Developing clinical roles to provide future workforce flexibility • 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
	To improve access for patients 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

2.2 National Clinical Standards

Following initial review, the following reports, standards and guidance have been identified. The key publication is the NHS Clinical Advisory Groups Report (September 2010)*
This list will be developed through the Clinical Reference Group:

*Regional Networks for Major Trauma: NHS Clinical Advisory Groups Report (September 2010)
http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Emergencymedicine/Regionalnetworksformajortrauma.pdf
http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf

Major trauma care in England: National Audit Office (February 2010)
http://www.nao.org.uk/wp-content/uploads/2010/02/0910213.pdf

Standards of practice and guidance for trauma radiology in severely-injured patients: Royal College of Radiologists (2011)
https://www.rcr.ac.uk/docs/radiology/pdf/BFCR(11)3_trauma.pdf

The British Orthopaedic Association Standards for Trauma (BOAST)
http://www.boa.ac.uk/publications/boa-standards-for-trauma-boasts/

BOAST 4: The management of severe open lower limb fractures
http://www.boa.ac.uk/publications/boast-4-the-management-of-sever-open-lower-limb-fractures/

Management of People with Spinal Cord Injury: NHS Clinical Advisory Groups Report (August 2011)
http://www.mascip.co.uk/sci-roadmap.aspx (This report is hosted on this site)

Brain Trauma Foundation guidelines for head injury care
https://www.braintrauma.org/coma-guidelines/searchable-guidelines/

Triage, assessment, investigation and early management of head injury in children, young people and adults: NICE Guideline - Head injury (CG176)
http://guidance.nice.org.uk/CG176

Rehabilitation after critical illness: NICE Guideline (CG83)
http://publications.nice.org.uk/rehabilitation-after-critical-illness-cg83

Specialist rehabilitation in the trauma pathway: British Society of Rehabilitation Medicine (BSRM) core standards version 1.2 (January 2013)
http://www.bsrm.co.uk/publications/BSRM%20Core%20standards%20for%20Major%20Trauma%2030-5-13.pdf

Rehabilitation for patients in the acute care pathway following severe disabling illness or injury: BSRM core standards for specialist rehabilitation (October 2014)
http://www.bsrm.co.uk/publications/Specialist%20rehabilitation%20prescription%20for%20acute%20care%2028%2011%202014%20JA%20%20ap1%20redrawn.pdf

Together for Health – A delivery plan for the critically ill: Welsh Government (2013)
http://wales.gov.uk/docs/dhss/publications/130611deliveryen.pdf

Regional Trauma Networks – NHS Clinical Advisory Group on Major Trauma Workforce, Centre for Workforce Intelligence (March 2011)
http://www.cfwi.org.uk/publications/nhs-clinical-advisory-group-on-major-trauma-workforce/@@publication-detail

National burn care standards: National Network for Burn Care (Revised 2013)
http://www.britishburnassociation.org/downloads/National_Burn_Care_Standards_2013.pdf

NHS England: NHS Standard Contract for Major Trauma Services (all ages) (2013)
http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf

Note: NICE is developing five pieces of guidance relating to trauma, with expected publication dates in June and October 2015 (to be confirmed). Each piece of guidance will focus on a different aspect of trauma care.

- Complex fractures: assessment and management of complex fractures (including pelvic fractures and open fractures of limbs)
- Fractures: diagnosis, management and follow up of fractures (excluding head and hip, pelvis, open and spinal)
- Major trauma: assessment and management of airway, breathing and ventilation, circulation, haemorrhage and temperature control.
- Spinal injury assessment: assessment and imaging of patients at high risk of spinal injury
- Trauma services: service delivery of trauma services

3. Service Model

3.1 Service overview

The aim of the service is to provide 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 rehabilitation. Calculation of the ISS requires a full diagnostic work-up and so the service is designed around the triage of patients at the point of wounding, to identify "candidate major trauma patients" on the basis of mechanism of injury and assessment of their symptoms and physical signs. The Major Trauma Centre (MTC) will have all the services available to receive and manage seriously injured adults and children. Patients who have been incorrectly triaged to, or have self- presented with serious injury at a hospital within the network, will be rapidly transferred to the MTC. In addition, some patients will need treatment in the MTC which will require transfer in within the first 2 days following injury.

Following assessment and initial treatment at the MTC or TU, children requiring intensive care will be received at the Children's Hospital for Wales which provides Paediatric Intensive Care Unit (PICU) facilities. See http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf - annex 1 for standards for provision of services for children.

The service is designed to deliver high quality specialist care to patients of all ages starting from the pre-hospital phase, through admission to the MTC, with full assessment and diagnostics in the emergency department. This may be followed by operative treatment and an episode in the critical care unit and ward. Rehabilitation will be required for a number for patients, and this rehabilitation will start in the MTC and continue through specialist rehabilitation or local rehabilitation services.

Appendix 3– Service Model

3.2 Clinical service interdependencies:

The table below sets out the key dependencies for the Major Trauma Centre and trauma units:

	Acute phase (continuum into ongoing care and reconstruction)																				
	Emergency radiology in ED	MRI 24/7	Teleradiology between MTC and TUs	General Surgery	Ophthalmology	ICU	Theatres / Anaes	Orthopaedic surgery	Plastic surgery	24/7 Interventional radiology	Vascular/ endovasc surgery – hybrid theatre	Cardiothoracics	Max-facial surgery	Neurosurgery	Spinal injury	Liver surgery	Burns	Emergency Medicine	Ear nose and throat surgery	Transfusion services	Pathology services	Organ donation
Trauma centre																						
Trauma unit																						

	Ongoing care and reconstruction										
	Radiology – MRI, IR, angiography	Critical care	Clinical psychology	Rehabilitation	Specialist rehabilitation	Specialist acute pain service	Craniofacial trauma support	Haematology	Obs/gynae	Respiratory physiotherapy (for pneumothoraces, chest drain and thracheostomies)	Complex peripheral nerve support
Trauma centre											
Trauma unit											

Red	Absolute dependency, requiring co-location on the same hospital site
Amber	Relationship under some circumstances, requiring varying levels of access and contact between specialists but not necessarily co-location

Acute Phase: Defined as the time period immediately after injury and transfer to hospital in which immediately or potentially life or limb threatening problems are recognised, diagnosed and managed utilising damage control principles or definitively where appropriate.

Ongoing Care & Reconstruction: Defined as the subsequent phase in patient care when temporary management is concluded with definitive treatment, integrating rehabilitation, re-ablement and discharge to the community. After the patient's surgical care is complete, this is likely to require transfer for ongoing rehabilitation, possibly involving repatriation to a hospital closer to the patient's home

Major trauma generates complex clinical injuries and problems; successful management involves a number of specialties and agencies. This model will describe how a service which crosses specialty boundaries is delivered to produce a comprehensive trauma service working within a robust governance framework.

3.3 Key characteristics of the major trauma network

Across the network there should be a focus on delivery of patient-centred services which consider all of the health and well-being needs of people who have sustained traumatic injuries. Coordination of medical, nursing and rehabilitation packages of care is crucial and trauma patients should receive appropriate levels of care and rehabilitation at all points along their care pathway. The important role of family and friends should be acknowledged and actively supported.

Rehabilitation should start as soon as is appropriate after admission, typically in the critical care setting, and continue at the intensity required, and for as long as is necessary, to enable patients to achieve their functional potential.

Any hospital within the network receiving trauma patients must have associated governance structures in place.

Organisational and network structures should facilitate follow up appointments to take place in the most appropriate setting.

3.4 Service models at each level of care

Service Delivery
Major trauma care is delivered through an inclusive trauma network delivery model. The major trauma network includes all providers of trauma care and, in particular, pre-hospital services, other hospitals receiving acute trauma admissions, and rehabilitation services, and will have appropriate links to social care and the voluntary/community sector.

The major trauma centre (MTC) will provide multi-specialty hospital care to seriously injured patients and manage all types of trauma but specifically will lead the management of major trauma patients, providing consultant-level care and access to tertiary and specialised level services. The MTC takes responsibility for the care of all patients with major trauma in the area covered by the network and provides specialist early/hyper acute rehabilitation as well as a managed transition to rehabilitation and the community.

The MTC will be required to work with the ambulance service, other hospitals receiving acute trauma admissions, and specialist and general rehabilitation services, to ensure delivery of the whole pathway including the specialised component and will itself deliver acute care and surgery, on-going care and acute/early phase rehabilitation.

Services will be delivered in line with the standards of the Regional Networks for Major Trauma NHS Clinical Advisory Groups Report (2010), supplemented with KPIs derived from the NHS England Standard Contract for Major Trauma Services(2013).

When treating children, the service will additionally follow the standards and criteria outlined for children's services (http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf annex 1).

Patients with an ISS>8 are covered by this service model.

3.5 Pathways of care

Pre-hospital phase

The requirements for pre-hospital care will be developed in conjunction with the EMRTS Project Board. The NHS Clinical Advisory Group report (2010) on major trauma sets out the following recommendations for pre-hospital care:

- A Trauma Triage Tool should be used to identify patients with major trauma
- A paramedic should be present in the Ambulance Control room 24 hours a day. Their role is to identify potential major trauma patients and coordinate the response
- All patients identified as major trauma should be taken to a Major Trauma Centre. Those who are within 45 minutes travelling time from the Centre should be taken there directly, bypassing other units
- Patients who are further away or who are critically unstable should be subject to further guidance on an individual basis
- Patients with major trauma who are taken to a local Trauma Unit should be transferred to a Major Trauma Centre after initial assessment and optimisation in the Emergency Department
- Enhanced care teams should be available 24/7 to provide care to the major trauma patient
- Major trauma patients should be transferred to an appropriate Major Trauma Centre when indicated
- A structured pre-alert should be given to the receiving hospital as early as possible
- On arrival at the hospital a structured handover should be given to the receiving team
- Secondary emergency department transfer to a major trauma centre should be provided by an appropriate trained team
- For time critical conditions, the transfer should be performed without delay
- A structured checklist and standardised documentation should be used and included in the patients' clinical records
- All components of the major trauma network including pre-hospital services should submit data for all major trauma patients to a national trauma dataset (currently TARN)

- Regular audit of the pre-hospital phase of trauma care is essential. Pre-hospital care providers should be given feedback on the patients they manage and should attend audit and other meetings in the MTC and network as part of good clinical governance

Referral
Patients will be triaged to the MTC directly or through a secondary transfer protocol. The MTC will have a policy of automatic acceptance for patients requiring MTC care from within the network. Hospitals within the MTN will work together ensuring patients have seamless access to care and transfer back to their local hospital when medically fit.

Emergency Care and Surgery:

- 24/7 Consultant (trauma team leader) available on the MTC site to receive the trauma patient on arrival (patient to be seen within 5 minutes of arrival)
- The trauma team should be appropriately trained and competent to deliver their role
- Trauma team present 24 hours a day for immediate reception of the patient
- Ability to undertake surgical and resuscitative thoracotomy in the emergency department (ED)
- A protocol to manage massive haemorrhage in place for patients with severe blood loss which includes the administration of tranexamic acid within 3 hours of injury, and transfusion specialist advice should be available 24 hours a day
- 24/7 immediate availability of fully staffed and equipped operating theatres
- All emergency operative interventions performed within the first 24 hours should have consultant involvement, and consultant presence in the operating room for life- or limb-threatening injuries. A consultant will be involved in surgical decision making; Emergency trauma surgery will be undertaken or directly supervised by consultants. There will be a network protocol in place and operational at the MTC for assessing the whole spine in Major Trauma patients.
- Consultants available on site within 30 minutes when required and senior trainees (ST5s and above or equivalent) on site 24/7 for:
    - Neurosurgery;
    - Spinal and spinal cord surgery;
    - Vascular surgery;
    - General surgery (adult or child);
    - Trauma and Orthopaedic surgery;
    - Cardiothoracic surgery;
    - Maxillofacial surgery;
    - Anaesthetics;
    - Interventional radiology;
    - Intensive care
    - Plastic surgery

Diagnostics and Radiology

- Immediate (within 30 minutes) access to computerised tomography (CT) scanning, initial reporting within 15 minutes and detailed reporting within 60 minutes of scan;
- Availability of interventional radiology within 60 minutes of referral
- MRI scanning should be available 24/7
- Tele-radiology facilities in place between all sites within the network

On-going Care and Reconstruction

- Immediate access to critical care or high dependency care (adult or paediatric) when required
- A defined team to manage on-going patient care, including a key worker (also referred to as trauma and rehabilitation co-ordinator) to support patients through the pathway and into rehabilitation.
- Specialist nursing and allied health professional trauma roles
- Access to cross speciality supporting services which will include pain management, rehabilitation medicine (which usually includes management of disturbed behaviour), neuropsychology and neuropsychiatry and psychosocial and mental health care
- A defined ward for major trauma patients
- A ward environment suitable for people with disability to practice and maintain their activities
- A nursing team in the ward, who are able to facilitate practice of and independence in functional activities by the patient, and undertake activities with the patient as advised, by the rehabilitation team

Early/Hyper Acute Phase Rehabilitation

- A defined service for early/hyper acute trauma rehabilitation service which meets the needs of patients with ISS >8
- Rehabilitation should start as soon as is appropriate after admission, typically in the critical care setting (and certainly within 72 hours), and continue at the intensity required, and for as long as is necessary, to enable patients to achieve their functional potential. A rehabilitation prescription should be provided to all trauma patients with identified needs. This prescription should be reviewed and amended in response to changes in condition.
- The prescription for rehabilitation reflects the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.
- All patients to have an initial rehabilitation prescription within 2-4 calendar days of presentation. The prescription may identify no further need for rehabilitation, may recommend monitoring or may require full active engagement of the wider rehabilitation team
- All patients to receive early phase rehabilitation and all other actions identified in the rehabilitation prescription; if action or input cannot be delivered, the reason should be recorded and intervening action to be undertaken
- All patients needing rehabilitation input or monitoring to be under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation. This team will meet weekly to discuss all patients within the scope of this specification in the MTC (Including those in Intensive Care Units

(ICU) and ward areas); a speciality trainee registrar at St4 or above in rehabilitation may deputise for a consultant on occasion but a consultant should attend over 80% of meetings and continue to provide supervision and support to the team

Rehabilitation phase (ongoing specialised and local rehabilitation)

- Trauma patients should receive routine screening of rehabilitation needs and appropriate levels of care and rehabilitation at all points along their care pathway
- Network to provide rehabilitation services appropriate the needs of complex trauma patients
- Provider therapy teams should provide access to rehabilitation assessment seven days a week.
- A discharge summary describing the patient's injuries, care received and ongoing needs and plans should be provided at the time of discharge or transfer from a Major Trauma Centre or Trauma Unit. This should include the rehabilitation prescription
- There should be rehabilitation and care coordinator posts throughout the network. Each patient should have an identified key worker to be a point of contact for them, their carers or family doctor and to ensure delivery of their personal prescription for rehabilitation
- Vocational rehabilitation should be a key component of the rehabilitation service
- There should be an adequately skilled and resourced multi-disciplinary rehabilitation team in all of the network's services. Multi-disciplinary teams should include: physiotherapists, occupational therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients
- Policies for nutritional management should be in place in Major Trauma Centre/s and Trauma Units
- Use should be made of VC/telehealth technology to support the rehabilitation phase enhancing shared care arrangements between generic providers of rehabilitation and the specialist trauma rehabilitation teams
- The needs of families and carers in all phases of major trauma rehabilitation should be considered, including the distances that may be incurred in travelling

Network Delivery

The Major Trauma Network will be led by a Network Director and will take responsibility for the care of all patients referred with major trauma in the area covered by the network, as defined by local protocols and capabilities of other hospitals receiving acute trauma admissions and transfer arrangements to a MTC for under triage and secondary transfer protocols. There should also be the identification of a Network Clinical Lead for Rehabilitation Services to coordinate the development and delivery of rehabilitation services and long-term support in the community, and the delivery of comprehensive and effective rehabilitation to meet the needs of traumatically injured patients, irrespective of their age.

The MTC will:

- Be responsible for all stages of care, including the rehabilitation and transfer aspects of the patient's pathway
- Provide clinical advice to other providers within the network. This will include pre-hospital treatment, patients awaiting transfer to the MTC for definitive treatment, and following acute care when the patient is discharged to on-going specialised and local rehabilitation services
- Accept the secondary transfer of major trauma patients in accordance with the clinical condition of the patient
- Be actively engaged and contribute to the operational requirements, training, governance and audit within and across the MTN

- Deliver care and access to treatment in line with locally agreed network protocols and guidelines

Discharge planning, continuing care and rehabilitation

Patient transfer

- There should be cross network agreements and adequate resources to ensure that once specialist trauma care has been completed, patients can be transferred to the care of a service which is able to meet their ongoing care and/or rehabilitation needs
- There should be a formal handover back to the local therapy team (including ALAS) via an identified therapy lead at the provider unit. The responsibility should be on the local team to 'pull' patients back to local services. This must be achieved in a timely manner with adequate notice to plan and support transition. The local therapy team should visit the patient at the provider unit as part of transfer planning. The transfer should be followed up with a visit from the provider therapy team following transfer
- A discharge summary must be provided to support the patient's transfer to an alternative healthcare setting or the community.
- Ongoing access to advice from provider therapy teams as required.

Communication

- There will be effective communication between all those responsible for the patient's care, the patient and where appropriate their family and other carers.
- Patients will be provided with a full range of condition-specific information in appropriate formats
- A directory of services and resources should be developed relating to rehabilitation and ongoing care to facilitate referral and access to these services. Links with the local authorities and third sector are integral to the rehabilitation model

Audit, data management, governance and quality improvement

- Full data submission to TARN within 25 calendar days following a patient's discharge
- The Major Trauma Network will be responsible for drawing down its report from TARN and ensuring the ISS is confirmed
- The Major Trauma Network will be responsible for clinical governance and collaborate with other hospitals in the network in reviewing and learning from TARN data
- There should be a review of the applicability of the UK National Dataset for Specialist Rehabilitation Services to all Major Trauma patients.

Representatives from hospitals within the networks will meet regularly to examine performance through formal governance processes. Performance improvement will be undertaken through regular mortality and morbidity meetings which will generate action plans for improvement.

3.6 Key risks

There are a number of risks associated with the development of the Major Trauma Network and Major Trauma Centre/s:

- Failure to identify and plan co/inter-dependencies
- Inconsistency of data across hospital sites to inform service modelling

- Lack of regional clinical consensus on service model
- Lack of stakeholder commitment to process
- Uncertainty regarding service changes
- Failure to fully capture capital and revenue implications, lack of affordability and failure to get agreement on funding flows
- Failure to fully capture staffing implications
- Failure to agree and implement network arrangement may adversely affect clinical recruitment and retention
- Clarity on commissioning arrangements
- Inadequate communications
- Failure to deliver informatics solutions at implementation

4. Workforce

The proposed service model is based on the following workforce-related principles:

- Services to meet national clinical and workforce standards
- Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate
- Access to senior medical advice and treatment 24/7 for major trauma patients
- Service models underpinned by realistic and deliverable workforce models
- Stable medical teams that deliver high-quality patient care in an effective environment in which to train and educate the next generation of doctors
- Integration of care and effective relationships with other health professions
- An appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs
- Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment
- Developing clinical roles to provide future workforce flexibility

The service model and standards describe some specific workforce requirements:

- The Major Trauma Network will be led by a Network Director
- There should be identification of a Network Clinical Lead for Rehabilitation Services
- Enhanced care teams should be available 24/7 to provide care to the major trauma patient
- 24/7 consultant (trauma team leader) available on the MTC site to receive the trauma patient on arrival
- Trauma team present 24 hours a day for immediate reception of the patient

- All emergency operative interventions performed within the first 24 hours should have consultant involvement, and consultant presence in the operating room for life- or limb-threatening injuries. A consultant will be involved in surgical decision making; emergency trauma surgery will be undertaken or directly supervised by consultants.
- Consultants available on site within 30 minutes when required and senior trainees (ST5s and above or equivalent) on site 24/7 for specified specialities
- A defined team to manage on-going patient care, including a key worker (also referred to as trauma and rehabilitation co-ordinator) to support patients through the pathway and into rehabilitation.
- Specialist nursing and allied health professional trauma roles
- A nursing team in the ward, able to facilitate practise of and independence in functional activities by the patient, and undertake activities with the patient as advised, by the rehabilitation team
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.
- All patients needing rehabilitation input or monitoring to be under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation. A speciality trainee registrar at St4 or above in rehabilitation may deputise for a consultant on occasion
- There should be rehabilitation and care coordinator posts throughout the network
- There should be an adequately skilled and resourced multi-disciplinary rehabilitation team in all of the network's services. Multi-disciplinary teams should include: physiotherapists, occupational therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients

5. Specialised Tertiary & Networked Services

- Paediatric Intensive Care (PICU) will remain at Children's Hospital for Wales
- Paediatric burns services will be delivered by Bristol
- Paediatric rehabilitation model will need to be considered by WHSSC
- Need to consider capacity requirements on WAST for secondary transfers

6. Key Performance Indicators

(To be completed in implementation phase)

7. References

- Regional Networks for Major Trauma: NHS Clinical Advisory Groups Report (September 2010)
- NHS England Standard Contract for Major Trauma (2013)
- Centre for Workforce Intelligence: Report on Regional Trauma Networks (March 2011)

SERVICE MODEL - REHABILITATION

1. Introduction

This paper describes the proposed rehabilitation service model for a major trauma network to serve South Wales, South Powys and West Wales.

The rehabilitation service model is being developed by the Major Trauma Network Rehabilitation Workstream, which reports to the Major Trauma Network Project Board. It has been developed via a series of three workshops with participants in the workshops nominated through members of the Major Trauma Project Board and included representatives from a broad spectrum of professionals within each Health Board – Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys, Welsh Ambulance Service Trust – Third Sector partners and Local Authorities. Invitations were also extended to Community Health Councils, Welsh Health Specialised Services Committee and patient representative groups.

The trauma service model has been developed by the Major Trauma Network Clinical Reference Group which is described in a separate document entitled, Clinical Model, May 2015, Final .

3. Clinical Model - May 2015 - Final.pdf

Throughout the work to develop the model, rehabilitation has consistently been highlighted as a key part of the patient pathway, commencing at admission, continuing through the inpatient phase to discharge from the major trauma centre or unit out into the community and is a true enabler to achieving the best outcomes for the patient.

2 Scope

Scope	The rehabilitation model will align with the major trauma network for South Wales, South Powys and West Wales and will serve the populations of Aneurin Bevan UHB, Abertawe Bro Morgannwg UHB, Cardiff & Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys tHB. The service model will provide a holistic patient-focussed treatment package. The service will comply with accepted best clinical practice and standards, provide improved patient outcomes and have robust governance arrangements. Consideration will be given as to how this service interfaces with other relevant developments and impacts on other clinical and support services.

Vision	To ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable trauma rehabilitation services at all points along their care pathway from the point of injury to rehabilitation, in line with best practice standard requirements.

Planning Principles	Key underpinning principles are the : • British Society of Rehabilitation Medicine, Specialist Rehabilitation in the Trauma pathway: core standards (version 1.4 – October 2013); • Regional Networks for Major Trauma: NHS Clinical Advisory Group Report (September 2010) recommendations for Early/Hyper Acute Phase Rehabilitation and the Rehabilitation phase (ongoing specialised and local); • The Initial Management of Adults with Spinal Cord Injuries, Advice for Major Trauma Networks and SCI Centres on the Development of Joint Protocols: National Spinal Cord Injury Strategy Board (May 2012); • National Spinal Cord Injury Database; and • NICE Guidelines on Major Trauma - no: 37, 38, 39, 40 and 41 (February 2016).

Appendix 4–Rehabiliation Service Model

Service Aims & Objectives	**To improve the quality of rehabilitation for patients by:** • Providing a comprehensive system of specialist and local rehabilitation for people who have suffered serious injury (major trauma) through the delivery of a regional trauma rehabilitation network; • 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/treatment; • 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 rehabilitation at all levels; • Ensuring robust arrangements for transferring treatment are in place; • Tailoring services to meet the needs of individual patients, including vulnerable patients; • Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment; and • Ensuring the quality of the system is monitored and subject to a process of continuous quality improvement.
	To improve the sustainability of services to patients by: • Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate; • Developing clinical roles to provide future workforce flexibility; • 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; and • Ensuring the network is kept under continuous review and responds to changes in relevant strategies, standards and policies.

	To improve access for patients by: • Delivering a rehabilitation system based on a pathway of care from acute care, ongoing care and rehabilitation and a return to socio-economic functioning; and • Improving information and support to patients and families to encourage them to be active participants in their rehabilitation.

3 Service Model

Network Delivery

There will be a Network Clinical Lead for Rehabilitation Services to coordinate the development and delivery of rehabilitation services and long-term support in the community, and the delivery of comprehensive and effective rehabilitation to meet the needs of traumatically injured patients, irrespective of their age.

Discharge planning, continuing care and rehabilitation

Patient transfer

- There should be cross network agreements and adequate resources to ensure that once specialist trauma care has been completed, patients can be transferred to the care of a service which is able to meet their ongoing care and/or rehabilitation needs.
- There should be a formal handover back to the local therapy team (including ALAS) via an identified therapy lead at the provider unit. The responsibility should be on the local team to 'pull' patients back to local services. This must be achieved in a timely manner with adequate notice to plan and support transition. The local therapy team should visit the patient at the provider unit as part of transfer planning. The transfer should be followed up with a visit from the provider therapy team following transfer.
- A discharge summary must be provided to support the patient's transfer to an alternative healthcare setting or the community.
- Ongoing access to advice from provider therapy teams as required.

Communication

- There will be effective communication between all those responsible for the patient's care, the patient and where appropriate their family and other carers.
- Patients will be provided with a full range of condition-specific information in appropriate formats.
- A directory of services and resources should be developed relating to rehabilitation and ongoing care to facilitate referral and access to these services. Links with the local authorities and third sector are integral to the rehabilitation model.

Audit, data management, governance and quality improvement

- Representatives from services within the rehabilitation network will meet regularly to examine performance through formal governance processes.
- A central database is required to monitor and measure rehabilitation outcomes.
- Use of the Network rehabilitation prescription will be mandated.

Workforce

- A defined team to manage on-going patient care, including a key worker (also referred to as trauma and rehabilitation coordinator) to support patients through the pathway and into rehabilitation.
- Specialist nursing and allied health professional trauma roles.
- Able to facilitate practice of and independence in functional activities by the patient, and undertake activities with the patient as advised, by the rehabilitation team.
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.

- All patients needing rehabilitation input or monitoring to be under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation. A specialty trainee registrar at St4 or above in rehabilitation may deputise for a consultant on occasion.
- There should be rehabilitation and care coordinator posts throughout the network.
- There should be an adequately skilled and resourced multi-disciplinary rehabilitation team in all of the network's services. Multi-disciplinary teams should include: physiotherapists, occupational therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients.

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.

Specialist rehabilitation is the total active care of patients with complex disabilities by a multi-professional team who have undergone recognised specialist training in rehabilitation led/supported by a consultant trained and accredited in rehabilitation medicine (Ref BSRM standards).

The aim of the rehabilitation service is to provide rehabilitation appropriate to the level of injury in the right setting. It will start in the Major Trauma Centre and continue through specialist or local rehabilitation services. To provide a holistic pathway of care, service requirements are as follows:

Early/Hyper Acute Phase Rehabilitation

• A defined service for early/hyper acute trauma rehabilitation service which meets the needs of patients with ISS >8.
• All patients have an initial rehabilitation prescription within 2-4 calendar days of presentation. The prescription may identify no further need for rehabilitation, may recommend monitoring or may require full active engagement of the wider rehabilitation team.
• Rehabilitation starts as soon as is appropriate after admission, typically in the critical care setting (and certainly within 72 hours), and continue at the intensity required, and for as long as is necessary, to enable patients to achieve their functional potential.

• The prescription for rehabilitation reflects the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient.
• An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.
• All patients receive early phase rehabilitation and all other actions identified in the rehabilitation prescription; if action or input cannot be delivered, the reason is recorded and intervening action is undertaken.
• All patients needing rehabilitation input or monitoring are under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation.
• This team meets weekly to discuss all patients within its scope. A consultant attends over 80% of meetings and continues to provide supervision and support to trainees and the team.

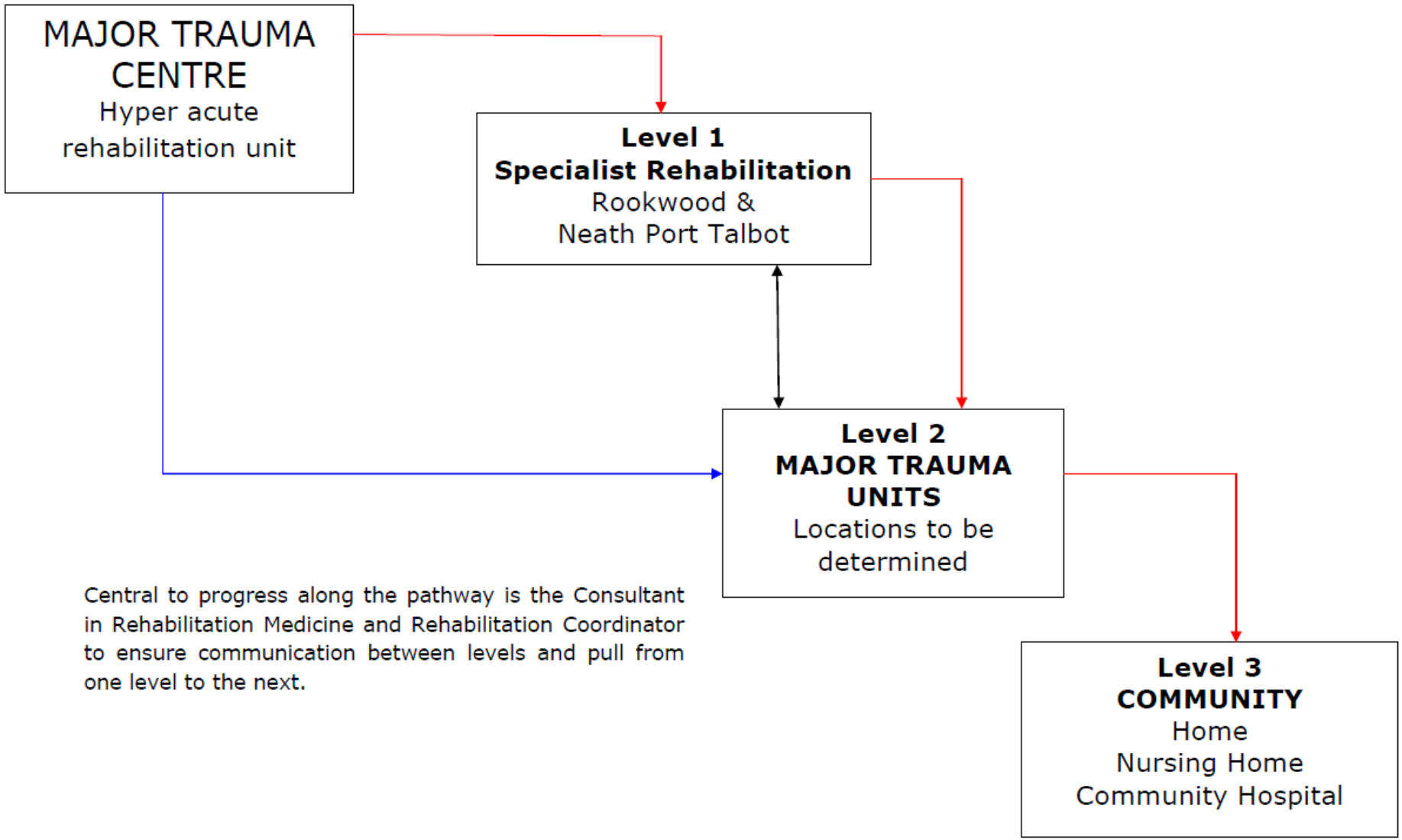
Rehabilitation phase (ongoing specialised and local rehabilitation)

• Trauma patients receive routine screening of rehabilitation needs and appropriate levels of care and rehabilitation at all points along their care pathway.
• Provider therapy teams provide access to rehabilitation assessment seven days a week.
• A discharge summary describing the patient's injuries, care received and ongoing needs and plans are provided at the time of discharge or transfer. This includes the rehabilitation prescription.
• There are rehabilitation and care coordinator posts in place. Each patient has an identified key worker to be a point of contact for them, their carers or family doctor and to ensure delivery of their personal prescription for rehabilitation.
• Vocational rehabilitation is a key component of the rehabilitation service.
• There is an adequately skilled and resourced multi-disciplinary rehabilitation team. Multi-disciplinary team includes: physiotherapists, occupational

therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients.
• Policies for nutritional management are in place.
• Use is made of VC/telehealth technology to support the rehabilitation phase, enhancing shared care arrangements between generic providers of rehabilitation and the specialist trauma rehabilitation teams.
• The needs of families and carers in all phases of major trauma rehabilitation are considered, including the distances that may be incurred in travelling.

Appendix 4–Rehabiliation Service Model

South Wales, South Powys and West Wales Rehabilitation Service Model



Central to progress along the pathway is the Consultant in Rehabilitation Medicine and Rehabilitation Coordinator to ensure communication between levels and pull from one level to the next.

Appendix 4–Rehabiliation Service Model

Description of Rehabilitation Levels

Hyper Acute rehabilitation
Rehabilitation should start as soon as is appropriate after admission, ideally in the critical care setting and in line with NICE Guidance: Rehabilitation after Critical Illness in Adults; (Reviewed February 2014). The hyper-acute service enables early rehabilitation input to patients who have intensive rehabilitation needs. Patients with poly-trauma, head injuries, spinal injuries or multiple fractures maybe co-located within a designated ward/unit area within the Major Trauma Centre 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, psychology and ALAS (list not exhaustive). Specialist rehabilitation input will be initiated early during the patient's journey. This may commence when the patient is in the intensive therapy unit ('ITU') and will continue beyond this phase of treatment. Rehabilitation input will commence with the initiation of a rehabilitation prescription within 72 hours. The prescription will be a standard form template in an electronic format to enable ongoing edit and revision. The prescription should be completed by a specialist in rehabilitation, including an allied health professional or therapist (band 7). Access to specialist rehabilitation will be provided by a rehabilitation consultant, through a specialist rehabilitation prescription. The designated Major Trauma Centre will incorporate hyper acute rehabilitation provision in order to provide rehabilitation to patients who also require ongoing acute medical treatment. This will enable patients to access relevant medical specialties. The facility will accommodate patients with tracheostomies and naso-gastric tubes. This could be provided on a medical ward or a dedicated major trauma ward and the Team will follow the patient.

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. The patient may not necessarily need to move through a pathway transferring to a lower level acute facility and then into the community. Where onward transfer to another facility is required, communication with the receiving unit will be proactive and clear. GPs will also receive information on the rehabilitation that the patient has received or been prescribed. Support from neuro-psychiatry will be provided as clinically required.

Continuity of care will be prioritised throughout the patient's journey. The patient will be allocated a key worker and will have access to a single point of contact (either a nurse or therapist) to enable them to raise queries at any point. Where patients are treated on a medical ward, the trauma team will be expected to work with the medical specialties to ensure that the provision of rehabilitation alongside medical treatment is seamless.

The patient and their family will be informed of relevant information throughout their time in rehabilitation. This will include the provision of an information booklet and an option to keep a patient or family diary. Support to families will also be prioritised and consideration should be given to providing facilities such as on-site accommodation where families travel long distances. Open visiting has also been identified as a priority, factoring in patient feedback. Early links with appropriate third sector agencies should be established.

Level 2 – acute ongoing rehabilitation – Major Trauma Units

For the majority of patients whose needs will be less complex and at a lower level, acute and ongoing rehabilitation will be provided within a Major Trauma Unit which will be more localised to their area of residence. They may be directly admitted to the Major Trauma Unit or via the Major Trauma Centre. The patients will require input from a wide range of rehabilitation disciplines, including trained nurses, physiotherapy, occupational therapy, dietetics, psychology and ALAS (list not exhaustive).

Rehabilitation input will commence with the initiation of a rehabilitation prescription within 72 hours and will be overseen by a Consultant in Rehabilitation Medicine. The prescription will be a standard form template in an electronic format to enable ongoing edit and revision. The prescription should be completed by a specialist in rehabilitation, including an allied health professional or therapist (band 7).

The Major Trauma Unit will enable patients to access relevant medical specialties and could be provided on a medical ward or a dedicated trauma ward.

The patient may not necessarily need to move through a pathway transferring to a lower level acute facility and then into the community. Where onward transfer to another facility is required, communication with the receiving unit/community will be proactive and clear. GPs will also receive information on the rehabilitation that the patient has received or been prescribed. The Major Trauma Unit Rehabilitation team will have the capacity and skill set to advise the community teams and local rehabilitation hospitals to outreach to local hospitals or units for patients with ongoing rehabilitation needs.

Continuity of care will be prioritised throughout the patient's journey. The patient will be allocated a key worker and will have access to a single point of contact (either a nurse or therapist) to enable them to raise queries at any point. Where patients are treated on a medical ward, the trauma team will be expected to work with the medical specialties to ensure that the provision of rehabilitation alongside medical treatment is seamless.

The patient and their family will be informed of relevant information throughout their time in rehabilitation. This will include the provision of an information booklet and an option to keep a patient or family diary. Support to families will also be prioritised and consideration should be given to providing facilities where families travel long distances. Open visiting has also been identified as a priority, factoring in patient feedback. Early links with appropriate third sector agencies should be established.

Level 3 – ongoing rehabilitation – 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 model of which will be determined by the local model of care which may be different across the network area depending on rural or urban localities and will contain vocational/social participation and third sector support as necessary. The 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 Level 2/specialised care.

To enable a seamless approach Community areas (to be determined) require:-

a) A Community rehabilitation co-ordinator equivalent to MTU Co-ordinator.

b) Early notification of patient injury (via coordinator?), to enable the appropriate people to be involved in planning care journey/ involve families where appropriate.

c) Regular meetings and updates on patient progress to enable informed decisions to be made early in the care journey e.g. modifications/ adaptations of property requires intervention as early as possible due to long lead in.

d) Pathways should be in place such that the same standard of treatment and care is provided pan Wales.

e) Sharing of data across HBs, Social Care and Agencies.

f) Knowledge of services available within the community (Directory – Dewis Cymru website with resource directory/database).

g) Clarity around "maintenance" of patients i.e. where one service ends / starts for lifelong support.

Paediatric Rehabilitation

The paediatric rehabilitation model requires further discussion with WHSCC in light of the acute paediatric rehabilitation services model and fixed points such as the Paediatric Intensive Care Unit remaining within the Children's Hospital for Wales and Paediatric Burns Centre services provided by Bristol. It is recommended that a pan Health Board Task & Finish Group is established to develop and/or confirm pathways based on the acute paediatric rehabilitation model outlined and agreed by WHSCC.

SOUTH WALES HEALTH COLLABORATIVE

MAJOR TRAUMA NETWORK DEVELOPMENT

PROCESS FOR NON FINANCIAL OPTION APPRAISAL EXERCISE

May 2015

PURPOSE

The purpose of this paper is to describe the process for undertaking the non financial option appraisal for the future delivery of a major trauma centre as part of the major trauma network to serve South and West Wales and South Powys.

INTRODUCTION

The service model for the major trauma network has been developed through the Major Trauma Network Clinical Reference Group (CRG) and Project Board.

The option appraisal will be to:

- Consider the number and siting of a major trauma centre to serve the population of South and West Wales and South Powys.

It is assumed that consultant-led emergency departments will act as the 'trauma units' within the major trauma network structure. Standards for a major trauma centre and trauma units have been defined through the work of the CRG, substantially informed by the NHS Clinical Advisory Group 'Regional Networks for Major Trauma' report (2010) and with reference to the NHS England: NHS Standard Contract for Major Trauma Services (all ages) (2013).

The workshop will need to consider:

- The infrastructure requirements for the number and siting of a major trauma centre, based on the agreed service model and the proposed activity that will be centralised in a major trauma centre;

- The co-located and interdependent services that will be needed in a major trauma centre; and

- Scoring of each option against each of the six benefit criteria.

SERVICE MODELS – THE INITIAL LIST OF OPTIONS

The aim of the service is to provide 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 rehabilitation. Calculation of the ISS requires a full diagnostic work-up and so the service is designed around the triage of patients at the point of wounding, to identify "candidate major trauma patients" on the basis of mechanism of injury and assessment of their symptoms and physical signs. A trauma triage tool will be used to identify patients with major trauma. Patients will be triaged to the major trauma centre directly or through a secondary transfer protocol. The major trauma centre will have a policy of automatic acceptance for patients requiring major trauma centre care from within the network. Hospitals within the major trauma network will work together ensuring patients have seamless access to care and transfer back to their local hospital when medically fit.

An initial "long list" of potential service models for the future delivery of a major trauma centre as part of the major trauma network to serve South and West Wales and South Powys is:

Option 1 – Do nothing
This option describes the current situation and clinical pathway delivery and is used as the baseline comparator. There is currently no major trauma network serving South and West Wales and South Powys and no hospitals have been designated as 'major trauma centres' or 'trauma units'.

Option 2 – Single site – University Hospital of Wales
This option would propose the development of a single-site Major Trauma Centre at the University Hospital of Wales Cardiff. This would mean the designation of the University Hospital of Wales as the major trauma centre serving South and West Wales and South Powys with all other consultant-led emergency departments acting as the 'trauma units' within the major trauma network structure, some of which may provide specialist services.

Option 3 – Single site – Morriston Hospital
This option would propose the development of a single-site Major Trauma Centre at the Morriston Hospital, Swansea. This would mean the designation of Morriston Hospital as the major trauma centre serving South and West Wales and South Powys with all other consultant-led emergency departments acting as the 'trauma units' within the major trauma network structure, some of which may provide specialist services.

Option 4 – Dual site
This option would propose the development of a Major Trauma Centre that would be delivered across two sites: University Hospital of Wales and Morriston Hospital. This **does not** mean that the full requirements for a major trauma centre would be provided on each site. This would mean the requirements for a major trauma centre serving South and West Wales and South Powys would be provided across the University Hospital of Wales and Morriston Hospital, one of which would need to be the designated lead for the major 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 the 'trauma units' within the major trauma network structure.

Option 5 – Outsourced service- no Major Trauma Centre in South Wales
This option would propose that a Major Trauma Centre is not established within South Wales but that this service would be commissioned from a provider partner outside Wales. This would mean the designation of a major trauma centre in England serving South and West Wales and South Powys with the consultant-led emergency departments in South and West Wales acting as the 'trauma units' within the major trauma network structure, some of which may provide specialist services.

AGREED SERVICE MODEL

The service model for the major trauma network has been developed through the Clinical Reference Group (CRG) and has been informed by a thorough review of the recommendations of the Clinical Advisory Group Report (2010) and with reference to the NHS England: NHS Standard Contract for Major Trauma Services (all ages) (2013) .

BENEFIT CRITERIA – NON FINANCIAL OPTION APPRAISAL

The financial and non financial criteria for this option appraisal have been informed by that previously agreed and used in the South Wales Programme (SWP) and other developing South Wales or all Wales business cases.

In order to assess each of the potential options for the number and siting of a major trauma centre, the benefit criteria, coverage of issues to be considered within each criterion, and the weighting, have been agreed by the CRG and the Project Board. The method of determining the weighting has been to give each criterion a value which, when all added together, equals 100. The agreed benefit criteria, coverage and weighting are:

Benefit Criteria	Definition / coverage	Weighting (%)
Quality & Safety	Meets agreed clinical, quality and safety standards; Compliance with legislation, regulations and accreditation standards / performance; Supports rapid adoption of best practice; Clinical effectiveness, including:- • Delivers improved outcomes for patients; • Supports R&D; • Improves consistency in clinical practice.	35
Equity	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
Strategic fit	Services delivered within network of integrated care; In line with outcomes of the SWP and other emerging service models. Does not destabilise other clinical services / developments;	15
Sustainability /Future proof	Availability of appropriately trained and skilled workforce; Service provided by a workforce which is "fit for purpose", re EWTD and clinical training standards;	25

	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.	
Access	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 major trauma centre and trauma units; Avoidable transfers minimised.	15
	Total	**100**

PROCESS

The non financial option appraisal will be undertaken through a stakeholder workshop.

The workshop will be independently chaired and will be facilitated by the South Wales Health Collaborative. Workshop participants, clinical and managerial, will be invited from each of the six health boards (Aneurin Bevan, Abertawe Bro Morgannwg, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys) and the Welsh Ambulance Services NHS Trust. Each health board and WAST will be allocated a maximum number of attendees (for health boards calculated as 2 representatives per 100,000 population and with 5 representatives from WAST) and will be expected to manage their representation across a range of specialities/disciplines directly involved in or supporting a major trauma centre service. Patient representatives will be invited through third sector support groups and fair geographical coverage will be sought. The CHCs will be invited to attend the workshop in an observer capacity.

Given the expected number of participants at the workshop, attendees will be allocated to one of six groups on arrival. This will be to ensure as much of a balance as possible on each of the groups between organisations, specialities and disciplines. Each group will then subsequently consider in detail a selected number of the above benefit criteria.

Before undertaking the detailed non financial option appraisal scoring, the workshop will:

- Receive a presentation to:
  - Describe the process to develop the service model, highlighting the infrastructure requirements and co-interdependencies
  - Explain the benefit criteria and weighting
  - Set out the options for the configuration of the major trauma network
  - Confirm the process for scoring
  - Describe how the results will then be collated and how the sensitivity analysis will be undertaken, as a post-workshop activity.

Scoring

The workshop will then need to undertake the detailed non financial option appraisal, through a scoring exercise. This will be as follows:

Each of the options being appraised will need to be allocated scores relating to how well or not it fulfils or delivers against each of the agreed criteria. To do this, each of the main, key benefit criteria above will be considered in detail through a range of "sub criteria", with each option being appraised then scored either 0, 1 or 2 for each of these sub criteria: 0 will indicate that the option does not deliver the relevant sub benefit at all, 1 partially delivers it and a score of 2 delivers this fully. These scores will then be averaged for each of the main key benefits, resulting in each being scored out of a total of 2, to give an unweighted total out of 10, for each option. Where possible, this will be informed by hard data and be evidence based and objective, although it is inevitably also going to include a degree of professional judgement. ***Appendix 1*** provides an example of the detailed and, consolidated scoring sheet following this exercise.

Each of the six groups will focus on a selected number of the main benefit criteria and will only score each of the options, for each of the sub benefits as above for each option, for these. This will be as follows, grouped to ensure that the weighted criteria are as equally spread across all of the participants as possible:

- Groups 1&2 – Quality and Safety;
- Groups 3&4 – Equity and Sustainability/future proofing
- Groups 5&6 – Strategic Fit and Access

The scoring for each of the options and categories being considered by each of the groups, for each of the relevant benefit criterion being considered, will need to be provided by each group, based on a consensus view. To assist in this, scoring sheets will be provided and each group will include an independent member to assist in facilitating this scoring.

POST WORKSHOP

When averaged and then consolidated, each of the above scoring for each benefit for each option being appraised will then have the above agreed weighting applied (by multiplying the average scores for each benefit by the weighting) to enable both a weighted and un-weighted outcome to be determined. This will then confirm a preferred option from a non financial appraisal point of view, and also how all of the evaluated options rank and how close any of them are between each other, in meeting the benefit criteria. All this will be vital information to use in conjunction with the subsequent financial appraisal in determining the overall preferred option. This will then be consolidated and completed to feed back to the Project Board, at which it is also expected that a consistency check of the outcomes of the scoring exercise will be undertaken. This will also then be shared with all participants of the workshop, as soon as possible.

Following the completion of this stage of the process, the outcomes will also be tested further through a sensitivity analysis, designed to assess how sensitive the outcome is to changes in some of the input criteria and data. As a minimum, this will review the outcome by:

- Reverse weighting: this will test how sensitive the outcome is to the weighting that has been applied to the benefit criteria. It does so by completely reversing the weighting, so that the highest weighted criteria becomes the lowest, the second highest the second lowest and so on.

- Equal weighting: similar to the above in terms of testing the sensitivity of the weighting applied, this will assume an equal weighting for each of the criteria, and what the resulting scores and ranking of options would therefore be.

- Reviewing the 2nd ranked option: this tests the sensitivity of the preferred option, through potentially two additional analyses. Firstly, it adds a marginal increase in score (typically 5-10%) to each and every criteria for the 2nd ranked option, to see if this would affect the preferred option outcome. If it does not, it then also goes on to test what increase in such scoring would be required to affect this.

All of this will also be undertaken in preparation for the Project Board meeting, to feed into this discussion and also inform the subsequent required financial appraisal. Subject to a final non financial option appraisal outcome at this stage, the detailed financial appraisal will then be undertaken, following any further sub option appraisal focussing on the whole major trauma network and pathway, to determine the overall preferred option.

The results will be fully captured in the resulting business case.

Appendix 1

South Wales Health Collaborative

Major Trauma Network Project

Draft proposed scoring mechanism for non financial option appraisal

Proposed scoring for each sub / detailed benefit:-

0 Option does not deliver benefit
1 Option partially delivers benefit
2 Option fully delivers benefit

		Scores				
Main benefit criteria	**Detailed benefit being apprised / scored within each**	**Option 1 Do nothing**	**Option 2 Single site - UHW**	**Option 3 Single site - Morriston**	**Option 4 Dual site - networked service**	**Option 5 Outsourced**
Quality & Safety (35)	Meets agreed clinical, quality and safety standards					
	Compliance with legislation, regulations and accreditation standards / performance					
	Supports rapid adoption of best practice					
	Clinical effectiveness, including:-					
	Delivers improved outcomes for patients					
	Supports R&D					
	Improves consistency in clinical practice					
	Sub total Quality & Safety gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Quality & Safety score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Equity (10)	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					
	Sub total Equity gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Equity score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Strategic Fit (15)	Services delivered within network of integrated care					
	In line with outcomes of the SWP and other emerging service models					
	Does not destabilise other clinical services / developments					
	Sub total Strategic Fit gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Strategic Fit score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Sustainability / Future proof (25)	Availability of appropriately trained and skilled workforce					
	Service provided by a workforce which is "fit for purpose", re EWTD and clinical training standards					
	Attracts and maintains an excellent workforce across all staff groups					
	Delivers the critical mass required to achieve full benefit from investment					
	Does not destabilise other clinical services / developments					
	Provides business continuity and service contingency in the event of a major incident, etc					
	Sub total Sustainability / Future proof gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Sustainability / Future proof score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Access (15)	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 major trauma centre/s and trauma units					
	Avoidable transfers minimised					
	Sub total Access gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Access score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
	Total gross unweighted scores	**0**	**0**	**0**	**0**	**0**
	Total average unweighted scores (out of a total of 10)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Appendix 1 (cont'd)

South Wales Health Collaborative

Major Trauma Network Project

Draft proposed scoring mechanism for non financial option appraisal

Summary

Benefit criteria	Option 1 – Do nothing			Option 2 – Single site - UHW			Option 3 – Single site - Morriston			Option 4 – Dual site - networked service			Option 5 – Outsourced		
	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score
Quality & Safety	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!
Equity	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!
Strategic Fit	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!
Sustainability / Future proof	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!
Access	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!
Total (out of 10 / 200)	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**

Appendix 6–Outcome for Non-financial Option Appraisal

CONFIDENTIAL REPORT

Major Trauma Independent Panel

High level draft financial information

Purpose

This briefing paper provides members of the Independent Panel with high level draft financial information.

Introduction

In order to support the NHS Wales Health Collaborative (NHSWC) to develop an option appraisal for the location of the South Wales Major Trauma Centre (MTC) both potential sites have undertaken an initial assessment of the revenue and capital consequences of providing the MTC.

It should be noted that finance and clinical colleagues, from both potential MTC sites and the NHSWC have worked closely and collaboratively to prepare these financial assessments.

Summary of Draft Financial Assessments

Both potential MTC sites have assessed their additional investment requirements for both capital and revenue.

Capital – assessed costs

At this stage it is possible to predict the capital impact of accommodating the MTC only in indicative terms. The indicative capital costs of both sites are summarised in the table below:-

Indicative Capital costs £m	
UHW Cardiff	£23m
Morriston Swansea	range from £9.9m - £12.8m with additional £3.1m if CT required

Revenue – assessed costs

Using the assessed additional capacity requirements both potential MTC sites have estimated their additional investment requirements:-

a) To fully meet the standards of a Major Trauma Centre; &
b) As an essential investment against each of the standards to accommodate the additional activity (until such time as funding is available to fund full standard compliance).

Indicative Revenue costs	Essential Minimum Assessed cost of Change £m	Meets standards Assessed cost of Change £m
UHW Cardiff	7.6	10.7
Morriston Swansea	9.1	11.8

Patient Activity Levels

The MTC Project Board has agreed that the baseline activity for each of the current centres should be based on 2014 Trauma Audit & Research Network (TARN) data. This is outlined below. Data for the remaining hospitals in the system was not available at this time.

Baseline	**UHW**	**Morriston**	**Total**
Major Trauma	251	175	426
Candidate Trauma	221	280	501
Total	**472**	**455**	**927**

The activity to be accommodated by the single centre has been modelled by NHS Wales Informatics Service (NWIS) on the basis of predicated incidence, Lower Super Output Areas (LSOA) population and travel time. The model assumes that a proportion of patient activity will be treated, and generates different MTC volumes for the Cardiff and Morriston options:

Modelled Activity	UHW	Morriston
Major Trauma	404	387
Candidate Trauma	455	427
Total	**859**	**814**

The additional activity that would be treated under each option would therefore be:

Additional Activity	UHW	Morriston
Major Trauma	153	212
Candidate Trauma	234	147
Total	**387**	**359**

Capacity Requirement Assumptions

The NWIS model included length of stay assumptions for general ward and ITU stays and bed occupancy, based on current practice. These assumptions have been applied to the additional activity flowing to each of the sites in order to estimate the additional capacity requirements.

Financial Assessment – Revenue costs

Using the additional capacity requirements (outlined above) both potential MTC sites have assessed their additional investment requirements:-

a) To fully meet the standards of a Major Trauma Centre; &
b) As an essential investment against each of the standards to accommodate the additional activity (until such time as funding is available to fund full standard compliance)

These additional requirements have been costed, and the key resource impacts are summarised in the table below:-

Assessed Revenue costs	Morriston Swansea Meets Standards £000's	Morriston Swansea Essential £000's	UHW Cardiff Meets standards £000's	UHW Cardiff Essential £000's
24 hr Consultant Cover	919	390	919	393
Trauma Training	10	10	10	10
24/7 Trauma Team	428	428	256	256
24/7 Theatre	1,593	774	1,664	808
Neurosurgery	1,125	885	0	0
Spinal	172	172	0	0
Vascular	0	0	0	0
General Surgery	0	0	0	0
T&O	240	240	288	242
Cardiothoracic	0	0	0	0
OMF	52	52	0	0
Anaesthetics	1,352	510	1,352	608
Interventional radiology	206	206	540	270
Plastics	120	120	640	192
ITU	1,558	1,558	1,138	1,138
Admin Support	179	118	168	168
Trauma Ward	2,172	2,172	2,859	2,684
Trauma Ward Therapies	796	621	0	0
Psychology	91	0	0	0
TARN	59	59	69	69
Non Pay	735	735	759	759
Total	**11,807**	**9,050**	**10,662**	**7,597**

13

Financial Assessment – Capital costs

At this stage it is possible to predict the capital impact of accommodating the MTC only in indicative terms.

For Morriston, Swansea a range of scenarios have been worked up to provide the additional capacity modelled from the activity flows and assumed Length of Stays and the assessed costs of these options are included in the table below:-

Morriston Swansea – indicative capital cost options

	Additional Capacity £000	CT Option £000	Total £000
Option 1	12,837	3,087	15,924
Option 2	14,307	3,087	17,394
Option 3	9,880	3,087	12,967

For UHW, Cardiff the estimate is that circa £23m capital resources could be required. This estimate is specific to the site at UHW and attempts to be realistic given the context of other changes and capital works, which are underway at the current time or being planned. If UHW was designated as an MTC then the solution and resultant costs could be quite different.

Appendix 8–Activity Modelling

Report from the Major Trauma Project Team in relation to the confirmation of Baseline Major Trauma activity figures in Wales

Introduction

At its meeting dated 11th May 2016, the MTC Project Team received a verbal report and discussed the options in relation to the assessment of the baseline patient activity levels, noting the discussion at the Project Board on 25th April. Discussions were also held at the Joint Workstream meeting on 11th May and the Clinical Reference Group on 19th May.

Initial Baseline Assessments

As part of the options appraisal process carried out in June 2015, the following figures were presented as the baseline estimates of average annual Major Trauma activity by TARN Injury Severity Score (ISS) at the University Hospital of Wales (UHW) and Morriston Hospital respectively.

Site	ISS 9-15	ISS >15
UHW	160	189
Morriston	220	127

These figures were based on official TARN returns for the period January 2012 to June 2014.

Proposed Revised information as at 25th April 2016

Subsequent to the initial options appraisal process, Cardiff & Vale UHB and Abertawe Bro Morgannwg UHB (ABMU) were asked to produce detailed impact assessments around the establishment of a Major Trauma Centre at UHW and Morriston respectively. This process involved estimating the requirements in terms of staff, beds and infrastructure to meet the standards and expected uplift in demand at those sites from their current baseline if they were to become a Major Trauma Centre. This led to some closer scrutiny of the initial baseline estimates, especially those in relation to UHW, where the view from Cardiff & Vale UHB was that these represented a significant understatement of current major trauma activity levels.

To this end, Cardiff & Vale UHB subsequently proposed a revised set of baseline estimates, based on more up to date TARN information (Calendar Year 2014), with additional grossing factors applied, taking into account the following:

1) the % of admissions which had not been clinically coded, and thus not possible to be categorised as trauma or not, and
2) the % of admissions with a trauma clinical code that were unable to be located in order to be reviewed by the TARN co-ordinator, and thus unable to be sent to TARN

In order to ensure comparability between UHW and Morriston, ABMU Health Board were requested to produce their own set of revised estimates using the 2014 date period and the same grossing methodology employed by Cardiff & Vale UHB.

Preliminary figures were then discussed at the Major Trauma Project Board meeting on the 25th April 2016. However, these figures were presented in the form of very detailed spreadsheets, with no

accompanying explanatory guide to the figures, and without a clear summary of the results. As a consequence, some specific and important issues relating to this data were not discussed.

A decision was taken by the Project Board to use the original data and uplift by 12%/13% across the bands of complexity with a need to describe the assumptions and the broad levels of risk associated with this calculation.

Summary and Context

A summary of the various baseline estimate options are shown:

	Original TARN-based estimates (Jan 12 - Jun 14)		Admissions-based TARN (2014)		Non admission-based TARN (2014)		TARN Total (2014) as @ PB 25/04/16		TARN Total (2014) May 2016		Grossed-up Admissions-based TARN		Grossed-up TARN (2014)	
ISS	9-15	>15	9-15	>15	9-15	>15	9-15	>15	9-15	>15	9-15	>15	9-15	>15
UHW	160	189	**209**	**213**	10	26	219	239	**221**	**251**	225	243	**235**	**269**
Morriston	220	127	**288**	**142**	0	32	288	174	**280**	**175**	292	144	**292**	**176**
UHW + Morriston	380	316	**497**	**355**	10	58	507	413	**501**	**426**	517	387	**527**	**445**
UHW incr			**31%**	**13%**					**38%**	**33%**			**47%**	**42%**
Morriston incr			**31%**	**12%**					**27%**	**38%**			**33%**	**39%**
UHW + Morriston			**31%**	**12%**					**32%**	**35%**			**39%**	**41%**

Key to table

The figures in amber show the baseline estimates that would be arrived at using the methodology proposed by Cardiff & Vale UHB (based on 2014), which include a grossing-up of the admission-based TARN figures. The figures in red are those which were agreed following discussions at the 25th April 2016 Project Board meeting. However, in reaching this decision, it should be noted that most of those discussions were focussed on whether or not to gross up the admissions-based TARN figures in the way suggested by Cardiff & Vale UHB, meaning that certain other matters were rather overlooked.

Having reviewed the figures, the project board agreed that baseline estimates should be revised such that they were based on the calendar year 2014 rather than the Jan 12 – Jun 14 period. As the unadjusted admissions-based TARN figures for 2014 were 12-13% higher than the original baseline estimates for ISS>15 and 31% higher for ISS 9-15, the project board decided that this represented a sufficient increase and that no additional grossing-up factors were required. However, what was rather overlooked was the fact that official TARN figures also include a significant element of non admissions-based activity, for example where a patient is attended to in an Emergency Department, but is not admitted to that hospital (due to death in ED or a transfer to another hospital), and through their recommendations, the project board, possibly unknowingly, were excluding this activity from the baseline figures. This represented a significant change to the methodology from what was used to compile the original baseline estimates.

The figures in green are the official 2014 TARN figures. These use a methodology which is consistent with that used for the original baseline estimates methodology. This would result in a revised baseline estimate shown in green in the table above, and shows increases of 33% and 38% for UHW and 38% and 27% for Morriston for ISS>15 and ISS 9-15 respectively.

It should be noted that there has been a suggestion that 2015 data is applied. Whilst 2015 data is available, it is incomplete and, as a consequence, it is felt to be unreliable at this point.

Conclusion

After reviewing the options, the Project team concluded that the use of the official green 2014 TARN figures is:-

- Consistent with the methodology that was originally agreed and used for the initial options appraisal process;
- Clear and easy to understand and would provide a consistent methodology for future data analysis and reporting

Recommendation

The Project Team recommends that the official 2014 TARN figures (green) are used as the baseline activity.

Project Board is asked consider this recommendation and confirm its position in respect of the baseline activity.

MTC Project Team -May 2016

Appendix 9a–Isochrones Maps
Major Trauma Scenarios – UHW as MTC

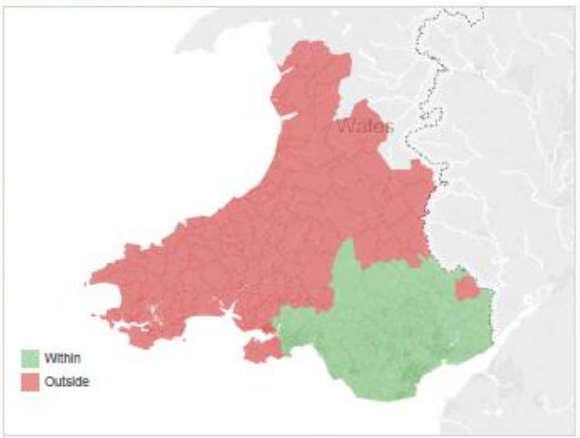
Choose Major Trauma Centre(s)
University Hospital Of Wales

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

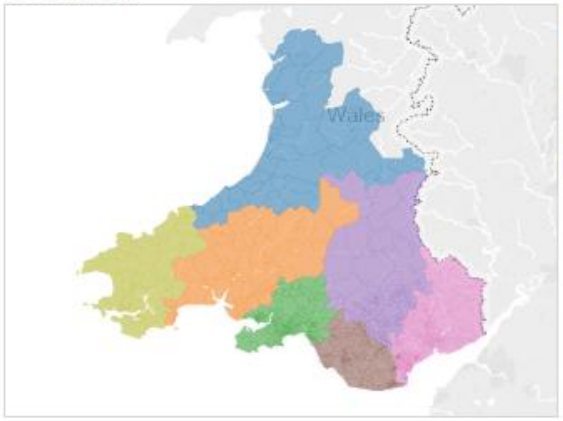
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	13	23	14	11	24	430	12	536
Candidate Major Trauma	11	16	28	16	13	28	477	14	603
Major & Candidate Major Trauma	21	29	51	30	24	52	907	27	1,139
Head	9	12	21	12	10	22	390	11	488
Non Head	12	17	29	17	14	30	517	15	652
Secondary Transfers In	0	0	0	0	0	0	123	0	123
Secondary Transfers Out	11	15	27	16	13	27	0	14	123
Beds	0.6	0.8	1.4	0.8	0.7	1.5	42.8	0.8	49.4
ICU Beds	0.1	0.1	0.2	0.1	0.1	0.2	5.6	0.1	6.5

MTC 60 minute isochrone

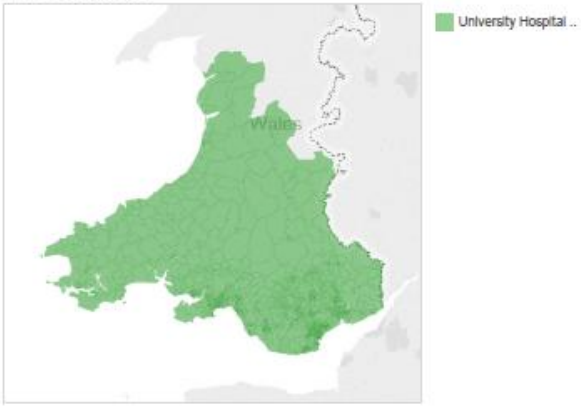


	Population	% Population
Within	1,886,846	80.09%
Outside	468,929	19.91%

TU Catchment



MTC Catchment



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Appendix 9b–Isochrones Maps
Major Trauma Scenarios – Morriston as MTC

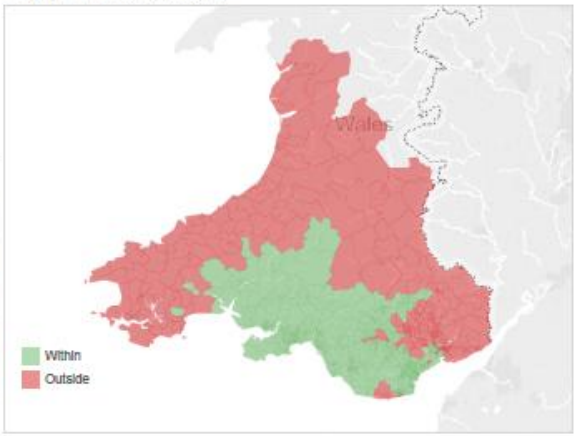
Choose Major Trauma Centre(s)
Morriston Hospital

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

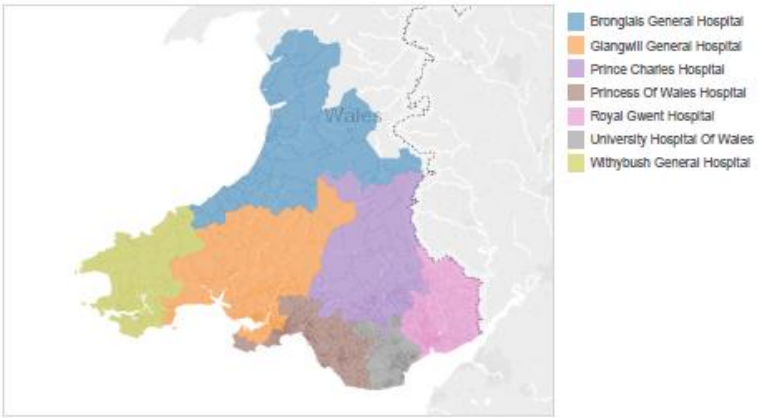
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	11	422	15	15	38	29	12	553
Candidate Major Trauma	11	13	460	18	18	46	35	14	615
Major & Candidate Major Trauma	21	25	882	33	32	84	64	27	1,168
Head	9	10	382	14	13	35	27	11	502
Non Head	12	14	500	19	19	49	37	15	666
Secondary Transfers In	0	0	151	0	0	0	0	0	151
Secondary Transfers Out	11	13	0	18	17	44	34	14	151
Beds	0.6	0.7	41.8	0.9	0.9	2.4	1.8	0.8	49.8
ICU Beds	0.1	0.1	5.5	0.1	0.1	0.3	0.2	0.1	6.6

MTC 60 minute isochrone

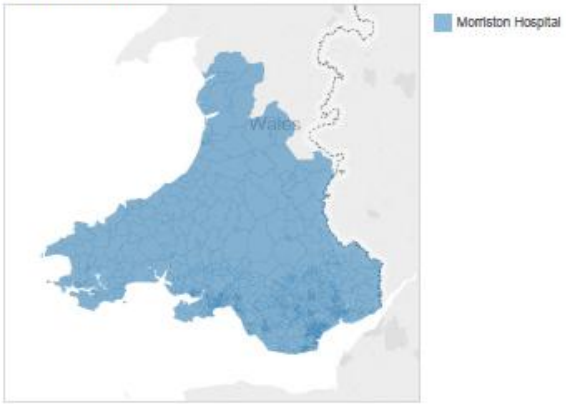


	Population	% Population
Within	1,612,535	68.45%
Outside	743,240	31.55%

TU Catchment



MTC Catchment



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MAJOR TRAUMA INDEPENDENT PANEL
TERMS OF REFERENCE - FINAL

1. PURPOSE

An independent panel has been commissioned by the NHS Wales Health Collaborative to provide a view on the development of a major trauma network across south Wales, south Powys and west Wales and to make a recommendation on a preferred model for the region. The recommendation will be advisory and will be used by the NHS Wales Health Collaborative to make a formal recommendation on the preferred site of the major trauma centre in the region

2. OBJECTIVES

The major trauma independent panel will be required 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 (ABM) and Cardiff and Vale UHB (CAV) and for the provision of a major trauma centre at Morriston Hospital, Swansea or the University Hospital of Wales (UHW), Cardiff as part of the major trauma network in south Wales.
- Provide an independent view on the two options for the location of the major trauma centre.
- Provide a view on the phasing of any implementation requirements and priorities for investment within a major trauma centre.
- Advise on the impact on remaining services at Morriston Hospital and UHW Hospital in the event they are not identified as the major trauma centre.
- Advise on the preferred location of a major trauma centre for the region.

In addressing the above, the panel will take into consideration DH guidelines for the establishment of regional networks for major trauma and NICE guidance for major trauma; these guidelines are based on the evidence of best practice and include a number of recommendations which are central to establishing a major trauma centre.

3. ASSUMPTIONS

- A non financial option appraisal has identified that only one trauma centre is viable to support a population of 2.2million (the population in south Wales, south Powys and west Wales)
- The major trauma centre for the region should be located in South Wales
- Morriston Hospital Swansea and UHW Cardiff are the only options for provision of a major trauma centre in Wales, due to the potential ability to meeting major trauma standards

- Key stakeholders from across the region will be invited to attend the Independent Panel in order to facilitate openness and transparency. A list of the stakeholders invited is attached.

4. RESPOSIBILITIES

The remit of the independent panel is as follows:

- Review data sets available to support major trauma centre in south Wales, south Powys and west Wales, to include:
  a. Contextual information
  b. Transport times
  c. Activity models
  d. Equality Impact Assessment
  e. Standards for major trauma
  f. Non financial option appraisal
  g. Service models for rehabilitation and acute service
  h. UK Standards for the management of open fractures
- Receive and consider the self assessments against peer review standards and TARN data from ABMU and CAV representatives.
- Hear and consider presentation from ABM and CAV in response to the following questions:
  a. How will the MTC provide all the service required?
  b. How will the Health Board as the MTC address the following service requirements:
- Neurosurgery
- Plastics
- Interventional radiology
- Paediatrics
- Cardiothoracics
- Maxilla-facial
- Critical care capacity
- rehabilitation
  a. How will the MT service be developed and what are the staffing issues that will need to be considered?
  b. How will trauma ward provision be addressed?
  c. What will the service look like on day 1?
  d. How will you address the infrastructure requirements in medium and long term?
  e. How will relatives and carers be managed in the MTC?
- Provide challenge to Health Boards when considering the presentation/information provided
- Receive and consider the views of EMRTS/WAST, in relation to a major trauma network in Wales
- Advise on the ability of Morriston Hospital and UHW to meet the primary requirements of a major trauma centre as recommended by the NHS Clinical Advisory Group (CAG) 'Regional Networks for Major Trauma' report.
- Advise on gaps in service at Morriston Hospital and UHW Hospital in the event they are identified as the major trauma centre

- Make recommendations to the NHS Wales Health Collaborative for the preferred location of the MTC
- Produce a report for the NHS Collaborative advising on the major issues which need to be considered to determine the most appropriate site for a MTC in Wales

5. MEMBERSHIP

The Independent panel comprises representatives from across major trauma services in the UK.

Panel members were invited on the basis of their national and international reputations as experts in trauma care and the development of trauma systems. All have been involved in the development of regional major trauma systems. The panel includes experts in key specialties that are essential for managing patients with severe multiple injuries.

The Independent panel will be chaired by Professor Chris Moran, the National Clinical Director for Trauma to the NHS in England and Professor of Orthopaedic Trauma Surgery at Nottingham University Hospital He has led the development of major trauma networks in England, which have increased the probability of surviving major injuries by 25%.

The membership of the panel is as follows:-

Professor Chris Moran	National Clinical Director for Trauma to the NHS in England and Professor of Orthopaedic Trauma Surgery	Nottingham University Hospital
Fionna Moore	Chief Executive	London Ambulance Trust
Tim Chesser	Consultant Trauma & Orthopaedics	North Bristol, NHS Trust
Mark Wilson	Consultant Neurosurgeon and pre hospital care specialist	Imperial college, London
David Lockey	Clinical Director for Severn Major Trauma Network, Consultant Anaesthetist and critical care Medicine	North Bristol NHS Trust
Shehan Hettiaratchy	Consultant and Honorary Lecturer	Imperial College, London
Rachel Botell	Consultant Rehabilitation Medicine.	Plymouth Hospitals NHS Trust
Sue O'Keeffe	Critical Care and Trauma Network Manager, North Wales	North Wales Major Trauma Network

It should be noted that Sue O'Keeffe will provide support in relation to the Welsh context only. She will not have a vote on the panel.

6. TIMESCALES

The Major Trauma Independent Panel will take place 21st February 2017.

The report outlining findings from the Independent panel will be submitted to the NHS Wales Health Collaborative within four weeks following the Independent Panel.

7. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

The major trauma Independent Panel will:

- Report their initial finding and advice at conclusion of the day to all attendees.
- Provide a report outlining their findings to Bob Hudson, Director NHS Wales Health Collaborative, on behalf of the NHS Wales Health Collaborative Board.

Drafted: December 2016

Agreed: January 2017

Date: 12.01.17

Attachment 1.

Representation from ABM and CAV:

- Chief Executive Officer
- Medical Director
- Lead Clinician for Trauma Care
- Lead for acute rehabilitation
- Planning lead

Other invited key stakeholders

- Chief Executive Officer Public health Wales
- Ministerial representative
- Community Health Councils
- Patient representative from ABM and CAV
- Lead clinician from Hywel Dda, Cwm Taf, Aneurin Bevan, Powys
- Director NHS Wales Health Collaborative

Appendix 11 – Independent Panel Report

Expert review South Wales Major Trauma System
February 2017

Summary

At the request of the Welsh Health Boards, a panel of independent, clinical experts in major trauma met on February 21st, 2017 to consider the structure of a major trauma network in South and West Wales and the potential site of the Major Trauma Centre within this network. The expert panel reviewed information in advance of the meeting and on the day received presentations from Public Health Wales, the Welsh Ambulance Service plus University Hospital of Wales, Cardiff and Morriston Hospital, Swansea.

The expert panel was impressed at the high standard of presentation, the enthusiasm from both clinical teams and the clear support demonstrated by the chief executives, medical directors and senior management teams at both centres.

The expert panel unanimously recommends that the Welsh Health Boards consider the following:

1. The rapid development of a major trauma network for South and West Wales with a clinical governance infrastructure.
2. The adult and children's Major Trauma Centres should be co-located on the same site
3. The Major Trauma Centre should be located at University Hospital of Wales, Cardiff
4. Morriston Hospital should become a large Trauma Unit and should lead the major trauma network
5. A clear and realistic timetable for the activation of the Trauma Network should be set.

13

Introduction

Major trauma is defined as a life-threatening or potentially life-changing injury. Injuries can occur to a single part of the body or at multiple sites and the best treatment requires a coordinated response from the accident site to hospital care and then rehabilitation. International experience has shown that this is best provided by a coordinated network of hospitals that work together to allow the patient to receive treatment in the most appropriate facility in a safe and timely fashion. The system should be designed to save life and prevent avoidable disability, returning patients to their families, work and education.

Trauma and injuries are common but only 1 in a 1,000 patients who arrive at an A&E department will have major trauma. It is impossible for every hospital to provide comprehensive care for all major injuries and so the network should identify these patients and ensure their rapid and safe transfer to a designated Major Trauma Centre (MTC) that has the facilities to provide comprehensive and definitive care for the patient. In general, each network will have one MTC together with a network of hospitals that have the facility to receive and provide early care for these patients, rapidly identify those that require the additional facilities at a MTC and then provide safe, onward transfer.

Patients in Mid and North Wales who suffer major trauma are currently transferred to designated MTCs in England. South and West Wales has a population of 2.2 million and the Welsh Health Boards are planning to develop a network to cover this area, which has a mixed urban and rural geography and some remote rural populations.

South and West Wales has two large teaching hospitals with the potential to develop into a Major Trauma Centre within the trauma network.

The aim of this review was for a group of independent clinical experts in major trauma to assess the available evidence and provide advice to the Welsh Health Boards on the best facility to site the Major Trauma Centre for South and West Wales.

Members

Professor Chris Moran	Professor of Orthopaedic Trauma Surgery, East Midlands Major Trauma Centre Nottingham University Hospital National Clinical Director for Trauma NHS-England
Dr. Fionna Moore	Chief Executive, London Ambulance Service
Mr. Tim Chesser	Consultant Trauma and Orthopaedic Surgeon Severn Major Trauma Centre North Bristol NHS Trust
Professor Mark Wilson	Consultant Neurosurgeon and Pre-hospital Specialist North West London Major Trauma Centre Imperial College, London
Professor David Lockey `	Clinical Director for Severn Major Trauma Network Consultant in Anaesthetics and Intensive Care North Bristol NHS Trust
Mr. Shehan Hettiaratchy	Clinical Director North West London Major Trauma Centre Consultant Plastic and Reconstructive Surgeon Imperial College, London
Dr. Rachel Botell	Consultant in Rehabilitation Medicine Peninsula Major Trauma Centre Plymouth
Mrs. Sue O'Keeffe*	Critical Care and Major Trauma Network Manager North Wales

* Mrs. O'Keeffe provided the panel with expert advice on network management and the Welsh Health Care System but did not have voting rights on the panel.

Evidence reviewed

The expert panel was provided with a bundle of evidence that included:

- Briefing
- Terms of Reference for independent panel
- Acute service model
- Rehabilitation service model
- Service Specification
- Equality impact assessment
- Major Trauma non-financial options appraisal
- Major Trauma flow – adults
- Major Trauma flow – children
- List of services currently provided at UHW
- ABMU major trauma indicators
- South Wales major trauma project

The presentations received followed the published programme for the day (Appendix-1).

Issues considered

Institutional commitment

Both Trusts gave excellent and well-researched presentations and there was evidence that both planned investment in the concept of hosting a MTC. There was good clinical engagement and support from most specialties in both centres and strong support from the chief executives, medical directors and senior management teams at both hospitals. Some of the proposals were aspirational and they should be strongly encouraged to deliver on their aspirations.

Geography

Public Health Wales and the Welsh Ambulance Service gave excellent and helpful presentations describing the geography of South and Mid Wales together with the population distribution and the estimated road transfer times to each of the proposed MTCs. In addition, the Welsh Emergency Medical Retrieval and Transfer Service (EMERTS) described their role in pre-hospital management and the facility to provide on-scene medical care, accurate triage and rapid air transfer to either of the proposed MTCs.

Morriston Hospital is geographically more central and has better coverage of the West Wales population but some western and eastern areas would be outside of the proposed 60 minute direct transfer time (by land ambulance) and require secondary transfer. University Hospital of Wales is more central to the urban population and a slightly greater percentage of the population would be within 60 minutes direct transport time. It would provide good coverage for the eastern area but a larger number of patients in West Wales would require initial treatment in a designated local hospital before secondary transfer to Cardiff.

Both hospital sites have excellent road access with motorways close by. Both have acceptable air-ambulance landing facilities.

Overall, the panel concluded that both sites give good access to the population and that geographical factors should not be a major issue in designating the site of the MTC.

Facilities

Reception and Resuscitation

Both hospitals have large accident and emergency departments with the facility to receive and resuscitate patients with major trauma. However, neither hospital has a big enough cohort of Emergency Physicians to support their existing workload. Neither hospital supports ambulance offloads as well as they should. University Hospital Wales has both ore ED Consultants and marginally better off-load times. Both Trusts accept that this is an area for investment, and both Trusts will need to plan how they provide 24/7 availability of a Consultant led trauma team.

University Hospital Wales has CT scanning within the emergency department and immediately adjacent to the Resuscitation Room. At the present time, Moriston Hospital requires a short transfer to the CT scanner: plans were presented to locate a new CT scanner within the emergency department.

Definitive Care

Neurosurgery

Neurosurgery and neuro-intensive care are key specialties in the management of major trauma as 60% of patients have a head injury and traumatic brain injury is an important cause of death and long-term disability. At the present time, both adult and children's neurosurgery is based at University Hospital of Wales and there is no neurosurgery at Morriston Hospital.

Morriston Hospital described its plan to develop an adult neurotrauma unit based upon the recruitment of six neurosurgical consultants with expertise in neurotrauma and spinal surgery and it was proposed that this would work in collaboration with the main neurosurgical unit in Cardiff. This service model has been used at two MTCs in England (Sheffield and St. Mary's, London) but in both cases the distance between the two units is less than 5 miles. There was no plan to move all of neurosurgery to a single site at Morriston Hospital. The WHSSC representative at the expert review clearly expressed the view that the development of a two-site service for neurosurgery in South Wales was against the strategic plan for the region.

The concerns of the expert panel are:

- Recruiting (good) neurosurgery consultants to a post that is half spinal and half trauma with no other components will be extremely difficult.
- Recruiting an adequate number of juniors who are craniotomy competent (8 for a rota) will be even more difficult, if not impossible.
- A stand-alone neurotrauma unit some distance from the main neurosurgical centre (with no plan to move all of neurosurgery there in a set time frame) may not be sustainable in the long term.
- A stand-alone neurotrauma unit is not a model that has professional support for the Society of British Neurosurgeons (SBNS).
- Interventional neuroradiology is now an integral part of trauma management and it is highly unlikely that South Wales could provide a comprehensive service of two sites.

Plastic surgery

There is an excellent plastic surgery department at Morriston Hospital with a Burns Centre that covers Wales and the South West of England and a high quality orthoplastic service. There is no provision for plastic surgery at University Hospital Wales. However, this specialty on its own would not justify placing the MTC at Moriston.

The most significant risk of Cardiff as the MTC is the lack of plastic surgery and orthoplastics. This is an immediate risk that needs to be resolved before day-1. There are numerous examples in England of offsite plastic surgery and Cardiff would be strongly encouraged to learn from these centres and also work closely with Swansea so that the network (and population of South Wales) gets access to the expertise that has been developed in Swansea.

Interventional Radiology

This is now a key specialty in the management of patients with severe bleeding that would have required life-saving surgery in the past. University Hospital Wales has a comprehensive service that would reach the specification for a MTC. Morriston Hospital has a service, which with some investment, could be expanded to meet this specification. Recruitment into interventional radiology is challenging because of low workforce numbers.

Paediatric Intensive Care

The regional paediatric intensive care unit (PICU) is at University Hospital Wales and there are no plans to develop a second PICU at Moriston Hospital. Thus, locating the Adult MTC in Morriston Hospital requires the development of a separate Children's MTC at University Hospital Wales. The catchment population would be similar to the smallest Children's MTC in England (based at Sheffield Children's Hospital) and so would be viable.

The expert panel does not support the concept of a single Adult and Children MTC at Morriston Hospital with a separate pathway for the most severely injured children that require PICU.

Health Care of the Elderly

Changes in the demographic of the population means that major trauma is becoming more frequent in those over 65 years and this age group now represents 35% of major trauma cases. University Hospital Wales presented plans to increase the number of physicians caring for elderly patients by expanding their current orthogeriatric service and including major trauma.

Rehabilitation

Access to this vital part of the patient pathway was much better thought through and available at University Hospital Wales, with facilities at Rookwood Hospital already in place.

Cardiff seems to have an advanced rehab system and exciting plans for the future. Providing the full pathway of trauma care is vital and it appeared that Cardiff had grasped that concept more completely with plans for coordinated rehabilitation within the acute hospital setting. The consultants in Rehabilitation Medicine already in-reach to the acute wards and 'pull' or signpost patients to the most appropriate rehabilitation service.

The Cardiff team described the new Rehabilitation Centre that would be able to accept all patients, not limited to those with neurological or spinal cord injuries and would include coordinated psychiatry and psychology input, which is key for many of the major trauma patients.

The expert panel was impressed with the dynamic Rehabilitation Lead in Cardiff who will be key in delivering this comprehensive rehabilitation service. They recognized the key role of the rehabilitation network to allow patients coordinated rehabilitation near to home.

Areas of concern

Although Cardiff gave good presentations some of their proposals were aspirational and the Health Boards should strongly encourage them to deliver on their aspirations.

The panel did not support using the air ambulance for repatriation from the MTC. We would encourage the development of a retrieval service with the provision of lit helipads at Trauma Units.

Concerns were raised about the desire and commitment from the orthopaedic department in University Hospital Wales and the impact of major trauma on the daily fracture service (for the local population) has been underestimated. There is a clear need to appoint a number of orthopaedic surgeons with a job-plan focused on trauma: a review of the provision of fracture surgery is essential.

The impact of being a MTC may have underestimated by both parties, particularly on the Emergency Departments and Critical Care Units. Contingency plans need to be in place for escalating critical care when they become full to allow continued reception of major trauma. These need to be formal network escalation plans.

Morriston Hospital presented an excellent vision for the Network. It is essential that the MTC understands its place within the network and we would recommend that the chair of the major trauma network board and the network clinical lead are not based within the MTC.

The Welsh Health Boards should ensure that the network has the power to make sure the promises are delivered if the service is commissioned. This should include accurate and achievable time lines with a requirement for the Rehabilitation Team, Trauma Team Leaders and Multidisciplinary Trauma Service to be in place from day-1.

It is essential that network agreements, protocols and guidelines are in place before the networks become operational and this should include agreement between hospitals, at Chief Executive level, on automatic transfer and automatic repatriation.

Options Considered

1. Combined Adult and Children's Major Trauma Centre at University Hospital Wales.
2. Adult Major Trauma Centre at Morriston Hospital plus Children's Major Trauma Centre at University Hospital Wales.
3. Combined Adult and Children's Major Trauma Centre at Morriston Hospital with an out-reach PICU trauma service at University Hospital Wales for the most severely injured children.

Recommendations

It is the unanimous view of the clinical expert panel that the Welsh Health Boards consider the following:

1. The rapid development of a major trauma network for South and West Wales with a clinical governance infrastructure.
2. The Adult and Children's Major Trauma Centres should be co-located on the same site.
3. The Major Trauma Centre should be located at University Hospital of Wales, Cardiff.
4. Morriston Hospital should become a large Trauma Unit and should lead the major trauma network.
5. A clear and realistic timetable for the activation of the Trauma Network should be set.

The main surgical specialty that will need development at University Hospital Wales is Plastic Surgery, with the formation of an orthoplastic unit. Ideally, this could be achieved by transferring the entire service to Cardiff. However, the panel recognise that this may produce major operational problems in the provision of the burns service for Wales and South West England. If this is not feasible, the panel recommends a collaborative approach between both hospitals. It will take time for this service to develop but it should be possible to put a safe clinical pathway in place so that the activation of the network is not delayed by this development. Joint consultant appointments between the two hospitals could achieve this with the establishment of routine orthoplastic operating lists at the MTC (minimum of two per week) with the appropriate equipment and facilities. Mr. Hettiaratchy is available to provide advice on this as a similar model has been developed in London.

Chris Moran
20th March 2017

Appendix 12 – Equality Impact Assessment

NHS WALES HEALTH COLLABORATIVE

MAJOR TRAUMA NETWORK DEVELOPMENT

EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT

Revised – January 2017

Introduction

This document presents the evidence collected to date in support of the equality impact assessment (EIA) process for the development of a major trauma network to serve South Wales, South Powys and West Wales.

The Equality Act 2010 places a positive duty on public authorities to promote equality for the nine protected characteristics [1] and requires Welsh public bodies to demonstrate how they pay 'due regard' when carrying out their functions and activities. Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways. In the context of this work we are required to assess the impact of policies and services on equality. The purpose of this is to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

The Human Rights Act 1998 also places a positive duty to promote and protect rights. We clearly recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that Wales is a country with two official languages: Welsh and English. We have a responsibility to comply with the new Welsh Language (Wales) Measure (2011). This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated safely

[1] Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)[2]. Our consideration of equality takes account of this.

EIA requires us to consider how the development of a major trauma service, leading to recommendations for the location of a major trauma centre, supporting trauma units and a comprehensive rehabilitation pathway, operating within a major trauma network structure for south Wales, south Powys and west Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

This document is not intended to be a definitive statement on the potential impact of the major trauma development on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact.

Background

The NHS Wales Health Collaborative, on behalf of Aneurin Bevan, Abertawe Bro Morgannwg, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys health boards, and the Welsh Ambulance Service NHS Trust (WAST), has been coordinating the development of proposals for a major trauma service for south Wales, south Powys and west Wales. The project is being led through the South Wales Major Trauma Network Project Board, which is overseeing the work, and is supported by a clinical reference group and a number of workstreams. The work will lead to recommendations for the location of a major trauma centre, supporting major trauma units and a comprehensive rehabilitation pathway, operating within a major trauma network structure for the region.

Through the project board, clinical reference group and rehabilitation workstream, clinicians and stakeholders have been working together to examine national standards and guidance and to develop service models to improve care, treatment, rehabilitation and outcomes for

[2] More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

the most seriously injured patients, who need to be seen at a specialist major trauma centre operating within an integrated major trauma network.

Rationale

The report 'Regional Networks for Major Trauma' (National Clinical Advisory Group, 2010)[3] compiles key recommendations from national reports and international guidance including from the American College of Surgeons to deliver standards for the care of major trauma patients. The evidence is consistent that the best outcomes are achieved within inclusive trauma systems with major trauma centres and trauma units.

The NCAG report comments that major trauma is a serious public health problem; it is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity.

Internationally, the establishment of trauma systems has been founded on trauma centres. These hospitals specialise in, and are designated for, the treatment of the severely injured. They see such patients with sufficient frequency to gain expertise in their management. Over several decades the evidence that this model improves trauma outcomes has become substantial. Their effect has been assessed using several methodologies and a consistent picture has emerged. Severely injured patients are 15-20% less likely to die if admitted to a major trauma centre than if admitted to other hospitals. A trauma system should have regard to the needs of all injured persons in its area.

Benefits to the whole injured population will derive from an inclusive trauma system that provides for the needs of all injured patients in its region by moving patients to the hospital best able to provide suitable care, freeing resources at other units. The benefits of trauma systems may take 3 years or more to be realised and depend upon an iterative process of needs analysis, service organisation and quality improvement.

At present, there is no major trauma network or designated major trauma centre operating across or within south Wales, south Powys and west Wales. Evidence demonstrates that the introduction of a major trauma centre supported by trauma units and a comprehensive rehabilitation pathway, working in an integrated and mutually supportive way, is expected to raise the quality of services, reduce deaths, and reduce regional limitations and variations in services.

Expected outcome

The vision for the major trauma service is to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable major trauma services at all points along their care pathway from the point of injury to rehabilitation, in line with best practice standard requirements, and evidenced through key performance indicators.

[3] Regional Networks for Major Trauma: National Clinical Advisory Group (2010)

The proposal is to establish a major trauma centre operating within an integrated major trauma network for south Wales, south Powys and west Wales. This will provide direct access for patients with very serious and often multiple injuries to the right level of service 24 hours a day, 365 days a year. The major trauma centre will be supported by a network of trauma units, delivered through designated consultant-led accident and emergency (A&E) departments, and rehabilitation provided through specialist and local rehabilitation services.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual, and their family and carers, are supported to achieve their maximum potential. It is a key part of the patient pathway, commencing at admission, continuing through the inpatient phase to discharge from the major trauma centre or trauma unit into the community and is a true enabler to achieving the best outcomes for individuals.

How it will be delivered

Emergency departments across the region see and treat many thousands of patients, approximately 750,000 over a year. Approximately 1500 patients will have, or be suspected to have had, a major trauma which is a very small proportion of the total number of patients (0.2%). When patients with a serious and complex injury need to come to hospital we want to have senior clinicians available to see them as soon as they arrive, whatever time of day or night. This means they will get the right diagnosis, start the right treatment quicker and get better faster. We need to offer everyone the sorts of medical advances which mean people involved in serious accidents have the best chance of survival. This kind of medicine should be delivered by teams of doctors, nurses and therapists who have specialist skills, which they use day in and day out so they remain experts in what they do. It can't be provided in every hospital because they wouldn't be able to keep up their skills because they wouldn't be seeing enough patients.

The NCAG report provides advice on delivering treatment for everyone which is based around the needs of individuals irrespective of where they suffer their injuries; transports the patient as rapidly and safely as possible to the hospital that can manage the definitive care for their injuries either directly or by expedited transfer to the major trauma centre; and moves the responsibility for definitive patient care from the receiving clinical team to the trauma network, when appropriate. The NCAG structures the patient pathway from pre-hospital care though to acute care to ongoing care and reconstruction to rehabilitation.

The NCAG report, together with the NHS England Standard Contract for Major Trauma (2013)[4], have been the main reference points for the development of the service model for south Wales, south Powys and west Wales. The British Society for Rehabilitation Medicine standards have been an additional key reference point in the development of the rehabilitation model.

[4] NHS Standard Contract for Major Trauma Services (All ages) D15/S/a: NHS England (2012)

People with a severe injury would be assessed by ambulance staff or assessed and treated by the Emergency Medical Retrieval and Transfer Service/EMRTS Cymru at the scene of the incident. They would then be taken by road or air ambulance directly to the major trauma centre if it was safe to do so, accessible within 60 minutes (NICE guideline, 2016) [5] and the patient did not need stabilising. At the major trauma centre patients would be cared for by an on-site consultant-led team. If the patient needed to be stabilised first, he or she would be taken to the nearest trauma unit, and once stabilised, transferred to the major trauma centre. Once the patient's specialist trauma care has been completed, patients will be transferred to the care of a service which is able to meet their ongoing care and/or rehabilitation needs. This may be a to a local hospital or for specialist rehabilitation

Rehabilitation services will be provided in the most appropriate setting for the level of injury and phase within the recovery process and is modelled on three levels. The model proposes improved communication for patients, across the system, with the implementation of a rehabilitation prescription which will identify the patient's needs, and ensure these are delivered throughout the pathway. Rehabilitation, delivered more locally will have positive impacts for patients, especially if there is equity of provision across the whole region, and the rehabilitation model aims to ensure that patients receive the highest quality, appropriate rehabilitation, irrespective of their location.

Who is affected?

Patients with major trauma are those with serious, often multiple injuries who require 24/7 emergency access to a wide range of clinical services and expertise. The term 'major trauma' is used to describe the most severe single injuries or multiple injuries. It can include major head injury, limb amputation, severe knife and gunshot wounds, multiple injuries or spinal injury and is often defined as an Injury Severity Score (ISS) [6] greater than 15. The definition of 'trauma services' generally includes less severe injuries such as fractured hip or ankle or minor head injury.

Major trauma patients require complex diagnostic, integrated and intensive early treatment from a wide range of specialities. Often multiple specialist resources are required with no or little delay, and access to the right service at the right time may be critical to survival.

The estimated incidence for major trauma cases is 185 per million and the estimated incidence of moderate trauma (ISS 9-15) is estimated at 220 per million per year. Modelling undertaken to assess the potential number of patients within the region who would need to be seen and treated within the major trauma network structure has estimated the number of cases as approximately 1500 per year, which would include secondary transfers between

[5] Major trauma: assessment and initial management: NICE guideline (February 2016)
[6] Those who are injured may have one or many injuries and the Injury Severity Score (ISS) is an anatomical score that measures the overall severity of injured patients. A major trauma is defined as the ISS being greater than 15. Moderate trauma is an ISS between 9 and 15: Trauma Audit and Research Network (TARN)

hospitals. This is a very small percentage of A&E workload, (0.2%), but these patients often have complex needs.

Where are we now?

Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, and through implementation and review.

This paper defines the proposal for change and the rationale, sets out the expected outcomes and who will be affected by the proposal, and considers potential impacts on different groups and any possible actions for reducing or eliminating disadvantage.

Stakeholder engagement is an important part of the development of the proposals. Stakeholders have been involved in reviewing the EIA and further opportunities will be taken to assess the impacts as the work progresses.

What the evidence tells us on the need for change

The case for change is founded on firm clinical evidence and guided by national and international good practice. Numerous studies have documented the benefit of organised, regional major trauma care. The findings of an independent audit published in 2013 showed that 20 per cent more patients were surviving severe trauma since the introduction of Major Trauma Networks in 2010 in England (Trauma Audit and Research Network, n.d.)[7].

In 2012, Professor Marcus Longley conducted a review (Longley, 2012) [8] of the evidence about the best configuration of acute hospital services in Wales. Prof Longley's report provided an objective analysis of the key issues facing the future of the NHS in Wales.

In respect of safety and quality, and on the basis of the available evidence, Prof Longley suggested there are several specialties for which we can be reasonably sure that we know how services should be configured included within which were major trauma services:

> Major trauma Services: There is evidence of significant outcome benefits for patients with major trauma when treated in a dedicated major trauma centre. In a typical year around 1,000 patients in Wales have major trauma:
>
> - Regionalisation of care to specialist trauma centres reduces mortality by 25% and length of stay by four days
> - High volume trauma centres reduce death from major injury by up to 50%
> - Time from injury to definitive surgery is the primary determinant of outcome in major trauma (not time to arrival in the nearest emergency department)

[7] Trauma Audit and Research Network (TARN)
[8] The best configuration of hospital services for Wales: a review of the evidence: Professor Marcus Longley, Welsh Institute for Health and Social Care (2012)

- Major trauma patients managed initially in local hospitals are 1.5 to five times more likely to die than patients transported directly to trauma centres
- One centre might typically serve a population of three to four million people.

The King's Fund published a report in November 2014[9] which set out the evidence for the reconfiguration of clinical services. This paper aims to help those planning and implementing major clinical service reconfigurations ensure that change is as evidence-based as possible. It investigates the five key drivers – quality, workforce, cost, access and technology – across 13 clinical service areas, summarising the research evidence and professional guidance available in each. Reconfiguration of trauma services was one of the clinical service areas reviewed.

The King's Fund summarised the evidence that should be taken into account when reconfiguring trauma services as:

- Formalised systems of trauma care, in which care for the most complex patients is centralised into a small number of trauma centres, improves patient outcomes
- Trauma centres need 24/7 access to fully staffed theatres and diagnostics, including CT, MRI and pathology. They also need comprehensive critical care and neurosurgical support

As referenced under the Rationale above, the report 'Regional Networks for Major Trauma' (National Clinical Advisory Group, 2010) compiles key recommendations from national reports and international guidance including from the American College of Surgeons to deliver standards for the care of major trauma patients. The evidence is consistent that the best outcomes are achieved within inclusive trauma systems with major trauma centres and trauma units.

In terms of access to healthcare, there is an increasing evidence base that, when given the facts, patients and carers will prioritise excellence and quality over convenience when it comes to their healthcare treatment, particularly for major treatment interventions and life-threatening conditions. A Welsh Confederation survey (YouGov, 2011) sought to establish the level of awareness about the management of the NHS in Wales, perceptions of quality and views on areas of policy including the future for hospital services. The survey found people in Wales say they don't mind travelling for specialist services if it means the care will be of higher quality, although there is no definition of what a specialist service is and, overall attitudes to concentrating services in fewer, larger hospitals are negative with most people opposing this and believing their local hospital should provide every type of service.

[9] The reconfiguration of clinical services: What is the evidence?: King's Fund 2014

What are the potential impacts on protected characteristic groups?

EIAs require analysing impacts on the basis of protected characteristics: sex; disability; race; religion or belief/non belief; age (younger people and older people); sexual orientation (lesbian; gay and bi-sexual people); gender reassignment; pregnancy and maternity; and marriage and civil partnerships. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a major trauma network and major trauma centre on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics. The proposals under consideration for the establishment of a major trauma network will result in the centralisation of life-saving treatment for a relatively very small number of patients but with the most serious and complex injuries. Trauma units and a comprehensive rehabilitation service will ensure that as a patient's condition improves responsibility for ongoing care will transfer to healthcare facilities closer to home. The key issue for the protected characteristic groups would seem to be one of access as evidence tells us that some traditionally underrepresented groups' access to health facilities is disproportionately low when compared to the general population. The same can be said with regard to good health outcomes.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' (those most likely to experience major trauma events) and the sections of the population which are likely to be most affected by the major trauma proposals (those groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

The first observation to make is that major trauma tends not to be closely associated with particular equality groups; events are not simple to predict on the basis of socio-economic characteristics. Of the protected characteristics, none are particularly susceptible to experiencing major trauma. However, a few groups are certainly key to consider in this assessment.

A literature review was carried out as a first stage of gathering evidence to inform the EIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders through work to develop the rehabilitation pathway.

Gender

Women are not a high risk group in terms of major trauma. Men are at far higher risk of experiencing major trauma. The NCEPOD report[10] showed that 75% of major trauma was in men. This is borne out by local data: in 2013, data for University Hospital of Wales, Cardiff, and Morriston Hospital, Swansea, shows that 70% of major trauma was in men.

Young men are at greater risk of being involved in major trauma accidents, typically arising from moving vehicles, tools or work. Death from trauma is higher in men than it is in women, believed to be because males are much more willing to engage in risk-taking activities.

Age

Age is a risk factor for suffering major trauma. It is the leading cause of death for people under 45 years and a significant cause of short and long-term morbidity (National Clinical Advisory Group, 2010)[11]. Children under the age of 15 only account for a very small percentage of major trauma and deaths as a result of major trauma. Teenagers and young adults are more likely to need hospitalisation from injuries than other age groups.

Whilst the elderly are infrequent victims of major trauma, their clinical outcomes including survival rates may not be as good as in the young. There is evidence, however, of a rising number of falls in the elderly that should be managed within a major trauma pathway and supported with a frail elderly rehabilitation pathway. The conclusion to a study published in 2015 (Emergency Medical Journal, 2015) [12] suggested that the major trauma population in the UK is becoming more elderly and the predominant mechanism that precipitates major trauma is a fall from lower than 2 metres.

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that the involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return 'home', or to the setting they came from. Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the major trauma network has all the skills required to care for these patients.

There is a need to consider further the transitional needs of young adults aged between 16 and 18 to ensure that they receive appropriate care and rehabilitation. Young people may

[10] Trauma: who cares? A report of the national confidential enquiry into patients outcomes and deaths (NCEPOD) (2007)
[11] NHS Clinical Advisory Groups Report: Regional Networks for Major Trauma (2010)
[12] The changing face of major trauma in the UK *Emerg Med J* 2015;**32**:911-915

also have different needs, and may require facilities to have relatives closer to them, for example in family rooms for patients from further away or more rural areas.

Race

Major trauma is more than twice as common in urban areas due to concentration of traffic and people. Additionally, it has been identified that black people and ethnic minorities are at a higher risk of incidence and mortality from major trauma, at least in part due to a correlation with concentration in urban areas and the relationship of minorities, deprivation and major trauma incidents[13].

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that there is a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in a chosen language.

Disability

Major trauma is the national leading cause of disability for those under 40 years of age. The improved number of survivals in young adults and the reduced disability will also improve the rate of return to work and socio-economic functioning. Evidence shows that there is a five to fifteen-fold return on the investment made in treatment. As most major trauma patients tend to be of working age, this is an important indicator that given the right care, it is possible for people suffering the most serious injuries to recover sufficiently to go on and have an active working life (NHS East Midlands, 2010)[14].

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that:

> Rehabilitation services should give choice to patients with pre-existing mobility issues, for example patient with multiple sclerosis should receive the same options for treatment. Specific patient needs, such as bariatric needs should be considered to ensure the ability to provide equipment across boundaries and within social care sector.
>
> As well as physical disability, there is a need to consider learning disabilities and mental health. It is recognised that the involvement of carers/family in any programme is more difficult the further away rehabilitation is from local support mechanisms, and patients are not always able to return to the 'home/setting' they

[13] Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)
[14] Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)
[15] All Wales Standards for Communication and Information for People with Sensory Loss 2013)

came from. Communication needs in these client groups may be more challenging and care should be adapted accordingly.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss15 that apply directly to emergency and unscheduled care and these outline the staff training requirements, communication systems and patient needs information which should be provided by health boards.

Improved service will reduce the rates of disability and increase socio-economic functioning.

Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

Religion or belief (including lack of belief)

It will be important to note that staff consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them[16]. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered.

Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay, Bisexual and Trans (LGBT) patients in Wales report significant barriers to health and social care services17 . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patient' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall have commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of

[16] http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp
[17] http://www.stonewallcymru.org.uk/our-work/research/have-your-say

staff and their patients. Health boards should continue to seek to make progress in this area.

Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth. In 'It's just Good Care: A guide for health staff caring for people who are Trans' 201519 Trans* people must be accommodated in line with their full-time gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. For people who are still in transition, any compromise must be temporary. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's GRC or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. There is a risk that the location of the major trauma centre within the major trauma network may impact negatively on Welsh language users. Service users who prefer to communicate in the medium of Welsh may be required to access services at sites which do not have sufficient Welsh speaking staff. This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of victims who speak Welsh will need to be taken into account. 'Language is the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual is an essential principle of maintaining dignity and respect in care within a bi-lingual setting (Welsh Language Services in Health, Social Services and Social Care, 2012)18.

[18] More than just words: Strategic Framework for welsh language services in Health, Social Services and Social Care (2012)

Socio-economic status

While socio-economic status is not a protected characteristic under the Equality Act 2010, it is particularly relevant in relation to the protected characteristics. There is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

As a group, and with regard to risk of major trauma, it would be expected that individuals living in deprived areas would be over-represented as pedestrians and under-represented as car occupants in road traffic accidents.

There is a strong relationship, particularly with children, between social deprivation and the incidence of injury and some evidence that the disadvantaged are less likely to survive (The Trauma Audit & Research Network: an overview).

What are the potential impacts on NHS staff?

Proposals to establish a major trauma network may affect NHS staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board boundaries.

There is anecdotal evidence that the establishment of a major trauma network and centre within South Wales would improve recruitment and retention for those clinicians who wish to practise in such a structure. It would also ensure the arrangements for the delivery of major trauma services in south Wales, south Powys and west Wales are on a par with the structures in the rest of the UK.

Staff will be engaged and consulted on the proposals and any staff affected by the final outcome will be supported by the NHS Wales Organisational Change Policy (2009). A partnership approach with trade union colleagues will be ensured to achieve an effective transition to any new arrangements.

What are the human rights implications of the major trauma development?

The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.

The assessment so far has indicated *Article two: the right to life*, and *Article eight: the right to respect for private and family life, home and correspondence,* are of particular relevance and potential impact to the development of proposals for a major trauma network.

Right to life (taking reasonable steps to protect life): It is anticipated that having a regionalised service for major trauma, with the most complex care provided from a major trauma centre, will improve clinical outcomes which will have a positive impact on individuals' right to have their life protected.

Right to respect for private and family life, home and correspondence: the improved quality of care possible through a major trauma network structure should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and individual members of the family.

This is not an absolute right and any interference should be justified, lawful, necessary and proportionate.

United Nations Convention on the Rights of the Child

Children under the age of 18 are protected by the United Nations Convention on the Rights of the Child (UNRNC). Healthcare providers have a duty to protect, promote and fulfil the rights of the child. The UNRNC should be considered in conjunction with the Human Rights Act and the duty to promote fairness, respect, equality, dignity and autonomy. Due regard must be given to the specific needs of a person of his/her age, and in particular the right to maintain contact with family members. This could apply to a child as a patient or a child/sibling of a patient. The convention recognises that children themselves, not adults, are entitled to be involved in decisions that affect them.

Initial summary conclusion

The introduction of a major trauma network, including rehabilitation and the designation of a major trauma centre and major trauma units, is intended to improve patient care and outcomes for major trauma:

- Time to access: time from injury to definitive trauma care is the primary determinant of outcome in major trauma
- Quality of outcome: regionalised trauma systems show a continuous improvement in results over time with reductions in morbidity and mortality
- Equality: standardisation of regional services, including rehabilitation with protocols should improve equality of access and reduce inequalities

The service redesign intends to standardise transfer for life-saving treatment to a specialised major trauma centre within a major trauma network which will reduce inequalities in outcome. *Providing rehabilitation on a network model standardises the approach across the three levels of care and improves local access.*

The proposed service redesign does not introduce any additional obstacles; improving standardisation for access and specialist treatment should improve outcomes across all social groups. At this stage, this assessment indicates that there are relatively few cases of major trauma and among them the equality groups are mostly under-represented, since, from national evidence and research, the majority occur in working age men although there are growing numbers of older people needing major trauma care. Assuming, in the majority of cases, major trauma leads to a 999 call, there should not be any particular equality-group impact in terms of access to the new services.

In certain geographic areas, there may be groups that will experience travel times longer than the target 60 minutes travel time for definitive care at a specialist major trauma centre. Consistent with major trauma structures across the UK, and in accordance with NICE guidance, major trauma units are an integral part of the network structure and provide for stabilisation of a patient's condition before onward transfer to the major trauma centre.

For those visiting major trauma victims whilst being cared for at a major trauma centre, longer and more complex journeys are likely to be necessary for some. Being required to travel to an unfamiliar hospital and longer distances could be particularly difficult and disorientating for people from equality groups, especially older people and disabled people. It is these groups who are more likely to experience problems with communication and understanding. Journey times will be considerably increased for users of public transport, which is highly relevant in terms of equality groups. Car ownership amongst most equality groups and, particularly, socially deprived communities tends to be lower than average, requiring a high reliance on public modes. Early transfer of the patient back to a 'local' hospital would help to mitigate long periods in unfamiliar surroundings.

What happens next?

The work of the South Wales Major Trauma Network Project Board, Clinical Reference Group and a number of workstreams, is continuing to plan for a major trauma service, leading to recommendations for the location of a major trauma centre, supporting major trauma units and a comprehensive rehabilitation pathway, operating within a trauma network structure for south Wales, south Powys and west Wales. The EIA will continue to be reviewed to further develop and refine this assessment and to ensure consideration is given to mitigate any identified negative impacts. Feedback from a planned awareness raising and engagement process will be incorporated into the next draft.

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Appendix 13 – Risk Register

Major Trauma Risk Log: Revised March 2017

Ref	Domain	Date risk identified	raised by	Risk	Cause	Effect	Controls	Owner	Risk Rating initial			Risk Rating current			Date of last update	Status	Comment
									I	L	Risk Score	I	L	Risk Score			
R7	adverse publicity/reputation	26.05.15		Delay in progressing the development of the MT network model because of lack of knowledge around MT as a result of not engaging openly with key stakeholders including CHCs	failure to communicate openly with stakeholders	delay in progressing development of the trauma network	monthly breifing following project board Regular update with Chief Officers Engage Chief Officers in developing further briefings	Project Board	4	4	16	4	4	16	26.05.17	**open**	
R25	business objectives/projects	16.03.17		delay in progressing the network model as a result of the unsuccessful candidate MTC site not engaging in developing a networked model	unhappy with proposal	delay in progressing development of the trauma network	Independent clinical advice taken help support a recommendation on a preferred site	Health Boards	4	3	12	4	3	12	26.05.17	**open**	
R24	business objectives/projects	16.03.17		Delay in progressing the network model as a result of unsuccessful candidate MTC site challenging the outcome	unhappy with proposal	delay in progressing development of the trauma network	Independent clinical advice taken help support a recommendation on a preferred site	Health Boards	4	4	16	4	2	8	26.05.17	**open**	**Does this need to be closed?**
R23	adverse publicity/reputation	16.03.17		Public perception of the major trauma network and the location of the centre is inaccurate due to incorrect information being made public	only selecte pieces of information shared	stakeholders do not have a complete picture of the case for change	Work with CHCs to develop overarching supporting documents HB to work with CHCs to cascade information through their networks Work with the BBC media to ensure a balanced story is given	Project Board	4	4	16	4	4	16	26.5.17	**open**	work on engagement has been postponed due to the General election on 8th June and purdah
R22	business objectives/projects	16.03.17		The major trauma network model is not progressed as a result of the public not accepting the case for a major trauma network for south Wales during the consultation phase	public do not agree with case for change and MT as a priority	MT network mdoel is not progressed	Work with CHCs to develop overarching supporting documents HB to work with CHCs to cascade information through their networks Work with the BBC media to ensure a balanced story is given	Health Collaborative/Health Boards	4	3	12	4	3	12	26.5.17	**open**	
R21	business objectives/projects	16.03.17		The recommended preferred location for the MTC based on advice from Independent Panel and wider information is not accepted by public	unhappy with proposal	delay in progressing development of the trauma network formal challenge to the proposal		Health Collaborative/Health Boards	4	3	12	4	3	12	26.5.17	**open**	
R20	business objectives/projects	16.03.17		The recommended preferred location for the MTC based on advice from Independent Panel and wider information is not accepted by some indiviudal Health Boards	unhappy with proposal	delay in progressing development of the trauma network formal challenge to the proposal		Health Collaborative/Health Boards	4	4	16	4	3	6	26.5.17	**open**	Formal report is intended to go to Leadership forum in June, following which it will go to indiviudal Health boards for consideraiton
R19	business objectives/projects	16.03.17		The recommendaded preferred location for the MTC based on advice from Independent Panel and wider information is not accepted by Collaborative Board	unable to reach as consensus on MTC location	delay in progressing development of the trauma network		Project Board	4	3	12	4	2	8	26.5.17	**open**	suggested this is now closed
R12	finance	26.05.15		Indiviudal Health Boards will not receive appropriate payment for out of area patients as there is no commissioning model in Wales to support the flow and payment of patients across health Boards	lack of commissioning framework	organisation incur signficant cost no incentive to repatriate patients to local TU	Commissioning work group to be established to progress the commissioning model formal discussion to be held with WHSSC, Collaborative Commissioning body to determine options available	Project Board	4	3	12	4	3	12	26.5.17	**open**	a commisionning T&F group is being established to develop a recommended commissioning model
R26	business objectives/projects	16.03.17		Delay in progressing the network model of MT because of lack of commitment from HB developing the model	lack of engagement from Health Boards	delay in progressing development of the trauma network	CEOs mandated NHSWHC to undertake the work	Health Boards	4	3	12	4	2	8	26.5.17	open	Executive Board approved development of the network at Board 23.5.17 **does this now need to be closed?**
R26	adverse publicity/reputation	29.03.17		Population of south Wales continue to have worse outcomes following a major trauma and more deaths than the rest of the UK as a result of a major trauma network not being implemented	no major trauma network in south Wales	more deaths and worse outcomes than the rest of UK (including north Wales)	Independent clinical advice taken help support a recommendation on a preferred site	Health Boards	5	5	25	5	5	25	26.5.17	open	
R27	adverse publicity/reputation	29.03.17	Ruth Alcolado	Population of south Wales continue to have worse outcomes following a major trauma and more deaths than the rest of the UK as a result of the decision on the location of the major trauma network being delayed	delay in agreeing location of MTC and Tus	more deaths and worse outcomes than the rest of UK (including north Wales)	HB to work with CHCs to cascade information Health Collaborative to continue to engage with CHC and Health Boards Leadership forum established to support decision making process and recommendations	Health Boards	4	4	16	4	4	16	26.5.17	open	
R28	service/business interruption	29.03.17		the development of the network facilitates uncertainty and unsustainable services outside of the centres (MTC and Tus)	the main sites are able to attract key clinicial posts and are supported by trainees via the deanery which may make it difficult to recruit to posts in the non truama units/mtc sites	vacancies in hospitals outside the major sites, which may lead to difficulties providing a clinical safe and effective service		Project Board	4	3	12	4	3	12	26.5.17	open	
	Finance	29.03.17		Delay in implementation of the major trauma network due to no commissioning framework in Wales to support cross Health Board management of patients	No agreed framework for managing patients across health boards	new service model not implemented	Commissioning work group to be established to progress the commissioning model formal discussion to be held with WHSSC, Collaborative Commissioning body to determine options available	Health Collaborative	4	3	12	4	3	12	26.5.17	open	a commisionning T&F group is being established to develop a recommended commissioning model
	Quality	11.04.17	Brendan Lloyd	Primary scene management & transfers are managed may not be managed as well as possible due to staff not undertaking the required training to tpport the new service model	insufficient training of WAST staff	patients managed inappropriately resulting worse outcomes Patients not being transferred appropriately	training requirements to be identified and plan developed as part of the next phase of the programme	Project Board/WAST	5	5	25	5	5	25	26.5.17	open	
	Fianance	11.04.17	Brendan Lloyd	Delay to implementation of the major trauma network due to insufficent training of WAST staff to support the change in service model as a result of insufficient funding	insufficient training funding not identified to support training requirements	delays in implementation of the service model patients managed inappropriately	Need for finanical implications associated with delivering WAST training and operational costs to be included in the commissioning framework	Project Board/WAST	4	3	12	4	3	12	26.5.17	open	
	Quality	29.03.14	Phil Kloer	Some patients have a worse outcome as the major trauma occurs more than 60 minutes away from the nearest TU or MTC	it is not possible for all areas across South wales, West wales and south Powys to be within 60 minutes of the MTC or a TU	potential for patients to have a worse outcome Delay in patients reaching an appropriate centre for treatment	Investment has been made in EMRTs to support transfer of major trauma cases in Wales to an appropriate centre It is recognised across the UK that there will be areas more than 60minutes away from a TU and MTC	Project Board	3	3	9	3	3	9	26.5.17	open	

13

SHAPING OUR FUTURE WELLBEING - DEVELOPING OUR ESTATES PLAN	
Name of Meeting : Board	**Date of Meeting :** 28th September 2017

Executive Lead : Director of Strategic Planning
Author : Director of Strategic Planning
Caring for People, Keeping People Well : *Shaping Our Future Wellbeing* sets out how we plan to improve the health outcomes for the population we serve over the next ten years and summarises the changes we will make to the way we deliver services to ensure they are sustainable in the long term. In order to deliver services in line with our strategy we need to significantly improve our infrastructure and replace some of our key facilities in order to be able to offer citizens the very best possible care.
Financial impact : We know that delivering services in facilities that are not fit for purpose is not cost effective, and we are experiencing major service failures, which have a cost, as a result of the condition of some of our buildings. Significant capital investment is required over the next decade in order to provide the facilities needed to deliver our strategy and ensure the provision of safe and sustainable services. The Welsh Government NHS Capital Programme is over-committed over the next three years, and business cases will need to be prioritised based on the benefit that they deliver.
Quality, Safety, Patient Experience impact: We are seeing service failures associated with the poor condition of some of our facilities which impacts directly on patient care. In other areas, the environments are not purpose build for modern health care delivery.
Health and Care Standard Number: The need to improve the environments in which we are delivering care supports the achievement of all Health and Care Standards
CRAF Reference Number: The condition of our estate, particularly in relation to statutory compliance, patient experience and having facilities that are fit for purpose, is identified as a significant risk to the UHB.
Equality and Health Impact Assessment Completed: EHIAs are produced for each business case.

ASSURANCE AND RECOMMENDATION

ASSURANCE – Assurance is provided through the Strategy and Engagement Committee's scrutiny of the Capital Programme on a quarterly basis. Individual business cases will be signed off by the Capital Management Group for consideration by the Board. The final estates plan will be scrutinised by the Strategy and Engagement Committee before coming to the Board for approval.

APPROVE – The Board is asked to:

- Note the work being undertaken on the development of the UHB's estates plan.
- Consider the implications and requirements of the plan over the next decade, recognising that the estates plan will need to be regularly refreshed to reflect the

14

emerging clinical services plan.
- And confirm that the direction of travel is in line with *Shaping Our Future Wellbeing* and the Wellbeing of Future Generations legislation.
- Agree to receive the estates plan for approval in Spring 2018.

SITUATION

Having published our ten year strategy, *Shaping Our Future Wellbeing*, in 2015 there is now an urgent need to complete our clinical service plan and infrastructure plan to confirm how our services will change over the next decade as we implement the strategy. A number of our plans have progressed over the last two years: Shaping Our Future Wellbeing in the Community is at an advanced stage; we are concluding the implementation of the South Wales programme; we are finalising regional service models for some specialties (ENT and vascular) and we have completed a significant amount of work with clinicians on what services should be provided across our two acute hospital sites, although there are no firm conclusions from this work.

The need to make rapid progress on ensuring that we have prioritised plans in place to provide the infrastructure we need for the future is pressing, particularly in light of increasing difficulties in the delivery of our current services due to infrastructure and equipment failures, particularly at UHW.

[This report does not refer to IM&T infrastructure and development plan is as this is already the subject of a separate strategic outline programme which has been submitted to Welsh Government.]

BACKGROUND

In 2015 we undertook a comprehensive review of our physical infrastructure (buildings, IT and equipment) which confirmed that many of our buildings are in poor condition and/or do not provide the right environment for the care and treatment we are now providing, and are certainly not fit for future service sustainability. The backlog in the replacement of both IT and medical equipment was substantial.

We have made some significant progress with addressing the most urgent and important infrastructure issues: our inpatient mental health services for working age adults are now delivered in state of the art facilities at UHL; the second phase of the children's hospital and the family accommodation centre have been completed providing the very best standards of care; we have completed the first phase of the re-provision of neonatal services at UHW so that we have modern fit for purpose facilities, and all phases will be completed by 2019.

Many other smaller schemes have also been completed and each year the capital programme (including developments requiring Welsh Government funding from the all-Wales NHS Capital Programme and those funded from our discretionary budget) is reviewed and prioritised and reflected in our IMTP so that the most urgent and important developments are progressed.

Through the HEART (Health Enterprise Alliance for Regional Transformation) collaboration we have been working with partners to ensure that we join our resources where it makes

sense to do so, and plan together to deliver a more citizen driven approach to local care. We have also committed to plan our infrastructure developments jointly so we are maximising the opportunities for sharing facilities and making the public pound stretch further. We have also prioritised ensuring that we have the facilities, the environment and culture to drive innovation and accelerate our research and development activities, increasing the contribution to economic growth in the region.

We are also experiencing the fastest growth of any city population outside of London and we need to ensure that we plan now for the housing developments and associated population growth that is planned for in the two Local Development Plans over the next decade.

ASSESSMENT

Developing our clinical services plans:

Shaping Our Future Wellbeing confirmed the priorities for the health board over the next ten years in order to respond to our vision for improving the health of our local population and reducing the health inequality, and ensuring that the services we provide are sustainable from a financial and workforce perspective, and deliver person-centred outcomes that benchmark well against national and international peers.

We have a number of plans in various stages of development or implementation which include:

- The South Wales Programme which confirmed a new regional service model for emergency medicine, paediatrics, obstetrics and neonatal services. Over the last two years, the detailed service, workforce and finance planning has been completed and the new service models will be implemented over the next 18 months (the timetable for some areas dictated by the need for substantial infrastructure capital developments that were subject to business cases to Welsh Government).
- We have been working with regional health board partners to develop regional models of service provision where population critical mass or workforce fragility has indicated that a new approach is needed. Over the last 18 months the regional models for vascular and ENT services have been developed and are now being finalised, with concerted effort to resolve a number of outstanding issues.
- The Shaping Our Future Wellbeing in the Community Programme has been running for over a year and sets out the service and infrastructure requirements to deliver more services, sustainably in the community, in line with our ‘home first’ design principle and the need to decongest out acute sites so that people access services in the most appropriate location. This work is aligned to the Perfect Locality service specification, our integrating health and social care programme and developing primary care.
- We have also taken forward a number of service changes set out in the Integrated Medium Term Plan, for example the changes to mental health services for older people, which over the last five years have resulted in a significant expansion in the provision of care in the community so that people are able to remain living at home, with the resultant reduction in demand for beds, and the reduction in our bed based services (including the closure of Iorwerth Jones which will close in this calendar year).

Developing the estates plan:
Work has commenced on developing an estates plan for the next decade which will set out the priorities we will take forward to ensure that we have the right infrastructure in place. The estates plan will reflect the service changes described above, and will be informed by a more detailed clinical services plan which will look at how we see our hospital based services (and any implications for our community services) developing over the next ten years. This work will reflect the outcome of an internal review of tertiary services, the longer term commissioning intentions of WHSSC, the outcome of the work of the South East Wales Regional Planning Forum and our own considerations of how best to deliver care across our two main hospital sites. The estates plan will describe what the expected future role of each of our facilities will be.

The estates plan will also respond to surveys of space utilisation which are currently being finalised. These indicate that the way we deliver care in some service areas results in very poor utilisation of our buildings. For example, we are delivering more care in people's homes and other community settings, with less direct patient care being delivered in some facilities. We are looking at the opportunities presented through the development of health and wellbeing hubs in each locality to bring some services together and rationalise some of our poorly utilised and maintained facilities.

We are also required to ensure that we have an estates plan for primary care in place. We have a draft primary care estates plan in place and this is being updated and reflected in Shaping Our Future Wellbeing in the Community and the business case for the implications of the population growth for primary care.

UHW master planning:
Work now needs to start in earnest on the development of the UHW re-placement master plan. We are currently establishing the programme that will oversee this work. The first year of the programme will focus on setting out the case for change in detail. This will need to include defining the opportunities and challenges of developing the concept of an academic health science campus model; producing the outline programme plan setting out the timelines, approach and resource requirement to develop the programme business case. Key to the success of this work will be developing an approach that identifies the critical services that can only be provided on the UHW site, those that could operate from other UHW facilities or partner facilities. The programme will need to define the opportunities to create environments that will attract the very best clinical academics and researchers, which in turn will support the growth of the life science sector in the region.

The final detailed specification for the UHW replacement will need to reflect the clinical services plan and respond to the design principles set out in the our strategy, namely a service model that is based on home first, empowering patients, outcomes that matter to people and prudent approach where we reduce avoidable harm, waste and clinical variation.

The UHB has commissioned architects to assess whether it is possible to re-provide UHW on the same site whilst allowing the existing services to continue. This work confirmed that this was possible, and some very early architect's impressions of what the new facility could look like were developed. When the full business case is developed, replacement on the

UHW site will need to be considered against other potential site options (of which there is likely to be only one or two other potential sites).

The detailed specification will also need to set out which services could be delivered from a remote site (such as laboratories) where digital technology could support rapid access to test results etc. The implementation of the Genomics Strategy in Wales, with the key services hosted by Cardiff and Vale UHB and Cardiff University will also have an important role to play in changing the shape of services resulting from increase DNA sequencing and patient specific medicine and treatment regimes.

The specification will also need to reflect the plan for tertiary services which will be developed over the next six months to inform our plans and discussions with the commissioners of these services (Welsh Health Specialist Services Commission). It is also likely that new regional models of service delivery will continue to emerge for emergency and out-of-hours elements of non-tertiary specialist services, were workforce and financial pressures mean that existing staffing rotas and clinical models are not sustainable.

UHW is the base for a significant amount of medical, nursing and allied health professional training. It also provides the Clinical Research Unit and currently houses the Clinical Innovation Partnership. Approximately a third of the UHW site is occupied by Cardiff University functions. The UHW master plan will need to reflect the opportunities to link with other research and development facilities – such as Cardiff University Brain Research Imaging Centre (CUBRIC) which provides the best imaging facilities in Europe. The planning for UHW will be undertaken jointly with Cardiff University.

There are also opportunities to strengthen links with other Cardiff University departments – we already work with colleagues in the mathematics department in relation to modelling, but there are shared advantages of strengthening links with engineering, architecture, social science departments and the Cardiff Business School. Relationships with other universities are also important and there are opportunities for strengthening these – particularly with the School of Design and School of Therapies.

In order to progress the next phase of this element of the HEART programme, a dedicated lead for the UHW master planning is being identified to complete the first year of what will be a complex and long term planning process.

Timetable:

1. The estates plan is currently being drafted and is based on a set of assumptions about how we see services developing, and what role each of our facilities will play in the delivery of local and regional health care. We will need to refresh the estates plan as the details of key elements of our clinical services plan are finalised. The aim is to complete the first version of the estates plan for considering by the Strategy and Engagement Committee over the winter.
2. The estates plan will also provide a prioritised programme of infrastructure developments that will be required over the next decade to ensure that we can continue to provide safe and sustainable services whilst the plans for major infrastructure re-provision are finalised. It will indicate the likely source of funding and the anticipated timetables for developing the associated business cases – recognising that full business

cases can take several years to develop and get approved depending on the complexity of the scheme.

3. The UHW re-provision programme is being established and it anticipated that the case for change and the outline business case would be developed over the next 12 – 18 months subject to the resources being available.
4. Work is commencing on pulling together the clinical service plan and the resource to undertake work over the next year is being identified.
5. The plan for tertiary services is being progressed to reflect how we see services developing over the next decade, recognising the fragility of some services and the need to consider different models of service delivery with other providers. This is a discrete piece of work but it will inform and be informed by the clinical services plan as the services cannot be seen in isolation. It is anticipated that this will be completed over the next six months.

Engagement and consultation:

As we develop our clinical service and estates plans, we will be engaging with key stakeholders (our staff, local communities, Cardiff University, the local authorities, neighbouring health boards and the CHC) on an ongoing basis. There will be a number of interconnected work programmes which will report into Management Executive, the Strategy and Engagement Committee and key decisions will be reserved for the Board to take.

THE FUTURE SHAPE OF THORACIC SURGERY SERVICES IN SOUTH WALES	
Name of Meeting : Board Meeting	**Date of Meeting** 28 September 2017

Executive Lead : Director of Strategy and Planning
Author : Strategic Partnership and Planning Manager Tel. 029 2184 7730
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : Welsh Health Specialised Services Committee (WHSSC) will develop a commissioning plan based on the outcome of the review of these services
Quality, Safety, Patient Experience impact : The service model agreed following the review will be designed to improve service quality and patient safety
Health and Care Standard Number 3.1, 3.2, 3.3, 5.1, 6.3, 7.1
CRAF Reference Number 1.1, 2.1, 2.3, 3.1, 4.1, 4.2, 4.3, 5.1, 6.2, 6.4, 7.1
Equality and Health Impact Assessment Completed: An Equality Impact Assessment has been developed by WHSSC

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The review is being led by the WHSSC Joint Committee made up of the Chief Executives of all seven Health Boards in Wales, WHSSC officers, independent members and an independent chair
- WHSSC has established a Thoracic Surgery Project Board to oversee the review, with representatives from all the Health Boards

The Board is asked to:

- **NOTE AND SUPPORT** the planned engagement exercise supporting the Thoracic Surgery Services review

SITUATION

The Welsh Health Specialised Services Committee (WHSSC) is leading a review of Thoracic Surgery Services in south Wales, which may lead to changes in the way these services are provided. Prospective service change requires stakeholder engagement and may need formal consultation. The purpose of this stakeholder engagement exercise is to obtain views and feedback from the public, patients and patient support groups, and professionals in the health service, to help us to decide whether we need both Morriston Hospital, Swansea (for the population of south west Wales) and University Hospital of Wales, Cardiff (for the population of south east Wales) to continue to provide thoracic surgery services for south Wales or whether

the services should be provided by just one of these hospitals for the whole of south Wales.

BACKGROUND

The reason WHSSC decided to undertake a review was because they knew that:

- Over the last year patients in Wales with lung cancer have waited longer than they should have for surgery
- Patients in Wales with lung cancer have some of the lowest survival rates in Europe
- Patients who require surgery but do not have lung cancer have very long waiting times. Our doctors and nurses tell us this is affecting the quality of care they can provide
- Thoracic surgery is becoming increasingly specialised and that better outcomes come from larger centres.
- Elsewhere in the UK and Europe services are restructuring into larger centres
- Because thoracic surgery is now so specialised, surgeons are no longer being trained to do both cardiac and thoracic operations. This means we cannot staff our small units in the way we have done in the past

WHSCC therefore want to improve the quality of services provided for patients in south Wales and ensure that these services are fit for the future.

ASSESSMENT AND ASSURANCE

We are asking for two things from our stakeholders, first, feedback on the process we are using and any additional information they think we should consider to inform the decision on whether there should be one or two centres. Second, if we decide to have one rather than two centres, the criteria that should be used to decide at which hospital to locate the service. We need to know whether stakeholders agree with the criteria or if they think there are others which we have missed out.

WHSSC has prepared a Stakeholder Engagement document which explains the background to why the changes are taking place, what the change means and how we intend to make the decision; this is attached as Appendix 1 and includes a form on which stakeholders can provide feedback. The proposal is for the engagement exercise to run between 29th September and 10th November 2017. WHSSC and Health Boards are liaising with the Community Health Councils on the proposed engagement.

The WHSSC Joint Committee agreed that all Health Boards would be asked to note and support the engagement exercise. In the event that we are subsequently required to enter into a formal consultation exercise in relation to this potential service change, this will be brought back to Health Boards.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

The Future Shape of Thoracic Surgery Services In South Wales

Stakeholder Engagement

15

1 INTRODUCTION

The purpose of this stakeholder engagement exercise is to obtain views and feedback from the public, patients and patient support groups, and professionals in the health service, to help us to decide whether we need both Morriston Hospital, Swansea (for the population of South West Wales) and University Hospital of Wales (for the population of South East Wales) to continue to provide two separate thoracic surgical services for their local population, or whether one of those hospitals should provide a larger combined service for the whole of South Wales.

This document explains the background to why the change is being considered, what the change means and how we intend to make the decision. We are looking for your help in providing feedback on the type of information we need to consider, and the process we are using, to make this decision.

It is really important we get the process right so that we make the best decision for our patients. This means we really require your input.

1.1 Who are 'we'?

We are the Welsh Health Specialised Services Committee (WHSSC), a part of the NHS in Wales. Our Board is a Joint Committee made up of the Chief Executives of all seven Health Boards in Wales, WHSSC Officers, independent members and an independent Chair.

We work on behalf of the seven Health Boards, to commission specialised medical services for the people of Wales. These are services which are provided for less common conditions and are usually only delivered by our larger hospitals or sometimes from only a few centres in the UK. We aim to provide access to safe, sustainable and effective services which offer the best experience for our patients. Thoracic surgery is one of the specialised services we commission for the population of Wales.

1.2 What is thoracic surgery?

Thoracic surgery involves operations on all parts of the chest including the chest wall, the contents of the chest and the lungs, but not the heart (this is cardiac surgery). A main part of a thoracic surgical team's work is on patients with lung cancer. They also operate on patients with other non-cancerous conditions such as complications from pneumonia or those who

have punctured lungs. In addition, they carry out biopsies on people with certain types of lung disease to help obtain a diagnosis.

Thoracic surgery is delivered from two centres in South Wales; Morriston Hospital, Swansea and the University Hospital of Wales, Cardiff. Each centre has two consultant thoracic surgeons delivering a service for both lung cancer patients and patients with non-cancer indications that require thoracic surgery.

The population of South Wales, South Powys and West Wales is approximately 2.2 million. The total number of patients requiring surgery (both cancer and non cancer reasons) is approximately 420 per year at Morriston Hospital, and 650 per year at the University Hospital of Wales.

1.3 Why do we want to change the way we deliver thoracic surgery in South Wales?

Improving thoracic surgery services in Wales will ensure they deliver the best care possible. There are a number of reasons we want to improve thoracic surgery services in Wales:

- We know that:
  - over the last year patients in Wales with lung cancer have waited longer than they should have for surgery
  - patients in Wales with lung cancer have some of the lowest survival rates in Europe
  - patients who require surgery but do not have lung cancer have very long waiting times. Our doctors and nurses tell us this is affecting the quality of care they can provide
  - thoracic surgery is becoming increasingly specialised and that better outcomes come from larger centres. Elsewhere in the UK and Europe services are restructuring into larger centres
  - Because thoracic surgery is now so specialised, surgeons are no longer being trained to do both cardiac and thoracic operations. This means we cannot staff our small units in the way we have done in the past

To help us decide how to do this, we asked the Royal College of Surgeons to look at thoracic surgery services in South Wales and advise us on how they can be improved. The Royal College of Surgeons have recommended that to ensure the future sustainability and quality of thoracic surgery in South Wales, there should only be one hospital delivering the service.

1.4 What are the options for delivering thoracic surgery in South Wales?

We believe there are 4 potential options:

1. Two separate centres (current model)
2. A single (larger) centre (Royal College of Surgeons recommendation)
3. Two centres working together (sharing resources e.g. surgeons and other staff)
4. A hospital Trust in England (thereby no centre in Wales)

We have considered these options and concluded that:

- Option 4 should be rejected because there are more than enough patients in South Wales to provide work for at least one centre, South Wales already has the expertise to provide high quality care and we do not want patients to travel longer distances than they already have to for treatment.
- Option 3 has also been rejected because it has been tried before and we were unable to recruit to these posts. This was because of the practical difficulties for staff working between two sites whilst trying to deliver such complicated treatment.

As a result there are therefore two potential options for the shape of the service: the current two centre mode (option 1) or a single centre model (option 2).

It is important to remember that this surgery is one very small part of a patient's treatment and all other parts, such as scans, biopsies and follow up care will happen in their local hospital. We are only considering changing the place where surgery takes place.

2. WHAT IS THE PROCESS FOR MAKING THE DECISION?

The final decision on the future shape of thoracic surgery services in Wales will be made by the ***Joint Committee*** (the Board of WHSSC as described above). That decision will be made on the basis of two separate recommendations:

- The first step will be a recommendation from the ***Thoracic Surgery Project Board*** on whether thoracic surgery should be provided from one or two centres in South Wales. We explain more about the Project Board later on in this document.

If the Project Board's recommendation is for one thoracic surgery centre there will be second step.

- The second step will involve an ***Independent Panel*** which will make a recommendation as to the preferred location of a single centre.

If the first step recommends one centre then we will move directly into the second step, we will not pause whilst the Joint Committee considers the recommendation. The reason for this is that:

1. We do not want to introduce any unnecessary delay. Our doctors and nurses tell us that our patients do not always receive the care they should and the longer we take to make a decision the more patients will be affected.

2. The Health Boards have advised us because there is strong evidence in favour of a single centre and believe the Project Board is likely to recommend a single centre, a more streamlined process is appropriate.

2.1 What is the role of the Thoracic Surgery Project Board?

The Project Board consists of people with expertise in these services, representatives from all the Health Boards in south Wales and lay members.

Below is the evidence and information that the WHSSC team has collected which they think should be considered by the Project Board to help them decide whether there should be one or two centres for thoracic surgery in South Wales.

In addition, information around travel times for patients will be provided as well as what we call an 'Equality Impact Assessment'. An 'Equality Impact Assessment' is an assessment of whether there are particular groups of people who might be disadvantaged by such a change, for example whether disabled people might find it more difficult to access treatment.

Although we have put together this evidence together we need your feedback to confirm whether or not we have missed anything out. This will help us make sure that the Project Board will make the best recommendation it can to the Joint Committee.

2.1.1. What evidence will be considered?

The report from the Royal College of Surgeons provided to WHSSC in January 2017

The Royal College of Surgeons carried out a review of the service and made a number of recommendations which were received in January 2017. These included a clear recommendation that thoracic surgery in

South Wales should be provided from a single centre. They concluded that the current two site model would not be sustainable.

The key recommendations were:

- *"It is the review team's recommendation that WHSSC adopts a single site thoracic surgery service model for South Wales."*

- *"The review team considered that this reconfiguration was in the best interests of patient care and was the most sustainable option for thoracic surgery going forward."*

- *"It was considered that changes to cardiac and thoracic surgery would mean there would not be a staffing resource that could adequately sustain a two site model in the future."*

  This is due to the new requirement to have enough thoracic surgeons to be able to provide an out of hours/emergency service while at the same time having sufficient numbers of patients for those surgeons to operate and maintain their skills.

  This is due to changes being introduced in thoracic surgery and its relationship with cardiac surgery (explained below).

  They suggested that the ideal number of surgeons for a single unit in South Wales was five. This was based on the size of the population and the number of surgeons needed to provide 24 hour emergency cover.

A summary from the Royal College of Surgeons on the planned changes to training in Thoracic Surgery in the UK

One of the reasons we asked the Royal College of Surgeons to undertake a review of thoracic surgery in Wales is because thoracic surgery has become more specialised. We wanted to see what this meant for the way we provide thoracic surgery services.

Until recently, many surgeons who carried out thoracic surgery also carried out cardiac (heart) surgery. They are known as "dual practice" cardiothoracic surgeons.

At the end of their training, surgeons now qualify as either a cardiac surgeon or a thoracic surgeon (and not as cardiothoracic surgeons). The Society for Cardiothoracic Surgery has said that from 2020 there will no longer be dual practice cardiothoracic surgeons.

This means that from 2020 all thoracic surgery, including the provision of on-call (out of normal hours) cover and emergency surgery, must be carried out by dedicated thoracic surgeons. This is an important change as currently cardiac surgeons provide much of the out of hours and emergency thoracic cover.

From 2020, we will need enough surgeons to provide a full on-call rota in each centre. The Royal College of Surgeons have advised this is not sustainable for two centres. We therefore require a single centre.

The recently agreed All Wales Service Specification which outlines the standards we would expect from a unit delivering high quality thoracic surgical services.

All centres and surgeons in the UK which provide thoracic surgery services should meet nationally recognised standards. In England they have described these in the NHS England Thoracic Surgery Service Specification. These standards are based on evidence and are designed to ensure that services are high quality, safe and give the best outcomes for patients.

We have also agreed a Thoracic Surgery Service Specification for Wales based on these standards. These were agreed through a consultation process, which took place at the beginning of 2017.

The standards include:

- *A minimum number of thoracic surgery procedures for primary lung cancer that must be carried out in the centre. There is evidence to show that there are better outcomes for patients if they receive their surgery for lung cancer at larger centres where higher numbers of operations take place each year.*

  The standard states that a **minimum** of 150 thoracic surgery procedures per year for primary lung cancer must be carried out in a centre. The table below shows the number of procedures carried out in 2015 at each of the two current thoracic surgery centres.

Thoracic Surgery Centre	Number of Primary Lung Cancer Cases Operated
Morriston, Swansea	139
UHW, Cardiff	151

We expect the numbers are now higher than this and that the number of primary lung cancer cases suitable for thoracic surgery is likely to increase further in the next 3 to 5 years. This is mainly due to the increasing number of older people within the population, a rising

incidence of lung cancer in women and more cases being diagnosed at an earlier stage and therefore suitable for surgery. However, in the longer term, this number is likely to fall due to reductions in smoking (Public Health Wales, 2017).

This implies that if we retain two centres, the minimum standard of 150 primary lung cancer procedures per year may be met in the short to medium term, but there is risk it will not be achievable in the long term. However, if there is a single centre, the minimum standard of 150 primary lung cancer procedures per year would be achieved over the long term.

- *Requirements for emergency and on-call cover. This standard helps to ensure patient safety at all times, 24 hours a day for 7 days of the week.*

  The standard specifies that a thoracic surgeon or dual practice cardiothoracic surgeon (until 2020) should provide emergency cover. Any other kind of cover is unacceptable.

  The standard also specifies that a sustainable rota must not be more frequent than one in four. This means that each thoracic surgeon should not provide on-call cover more often than once in every four days. This ensures that surgeons are properly rested and able to provide a safe service for patients.

  For South Wales, this would mean that at least four thoracic surgeons will be needed at a centre. Therefore two centres in south Wales would need at least eight surgeons. Remember that the Royal College of Surgeons recommended that five surgeons would be an appropriate number for the size of population. There is unlikely to be enough demand across south Wales to give eight surgeons enough work to be able to keep their skills up to date.

Details of the staffing numbers, physical infrastructure and support services at the two units currently providing services

Resilience means the ability of the service to cope with unpredictable changes or risks. These might include:

- Episodes of staff sickness (across the whole team)
- Vacancies in the team
- National policy changes (e.g. affecting numbers of trainee surgeons or anaesthetists)
- Impacts from temporary reductions in the number of patients who can be cared for (e.g. a technical failure; infection control)

15

- Fluctuations in the numbers of patients requiring treatment

In general, a larger centre has more flexibility with which to manage these risks. This is due to it having a greater number of staff and larger facilities than a smaller centre. The greater opportunities for cross cover in a larger centre will help to maintain levels of service.

A larger team will provide the opportunity for surgeons, and other staff, to develop sub-specialty expertise. This will broaden the range of service that can be offered to the local population, which will reduce the need to travel to centres further away. This also helps to attract and keep staff as it provides greater opportunity to develop their skills and career.

Summary of the Reasons for Change

Table 1 summarises the reasons for change to a single centre model based on the evidence considered in this document.

Table 1: Summary of the reasons for change:

	Issue Considered	Implications for two centre model	Implications for single centre model
External professional advice: Royal College of Surgeons	Ability to maintain staffing in light of changes in cardiac and thoracic surgery training	Advice from RCS that there would not be enough staff that could adequately maintain a two site model in the future.	Clear recommendation from RCS to adopt a single centre model to ensure sufficient staffing is maintained.
Service Specification: Quality standards	Minimum 150 lung cancer operations per annum	While it is likely we are able to achieve or nearly achieve the minimum numbers in the next 3-5 years, it is less clear we can do this in the longer term.	Minimum number of operations will be performed consistently over the long term.
	Ability to maintain an on-call rota (not less than 1 in 4)	If we employed 8 surgeons across south Wales there would not be enough work for them to do when they are not on-call. This would mean we would find recruitment difficult.	The rota will be able to be maintained.
Service Delivery	Service flexibility & benefits of scale	Smaller units mean it's more difficult to cover sickness or unexpected changes. Also we will not have enough staff for sub-specialisation.	More likely to be flexible because there will be enough staff to cover during periods of increased demand or sickness. Improved opportunity for sub-specialisation.

15

Are there any risks to other services if thoracic surgery is moved from one hospital and concentrated in a single hospital site?

Some health services are 'inter-dependent' with others such that if one of the services is taken away, another service will have problems functioning. However, this is not the case with thoracic surgery. If thoracic surgery was moved from the University Hospital of Wales to Morriston Hospital, or vice versa, this would not affect the ability of other services at either of these hospitals to continue as normal.

Having considered the evidence, if the Project Board recommends there should be a single centre, its preferred location will be informed by an assessment against agreed criteria. This will be conducted by an Independent Panel.

2.2 What is the role of the Independent Panel?

The Independent Panel will be made up of a range of clinical experts, service users, third sector representatives and an independent Chair. It will not include representatives from the local region because it's important that the panel is truly independent. The panel will make sure there is balance, transparency and clarity.

The panel will use the criteria which come out of this engagement process to make a recommendation on which site thoracic surgery should be situated in the future. To do this they will look at the evidence provided to them by the WHSSC team and will score the centres using their expertise and experience. There will be support for the panel in doing this by the Swansea Centre for Health Economics based at Swansea University who are experts in what we call 'group decision making'.

They will consider, if surgery is to be performed at only one centre, where that centre should be. This will then go as a recommendation to the Joint Committee. The panel will only consider Morriston Hospital, Swansea, or the University Hospital of Wales, Cardiff. The reason is that these are the only 2 centres who already have the expertise in how to delivery thoracic surgery and have cardiac surgery on site. The service specification recommends co-location with cardiac surgery:

- *Other co-located services*
  The thoracic surgery service will benefit from co-location with cardiac surgery:
  - *To share cardiothoracic trainees*
  - *Operational efficiencies from pool of support staff skilled in both thoracic and cardiac surgery.*

Thoracic surgery services must be located on a site where there is cardiac surgery but they are not dependent on any other major services. You may be aware that there is work underway to decide on the location of a major trauma centre for South Wales. It is important to understand that thoracic surgery does **not** need to be on the same site as major trauma services. This means that if we decide to have a single centre for thoracic surgery, this will not have an impact on the decision around a major trauma centre and visa versa.

2.2.1 What criteria will be used by the Independent panel to make a recommendation?

Below are the 4 criteria which we think are important:

A. **How easy will it be for patients to access care at that unit?** To measure this we will look at travel times/distance and the availability of public transport

B. **How easy will it be for the unit to meet the standards required of a high quality unit (these standards are described in the Service Specification)?** By Standards we mean whether they have the staff, equipment, space, particularly surgical theatre space etc which are necessary to deliver high quality care. To measure this we will look at the current standard of service, the gaps between the current services and the standards described in the Service Specification.

C. **How sustainable is the unit? By this we mean how likely is the unit to be able to meet our needs in the future?** We will want to know if the unit could increase their capacity (the number of patients they can treat) in the future if needed. We want to know if the unit has problems recruiting staff at the moment and if they do what are their plans for the future. Also whether there other developments planned at the site which may have an effect on the delivery of thoracic surgery.

D. **Will the unit help improve the standards of care across South Wales?** To measure this we want to know if the unit has links with universities or colleges. Does the unit have other experts (non-surgeons) or links with other experts who will help develop new services this includes services for patients who are being treated in local hospitals outside the centre.

3. WHAT DO YOU, AS STAKEHOLDERS, NEED TO DO?

Having read this document, we need you to give us feedback on the form provided at the back of the document.

We would like feedback on the following points:

1. Is there other evidence we should provide to the project Board to help them make a decision on whether there should be one or two sites?
2. Is there anything else we should do to improve this part of the process?

If the project board recommends one site then we will ask an independent panel to make a recommendation on whether this should be sited at Morriston Hospital or the University Hospital of Wales. We therefore also need your feedback on the criteria we use. We have suggested some criteria above and we need to know:

1. Whether you agree with the criteria or if you think there are other criteria which we have missed out?

2. What sort of evidence you think we should consider to measure how well the units can meet these criteria. Do you think our suggestions work or whether we could measure them differently?

People can provide feedback either as individuals or through their organisation (just let us know which one).

We would like feedback as soon as possible but the deadline is **10th November 2017**.

It is very important we get the process right in order we make the best decision we can, so the more feedback we receive the better.

Further information:

Below are links to further information which you may find helpful in understanding the situation and the planned process:

- Specialised Services Service Specification: Thoracic Surgery http://www.whssc.wales.nhs.uk/policies-and-procedures-1
- Royal College of Surgeons http://www.whssc.wales.nhs.uk/reviews-other-
- Lung Cancer Guidelines https://www.nice.org.uk/guidance/CG121
- British Thoracic Society https://www.brit-thoracic.org.uk/

15

- Cancer research UK http://www.cancerresearchuk.org/about-cancer/lung-cancer
- MacMillian Cancer Support http://www.macmillan.org.uk/information-and-support/lung-cancer/non-small-cell-lung-cancer/treating/surgery/surgery-explained/surgery-for-non-small-cell-lung-cancer.html -
- Roy Castle Lung Cancer Foundation https://www.roycastle.org/how-we-help/lung-cancer-information/information-about-treatments/surgery

15

Thoracic Surgery Services in South Wales Engagement

Stakeholder Response

Deadline for comments	Please complete and return your form by e-mail to ThoracicSurgeryReview@wales.nhs.uk by 5.00pm on 10th November 2017
Your Name	
Are you replying on behalf of an organisation?	Yes / No
If yes, name of organisation	

Declaration: Before completing this feedback form you must declare any financial or other interests in relation to any specialised services directly relevant to this engagement process. [Please refer to the WHSSC 'Standards of Behaviour' policy]
Interests to be declared:

Instructions for submitting comments

- Answer the questions overleaf
- Please note that responses will be made public. Therefore please underline and highlight any confidential information or other material that you do not wish to be made public
- Do not include medical information about yourself or another person from which you or the person could be identified
- Spell out any abbreviations you use
- For copyright reasons, comment forms must not include attachments such as research articles, letters or leaflets.

15

Questions for stakeholders	
1	Is there any other information you think we should consider in order to decide whether we need one or two thoracic surgery centres in South Wales? …… …… …… …… ……
2	Is there any other information you think we should include in the criteria that will be used by the Independent Panel? …… …… …… …… ……
3	Do you have comments on the process we are using to inform recommendations on the future thoracic surgery services? …… …… …… …… ……
4	Do you have any other comments on the information presented in this document? …… …… …… …… …… ……

AUDIT OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD'S CONTRACTUAL RELATIONSHIPS WITH RKC ASSOCIATES LIMITED AND ITS OWNER	
Name of Meeting: Board Meeting	**Date of Meeting:** 28 September 2017

Executive Lead: Chief Executive
Author: Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well: This report underpins the "Values" element of the Health Board's Strategy.
Financial impact: As identified in the Wales Audit Office report
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number: Governance, leadership and accountability and Standard 7.1 Workforce
CRAF Reference Numbers: 8 and 9
Equality and Health Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Audit Committee's monitoring of the action plan provided as part of this report.

RECOMMENDATION

The Board is asked to:

- **NOTE** the contents of this report.

SITUATION

The report of the Auditor General for Wales regarding the UHB's Contractual Relationships with RKC Associates Ltd and its Owner was published in July 2017. It identified a number of serious concerns in relation to the awarding of the consultancy contracts to RKC Associates Ltd, the management of the recruitment process to appoint the replacement Director of WOD, and the way in which information was relayed to the UHB Board and its Remuneration and Terms of Service Committee.

BACKGROUND

A report was provided to the Board on 27 July 2017 where it was agreed that the Audit Committee would monitor the progress of actions and provide the Board with the assurances required.

ASSESSMENT AND ASSURANCE

The UHB, in conjunction with its colleagues in Procurement and Human Resources / Workforce, has developed a comprehensive action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future.

This action plan is included with this report at Appendix 1 and seeks to provide the Board with the assurance that the UHB has learned fully from this incident and taken definite steps to avoid this happening again.

It should be noted that the Chair and Chief Executive attended the Public Accounts Committee on 25 September to discuss the Auditor General's report, and the action plan was provided to that Committee.

The action plan was presented to the UHB's Management Executive Team meeting on 21 August 2017 and its HSMB on 21 September 2017. As agreed at the previous Board meeting the action plan is being presented at the Audit Committee on 26 September 2017 and will thereafter be monitored by it. The action plan has also been shared with the Wales Audit Office.

The UHB identified a number of additional improvements that are required in addition to those highlighted by the Auditor General and these are included within the action plan.

Action Plan in Response to the Wales Audit Office Report in Respect of Cardiff and Vale University Health Board's Contractual Relationships with RKC Associates Ltd and its Owner

Conclusion 1 - The way in which the Cardiff and Vale University Health Board (UHB) procured and managed HR consultancy contracts awarded to RKC Associates fell well short of the standard that the public has a right to expect of a public body
a) The UHB failed to comply with its own procurement procedures when it awarded consultancy contracts to RKC Associates in November 2014 and June 2015 and in consequence both the contracts and payments made under them are potentially unlawful. b) The award of consultancy contracts to RKC Associates breached public procurement rules. c) The UHB failed to undertake due diligence checks of RKC Associates resulting in the UHB being exposed unnecessarily to financial and reputational risk. d) The UHB was in breach of its own Standing Financial Instructions when it agreed contracts with RKC Associates which had been drafted by the owner of RKC Associates. e) The UHB appointed the owner of RKC Associates to deliver consultancy projects, but the UHB utilised her as a senior member of staff and, in consequence, has potentially over-claimed VAT amounting to £58,162. f) As the Officer who signed the contracts with RKC Associates in November 2014 and June 2015, the UHB's Chief Operating Officer had a duty to ensure proper process had been followed. The failure to do so has cast doubt on whether the decisions to award these contracts were based entirely on valid considerations. g) The UHB did not exercise effective financial monitoring of its contracts with RKC Associates, with payments exceeding the contracted value and contractual expenses not being verified.

Dated: 8 September 2017

Appendix 1

UHB Response to Conclusion 1

Following publication of the Wales Audit Office report, a full report was received at the UHB's Board meeting on 27 July 2017 and discussion conducted in the public session of that meeting. In addition, the report has been raised at the meetings of our Management Executive (ME) and Health Systems Management Board (HSMB), and discussed with Senior Trade Union / Staff Side representatives and at our Local Partnership Forum (LPF).

As acknowledged by the Wales Audit Office, the UHB has a number of detailed policies and procedures covering this area. These have been developed to standardise processes based on best procurement practice and set out the governing principles for public procurement, for example, the Scheme of Delegation, Standing Orders, Standing Financial Instructions and Financial Control Procedures. Regrettably, these processes were not followed on this occasion, and there was no reference to the UHB's Head of Procurement as provided for in our Scheme of Delegation.

The Procurement Guide for Staff which was developed in conjunction with NHS Wales Shared Services Partnership Procurement Services, and approved through the All Wales Directors of Finance Sub Group in 2015, is provided to UHB staff as part of the training delivered by the UHB Procurement Department and will be further reinforced throughout the UHB.

Prior to the Wales Audit Office report, a review of our processes was already in train in response to changes to the IR35 legislation[23] relating to off-payroll working in the public sector. In addition, the process around requesting approval of contracts has been changed, a procurement checklist that sets out a defined approval hierarchy has been implemented to ensure compliance with Standing Orders and EC Regulations and that more than one signatory is obtained. All external Consultancy contracts are now signed off by the CEO.

The UHB, in conjunction with its colleagues in Procurement and Human Resources / Workforce, has developed this action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future. The Action Plan will be presented to the UHB Board on 28 September 2017 and its Audit Committee on 26 September 2017 and will thereafter be monitored by the Audit Committee. The Action Plan has also been shared with Wales Audit Office.

1 Her Majesty's Revenue and Customs (HMRC) introduced the 'intermediaries legislation' commonly known as IR35or off-payroll rules in April 2000. This legislation is intended to combat tax abuse by an individual who would be treated as an employee were it not for the fact that they provide their services via their own company, called 'disguised employees' by HMRC. From April 2017, where a public sector organisation engages an off-payroll worker through their own limited company, that organisation will become responsible for determining whether the rules should apply, and, if so, for paying the right tax and National Insurance Contributions.

8 September 2017

Appendix 1

Conclusion 1 Action Plan	Lead	Completion	Update
Training			
1. Provide training for all Board members on the law, rules and regulations relating to employment and procurement at the August Board Development Day.	Director of Corporate Governance	August 2017	**Complete** Training delivered on 31 August 2017.
2. Cascade the training provided at Clinical Board senior management teams and throughout the organisation to Directorate Management level.	Executive and Clinical Board Directors	October 2017	Discussed at ME on 4 September 2017.
Review			
3. Undertake review of external consultancy categories in the purchase to pay system for period 2014-2017 to ensure compliance with procurement rules.	Head of Procurement	August 2017	**Complete** Reports received by CEO and Director of Finance.
4. Review the Procurement Guide for Staff and revise to reflect process changes connected with the IR35 legislation.	Head of Procurement	September 2017	**Complete**
Process			
5. Provide the Procurement Guide for Staff to the Management Executive Team meeting for cascading to Clinical Boards, and Corporate Departments.	Director of Finance	September 2017	To be presented to ME on 22 September 2017.
6. Publish the Procurement Guide for Staff across the UHB and place on intranet and internet for ease of staff access.	Director of Corporate Governance	October 2017	
7. Implement a no purchase order, no payment system to prevent the processing of manual payments.	Head of Procurement	March 2018	Phased implementation, commencing September 2017, full implementation by March 2018.
8. Develop and cascade process guidance for off-payroll working.	Head of Procurement	August 2017	**Complete** Approved by ME on 14 August 2017, taken to HSMB on 17 August 2017 for cascading by Clinical Board Directors.

8 September 2017

Appendix 1

Conclusion 2 - The way in which an HR consultancy contract was awarded to RKC Associates in February 2016, along with the actions of key decision-makers, compromised the integrity of the procurement process
a) The UHB embarked upon a procurement process for a contract and invited and evaluated tenders for that contract, despite the fact that RKC Associates had been engaged in advance of the tender process. b) The robustness and integrity of the advertised procurement process was compromised in several key respects and the UHB's Chief Operating Officer participated in the process despite knowing that RKC Associates had already been engaged in advance of the procurement process commencing. c) The Procurement Department failed to keep adequate documentation of the procurement process. d) The UHB delayed seeking formal written approval for the fixed-term appointment of a new Director of Workforce and Organisational Development, resulting in the UHB incurring unnecessary expenditure on a consultancy contract.
UHB Response to Conclusion 2 The UHB has taken steps to strengthen its existing processes and extend training at all levels to reinforce the requirements in relation to these areas. We recognise however that policies / procedures and training, whilst the foundation of good practice, are part of a bigger picture that includes a culture of sound behaviours and values, adherence to the rules at all levels of the organization, checks to ensure this is happening and an environment that enables individuals to confidently highlight departure from any rules no matter how senior those involved. As part of the communication with the UHB following receipt of this report, the CEO has asked staff to share any concerns they may have with him and provided assurance that anything raised will be explored to provide reassurance regarding our systems / processes and decisions made. Procurement compliance reports are already presented to the UHB's Audit Committee outlining for example Contract Extensions and Single Quotation or Single Tender Actions. Steps are also being taken to put in place more vigorous checks around our processes to flag potential issues and to achieve more robust oversight and business scrutiny by our Management Executive Team, Board and its Committees. We are committed to utilising temporary employment contracts rather than consultancy contracts wherever possible.

8 September 2017

Appendix 1

Conclusion 2 Action Plan	Lead	Completion	Update
Training			
1. Develop and deliver an enhanced training programme for procurement staff focusing on the conclusions of the Wales Audit Office report.	Head of Procurement	September 2017	Training underway
2. Obtain quality management accreditation for the Procurement Department in respect of its tendering processes.	Head of Procurement	November 2017	Applied for accreditation, assessment taking place in October 2017.
3. Develop a Procurement flowchart for use by Board and Senior Managers.	Head of Procurement	October 2017	Draft developed, for presentation to ME.
Audit			
4. Enhance existing audit processes within the Procurement Department to verify compliance with contract procedure.	Head of Procurement	September 2017	Frontline Audit Review Guidance produced, 30 audits completed to date with no significant issues highlighted.
5. Review Internal Audit Programme to include audits relevant to the issues highlighted in this report and to test compliance with new processes.	Director of Finance	September 2017	Appropriate Internal Audit days identified in programme for 2018.
Assurance			
6. Enhance the statutory compliance report provided at each Audit Committee to include our compliance with and exceptions to recruitment requirements, Standing Orders and Standing Financial Instructions.	Directors of Finance and Workforce and Organisational Development	September 2017	Report to be presented to September Audit Committee and further developed.
7. Review the Terms of Reference for the Remuneration and Terms of Service Committee to include a requirement to report any Executive level secondments and Consultancy appointments for approval to this Committee.	Director of Corporate Governance	October 2017	

8 September 2017

Appendix 1

Conclusion 3 - The process followed by the UHB that led to the appointment of the owner of RKC Associates to the position of Director of Workforce and Organisational Development in April 2016 was fundamentally compromised, lacked transparency and was poorly documented.
a) It is unclear why the UHB decided to proceed with a recruitment process for a Board level position with only a single candidate who had not applied for the position when it was originally advertised. b) The recruitment process was poorly documented and, as a consequence, it is not clear when the person who had been overseeing the recruitment exercise became a candidate. c) The integrity of the recruitment process was compromised because the sole candidate had access to some of the assessment questions in advance of being interviewed for the position. d) The information provided to the Board and its Remuneration and Terms of Service Committee regarding the appointment was inaccurate, incomplete and inconsistent.
UHB Response to Conclusion 3 High level appointments are not as frequent as other positions within the UHB and are often challenging to recruit due to small numbers of applicants with the relevant skills and experience. As a result of this report, the UHB has looked at how these senior appointment processes are conducted and how the office of the Chief Executive and Director of Workforce and Organisational Development can work better together to ensure compliance with processes and that satisfactory documentation is maintained. We also recognise that we can better support our Independent Board Members in relation to their Committee roles, to equip them to confidently scrutinise decisions and hold us to account.

8 September 2017

Appendix 1

Conclusion 3 Action Plan	Lead	Completion	Update
Review			
1. Review the procedures used to recruit Executive Directors and other Senior Managers.	Assistant Director of Workforce and Organisational Development	July 2017	**Complete**
2. Review the quality of information and its presentation to the Remuneration and Terms of Service Committee.	Chair and Director of Corporate Governance	September 2017	
Process			
3. Revise the Executive recruitment process to include a clear defined role for the Director of Workforce and Organisational Development which can be delegated to their Deputy or Director of Corporate Governance if circumstances require or a conflict arises.	Chief Executive	August 2017	**Complete** Used for the recruitment of the substantive Director of Workforce and Organisational Development in August 2017.
Training			
4. Arrange training for Independent Board Members, including those sitting on the Remuneration and Terms of Service Committee, covering their roles and responsibilities. This should also provide them with example questions they may wish to ask and the minimum information they may require to assist them in discharging their role.	Director of Corporate Governance	August 2017	**Complete** Included in the programme for the August Board Development Day.
5. Provide legal and governance training for all Board members on their roles and responsibilities at the October Board Development Day.	Director of Corporate Governance	October 2017	Training confirmed and programme planned.

8 September 2017

Appendix 1

Additional Improvements			
Action Plan	**Lead**	**Completion**	**Update**
Whistleblowing			
1. Review current Procedure for NHS Staff to Raise Concerns which includes whistleblowing to ensure it is fit for purpose and easy for staff to raise any concerns regarding non-compliance.	Director of Workforce and Organisational Development	October 2017	As this is an All Wales Procedure, to be raised at the Directors of Workforce and Organisational Development Group.
2. Develop an internal protocol providing a system for senior leaders to raise concerns, with clear lines of reporting should a concern relate to the Chair, Vice Chair or Chief Executive.	Director of Corporate Governance	October 2017	To be raised at the August All Wales Board Secretaries Group to explore best practice.
Governance and Accountability Framework			
3. Revise the UHB Governance and Accountability Framework to reflect any amendments by the Directors of Finance All Wales Group to the Standing Financial Instructions and Standing Orders.	Director of Corporate Governance	March 2018	Update provided to Audit Committee in September 2017 and each subsequent meeting.
4. Review and revise the UHB's Scheme of Delegation.	Director of Finance	October 2017	
5. Circulate a bulletin to the UHB Board and throughout the UHB reinforcing the Nolan principles of Good Governance and duties of probity / candour and the Values and Standards of Behaviour Framework.	Directors of Corporate Governance and Communications	October 2017	Communications strategy agreed.
Communication			
6. Communicate openly and transparently with staff about the findings of this report, the actions being taken by the UHB and their progress. This will include public meetings of Board / Audit Committee and meetings of LPF, Clinical Board Directors, HSMB and publishing of the action plan on the intranet for access by all staff, supplemented by other communication bulletins.	Chief Executive and Chair	October 2017	Reports at Board, ME, HSMB, LPF. Continued dialogue with Senior Trade Union / Staff Side representatives and CEO communication placed on intranet and internet.

8 September 2017

FINANCIAL GOVERNANCE REVIEW OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD	
Name of Meeting : Board Meeting	**Date of Meeting:** 28th September 2017

Executive Lead: Chief Executive
Author : Director of Corporate Governance
Caring for People, Keeping People Well: The review supports the robustness of the financial plan to support the IMTP/ Operational plan.
Financial impact : The cost of the review was funded by Welsh Government
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number: 1
CRAF Reference Number: 6.7
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The review was commissioned by Welsh Government
- The report is an independent review of the financial governance of Cardiff and Vale University Health Board carried out by Deloittes LLP
- The methodology to be used for the review was agreed between Deloittes and Welsh Government

RECCOMMENDATIONS
The Board is asked to:

- **NOTE** the contents of the Report on the independent review of financial governance of the Health Board
- **AGREE** for the Audit Committee to progress and monitor the recommendations in the report and receive assurances where necessary.

SITUATION

This report summarises the outcome of an independent financial governance review of Cardiff and Vale University Health Board. This was carried out by Deloittes LLP against a scope set out in a contract with Welsh Government dated 2nd March 2017. Deloittes undertook their review between March to May 2017. The outcome was presented to Welsh Government and the Health Board in early July 2017. Attached report is the Action Plan to address recommendations from the report.

BACKGROUND

On the 6th March 2017, the Director of Finance in Welsh Government wrote to the Interim Chief Executive explaining the role and purpose of the independent review to be conducted by Deloittes LLP.

As part of the targeted intervention the Welsh Government had commissioned Deloittes LLP to undertake this financial review of the development, adaptation and performance of the Health Board's 2016-17 financial plans. The aims and objectives of the review were:

Aim:

To review, on behalf of the Welsh Government, the internal governance arrangements of designated NHS Wales organisations with regard to the development, adoption and performance of their financial plans. To identify lessons to be learned by the organisations, other NHS Wales organisations and Welsh Government on this process.

Objectives:

Deloittes LLP review included:

- Review the management processes adopted for constructing draft and final versions of the 2016-17 financial plan as part of the IMTP or operational plan process.

- Review the process for seeking and obtaining Board approval for the draft and final versions of the financial plans.

- Review the process for considering and addressing issues raised by Welsh Government on the draft and final financial plans

- Review the process for monitoring monthly financial performance against the plan.

- Review the process for reporting performance to the Board

- Review the process for reporting financial performance to Welsh Government

- To make recommendations to the Board for improvements in the processes of constructing and monitoring performance against financial plans

- To make recommendations to Welsh Government on any wider governance lessons to be learned across NHS Wales.

ASSESSMENT AND ASSURANCE

The independent review was conducted through methodology set out in the contract with Welsh Government in March 2017. The review included the following activities:

- Desk top review of key Health Board documentation, including Minutes, Board and Committee reports, Terms of References and Policies
- Non-attributable interviews with a range of external partners, Board Members and senior staff
- Observations of Board and Committees
- Board and Key Staff surveys
- Focus group, including financial leads
- Update and validation meetings with Welsh Government and the Health Board

The findings of the review are summarized below :

- Cardiff and Vale is at the start of a period of change in relation to strengthening financial awareness, accountability and responsibility. There was created a culture of reliance on non-recurrent support without real focus on grip and control to manage budgets. The interim Chief Executive Officer and Director of Finance, in close co -operation with the wider Executive Team, have introduced successful measures to increase grip and control, such as “Turning the Curve” to reduce the 2016/17 forecast deficit and the introduction of a new Finance Committee.

- The Independent Member (IM) cohort has experienced capacity gaps for much of 2016/17 and there will be further gaps as a number come to the end of their terms in 2017/18. However, IMs who will continue in role have a good range of financial and commercial expertise, demonstrated good levels of challenge and debate and the Chair appears to actively encourage openness and transparency.
- Board members are also actively engaged in the scrutiny of financial plans and the Integrated Medium Term Plan (IMTP). The arrival of a substantive Chief Executive Officer and other new members to the Board presents an opportunity to build on the work already undertaken in relation to Executive team and Board development.

- The current approach to financial planning is traditional, based on adjustments to rollover budgets with limited provision for changes to service models, demand and capacity. In addition, Cost Improvement Programmes (CIPs) have primarily been delivered in a transactional, Clinical Board-centric manner. The Health Board does however recognize the requirement to move towards a cross organisational approach to transformational savings. Finance, PMO and Planning support should be strengthened to support development and

implementation of an approved IMTP, CIPs and associated financial plan.

- The IMTP and 2017/18 operating plan sit within the context of a 10 year strategic plan. Limited reference was observed to the financial impact of initiatives within the IMTP however, and the financial plan is not currently linked to service and enabling plans. There is an imperative for the Health Board to establish a clearly integrated strategy to identify and deliver the service changes and cost reductions essential to moving the Health Board into sustainable financial balance.

- Clinical Board structures are well established, supported by a Performance Management Framework. Clinical Board engagement is good and improving, particularly clinical engagement under the Interim Chief Executive Officer. Stronger challenge could be delivered by the Executive Directors in the Clinical Board performance meetings. There is also opportunity to strengthen financial reporting for these meetings, and at Clinical Board and directorate level including narrative driving insight into factors underpinning financial performance, risks and mitigating actions. There has been a focus during 2016/17 on leadership development in Cardiff & Vale; however this included limited focus on financial skills and knowledge development.

- Opportunities exist to strengthen reporting to the Board and Finance Committee, such as inclusion of the underlying trading position insight driving narrative, and increased integration of financial, CIP and operational information.

The review identified 22 recommendations which can be summarized into the following categories:

- Delivery and Board monitoring
- Management processes
- Board approval
- Delivery

The attached action plan has been developed to address each recommendation in the report. This was presented to Audit Committee on 26th September2017 and will be further reviewed at the meeting on the 5th December 2017.
The Audit Committee will regularly up-date the Board on progress and provide the Board with appropriate assurances.

Independent Review of Financial Governance Within Cardiff and Vale University Health Board Undertaken by Deloittes - Recommendations/Action Plan 2017

1st Draft 08.08.17

Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (Describe)	Assurance Committee	Date Reported to Assurance Committee
Implement an Executive Director (ED) Team Development Programme to focus on further developing an effective team	Chief Executive	The Chief Executive is considering team development for later in the year. In the first instance, a weekly two hour Executive Director's "time out" - was established in July 2017. This will provide opportunities for Executive Team development	In progress	Formal Management Executive Meeting	Monthly review
Consider the appropriateness of the current ED responsibilities for Informatics and Information Technology	Chief Executive	Review to be completed by November 2017	In progress	Strategy & Engagement	Dec-17
Ensure there is allocated time within the current Board Development Programme to provide training and support to interpret financial management information, particularly for the new IMs	Executive Director of Finance	Supplementary training sessions introduced in 2017 for new IM's with further sessions planned this year.	Sessions started and to be completed for new Independent Members	Governance Coordinating Group	Dec-17
Introduce monthly Board meetings in addition to bi-monthly Board Development sessions to provide an opportunity for BMs to receive and challenge assurance reports, particularly from the Finance Committee	Chair	Not required. We have a monthly Finance Committee meeting which is working effectively and providing the financial scrutiny required. These assurances are then provided to each meeting of the Board	No further action required	Finance Committee/Board	Nov-17
Update the terms of reference of the Finance Committee to ensure that the Board Chair is not a member or the Chair of this committee, and all committee Terms of Reference to state that the Board Chair should attend each committee on a rolling basis	Chair	To be reviewed by end of October 2017 when new Independent Members identified. This will include review of Committee Membership including Chair of this Committee.	Awaiting new IMs to start to undertake review of Committee membership and Chairs	Board	Oct-17
Improve the committee reporting process to Board by ensuring the assurances or gaps in assurance are clearly drawn out from committee meetings, and co-locate the committee minutes/Executive Summary with the relevant ED report	Executive Directors	The Board and Committees paper template has a section on assurances to be provided and be further emphasized. In addition the governance coordinating group review regularly cross committee working and this recommendation will be also be brought to their attention	Completed	Board	Sep-17
Address areas for development identified within the Board and Finance Committee finance reports, such as inclusion of the underlying financial position, increased insight driving narrative, and greater integration of financial, operational performance and CIP information	Executive Director of Finance	Recent improvements will continue to be developed to incorporate issues highlighted	In progress	Finance Committee	Apr-18
Develop more detailed budget setting guidance, supporting increased transparency in budget allocation to Clinical Boards, directorates and cost centres and strengthened ownership for delivery. This should include more direct linkage between expenditure budgets and activity and productivity targets	Executive Director of Finance	Consideration for incorporation into 2018/19 budget setting process. Budget setting guidance to be developed and to be introduced in January 2018 for implementation in new financial year linked to activity	In progress	Finance Committee	Jan-18
Introduce a formal budget sign-off process at Clinical Board and directorate level, supporting increased understanding of budgets allocations and more explicit ownershp for delivery	Executive Director of Finance	The practicality of this will be explored v benefits derived	In progress	Finance Committee	Apr-18
Consider simplification of the range of Cost Reduction Programmes, articulating and communicating the objectives of individual initiatives and their interrelationship across the organisation	Executive Director of Finance	Primary budget holder will be requested to provide information in performance meetings and implemented from January 2018	In progress	Finance Committee	Jan-18
Investigate and assess cross-cutting and transformational cost reduction opportunities, including identification of underpinning initiatives and quantification of financial impact. Prioritise initiatives and develop plans for implementation, including mechanisms to support and incentives cross-CB implementation at pace	Executive Director of Finance	1. Cross Cutting items forecast reduction already in place. 2. Transformation opportunities will be part of this implementation including cross CB working.	Completed	Finance Committee	October 2017
Define future finance function focus, required skills and capabilities, to allow the function to act as a key enabler for implementation of the IMTP	Executive Director of Finance	Ongoing as part of all Wales NHS finance staff development, clear working with planning department established	Completed	Finance Committee	Oct-17

Independent Review of Financial Governance Within Cardiff and Vale University Health Board Undertaken by Deloittes - Recommendations/Action Plan 2017

1st Draft 08.08.17

Determine future planning function required in the organisation to both develop an approved IMTP, with balanced financial plan and deliver its implementation	Chief Executive	Strengthen planning function to enable additional finance planning capacity. Review of Corporate resources being undertaken in October 2017	In progress	Management Executive	Nov-17
Determine the future PMO function, including focus, skills and capabilities, establishing a function that will act as a critical enabler for implementation of the IMTP and financial recovery at increased pace	Executive Director of Strategic Planning	Review to be implemented and completed by end of October 2017. For discussion with the Chief Executive	In progress	Director of Planning / Chief Executive	Nov-17
Develop an enhanced financial strategy taking account of expected demand, capacity, service, corporate and wider transformational changes (short, medium and longer term)	Executive Director of Finance	Will be incorporate into an integrated improved IMTP process	As per IMTP implementation dates	Management Executive/Board	Nov-17
Ensure regular Board level scrutiny of financial risks within the 2017-18 financial plan and actions in place to mitigate these	Executive Director of Finance	Scrutiny taken place already but level of scrutiny to be increased - training planned for Board memebers October 2017. Risk Register and assurances provided to the Board by Chair of Finance Committee	Completed	Board	Nov-17
Create opportunities for Clinical Board leadership teams to share information to ensure that good practice can be shared widely. The EDs have a role to play in this as part of their oversight of operational structures	Executive Directors	To be included in Performance Reviews, commencing September 2017	Completed	Management Executive	Nov-17
Ensure that there is a coordinated approach to leadership development for the Clinical Board and Clinical Directorate leadership team, including arrangements for specific finance focused training	Chief Operating Officer	To be discussed with the new Director of Workforce and Organisational Development when in post (October 2017)	In progress	Performance Reviews	Jan-17
Clarify the trigger point(s) for a Clinical Board to be placed into protected administration, and ensure that all CB leadership teams understand this	Chief Executive	Discussed at Executive Directors 'Time Out' on 28 July 2017. Chief Executive review of escalation processes in progress	In progress - further reviewed planned	Audit Committee	Nov-17
Ensure the Clinical Board Performance Review Meetings are both challenging and supportive, and focused on clear, timely actions to address areas of concern	Chief Executive	Management Executive to review performance reviews	In progress	Management Executive	Oct-17
Use the opportunity of the new CEO to reconsider the focus of Health Services Management Board to ensure that it fulfils its role as the key forum to oversee all aspects of operational delivery	Chief Executive	HSMB to be reviewed by Chief Executive by end of October 2017	In progress	Management Executive	Oct-17
Improve the quality of Clinical Board performance information, including drilling down to directorate level metrics with a supporting narrative	Chief Operating Officer	To be considered as part of the Performance Reviews	In progress	Management Executive	Nov-17

CHAIR'S ACTION TAKEN ON BEHALF OF THE BOARD	
Name of Meeting : Board Meeting	**Date of Meeting** : 28th September 2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well not applicable
Financial impact: All Capital investments are funded from within the UHB Capital Programme.
Quality, Safety, Patient Experience impact: appropriate policies and procedures have been adhered to.
Health and Care Standard Number : Governance Leadership and Accountability
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Adherence to UHB Standing Orders

The Board is asked to:

- **RATIFY** the action taken by the Chair.

SITUATION AND BACKGROUND

This report details actions 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.

ASSESSMENT AND ASSURANCE

Affixing the UHB Common Seal

The UHB Common Seal has been applied to 3 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.

Register No.	Description of documents sealed
825	Contract Sale of Freehold Land @Longcross House, Longcross St between C&V UHB and Cardiff Community Housing Association Ltd
826	Licence for Alterations (minor works). Aeron Properties Limited & Cardiff & Vale UHB
828	Lease – Cardiff and Vale University Local Health Board and Cardiff University. Lease of land at University Hospital of Wales, Heath Park, Cardiff, CF14 4XW.

Chair's Action

31/07/2017 – Procurement Strategy for the proposal temporary modular theatre at University Hospital Llandough

30/08/2017 – Report title provision of hand towels and toilet tissue

12/09/2017 – Picture Archiving Computerised System (PAC). NWIS All Wales Framework Contract

Other Signed Legal Documents

24/07/2017 – Supplemental Agreement relating to an Agreement for Lease and Development of Land at University Hospital of Wales, Heath Park, Cardiff

24/07/2017 – Managed Services Contract (Haematology) Period (1st Oct 2017 to 30th Sept 2025). Approved at the private meeting of the Board at 27/07/2017

06/09/2017 – Delivery Agreement Part B. Provision of Project Management, Cost Management Structural and M&E Design, for the installation of the temporary theatre modular unit/services between Cardiff and Vale University Health Board and Perfect Circle JV Ltd, UHL Temporary Modular Single Theatre and 2nr Recovery Bays, CFMS0095

CORPORATE RISK AND ASSURANCE FRAMEWORK – UPDATE REPORT	
Name of Meeting: Board	**Date of Meeting:** 28 September 2017

Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact: The CRAF includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number: 2.1
CRAF Reference Number: Not applicable
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mitigation of our risks being monitored by Board and the appropriate Committees of the Board albeit the information provided via the CRAF requires strengthening.

The Board is asked to:

- **CONSIDER** the CRAF Update Report.

SITUATION

Following the Board meeting on 25 May 2017, and agreement to review and renew the Risk Management Process, we are continuing to engage with Clinical Boards and Corporate areas to support review / amendment of their risk registers.

This analysis is resulting in many areas having to revisit their registers and make significant changes to more accurately capture their risks and controls, and identify appropriate target scores and key actions required to achieve these.

The short, simple procedural guide referred to in the previous report is now being finalized following feedback and will be disseminated at the start of October 2017.

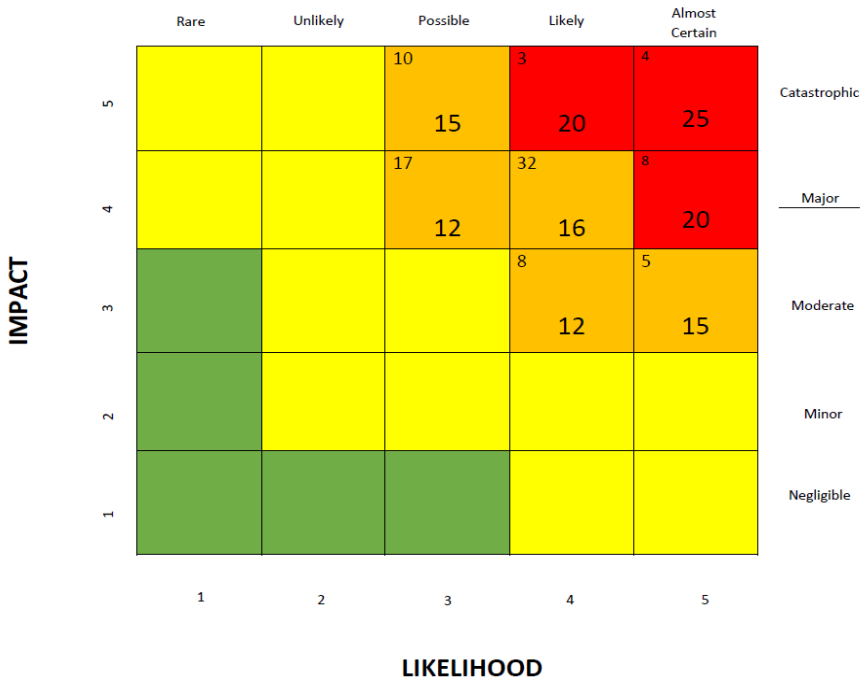
BACKGROUND

Each risk contained within the CRAF is assigned to Board or a Lead Committee for oversight.

The Board agreed the production of more visual, less text based standardized reports and this report is prepared with that aim in mind albeit the detail is extracted from the CRAF in its current format (updated 11 September 2017). As work progresses, the Board, its Committees and our stakeholders should more easily be able to gain assurance from the CRAF.

ASSESSMENT AND ASSURANCE

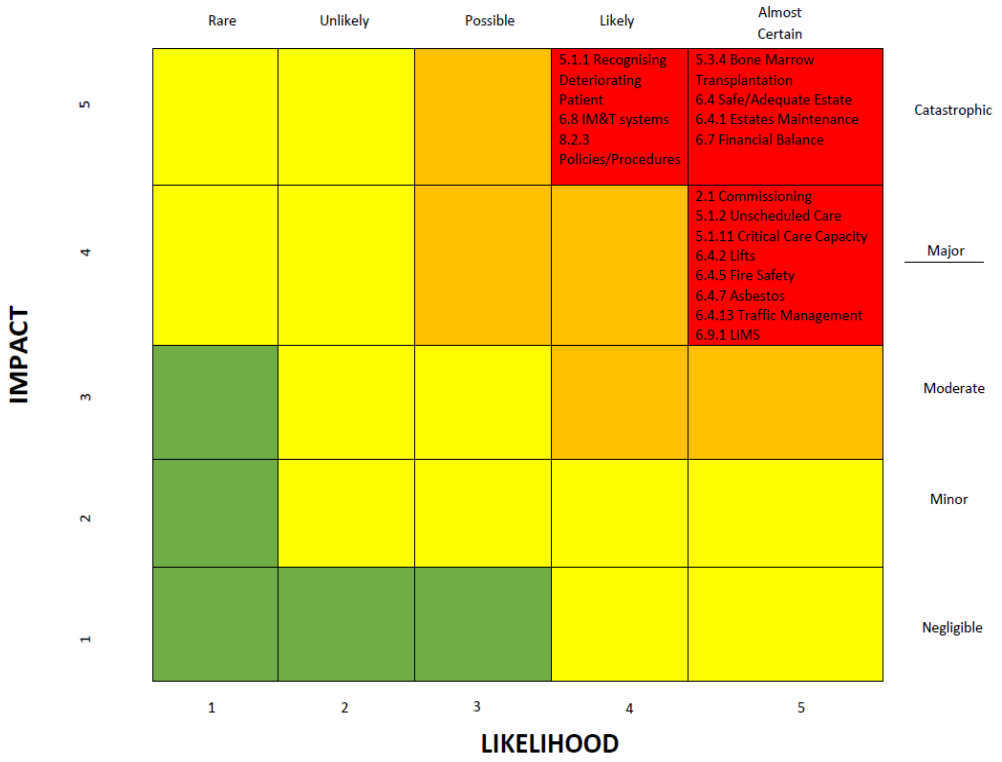
The below Heat Map provides the profile of all risks currently contained within the CRAF.



The latest version of the full CRAF can be found at:

http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/248865

According to the CRAF the extreme risks (20 and 25) facing the organization remain as:



There has been only one change to risks assigned to the Board since the last report as captured below:

- 2.4 “Risk of failure to implement service changes emanating from the South Wales Programme in a timely coordinated way” (risk no. 10 on the CRAF), there has been a delay in the UHB’s capital build resulting in a misalignment of the programme to December 2018; it had been thought that it would be concluded in April 2017

RESEARCH AND DEVELOPMENT IMPLEMENTATION PLAN	
Name of Meeting : Board Meeting	**Date of Meeting:** 28 September 2017

Executive Lead : Medical Director
Author : Director of Research and Development, R&D Office, Room 15A, Floor 2, TB2 University Hospital of Wales, Heath Park, Cardiff. Tel:029 20743742
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Culture" elements of the Health Board's Strategy.
Financial impact : The Research and Development Budget from Welsh Government is approximately £4M - £5M per annum. Commercial income to the UHB around £1M per annum together with the added reputational and financial benefits of free drugs. Research grant income also contributes positively to the financial position of the UHB
Quality, Safety, Patient Experience impact : High quality research has a positive impact on patient experience and in some cases can lead to improved clinical outcomes
Health and Care Standard Number: 3.3
CRAF Reference Number: 7.3
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by :

- Evidence provided in the Implementation Plan of Clinical Board Research activity and commitment to R&D as part of their overall planning/IMTPprocess.

The Board is asked to:

- **NOTE** and
- **APPROVE** the Research and Development (R&D) Implementation Plan and its submission to Welsh Government

SITUATION

The document is being presented to the Board for approval in accordance with the requirement from Welsh Government that the UHB has an up to date R&D Strategy. The UHB approved the R&D Strategy in 2015/16. The relevant sections of this document have been updated by Clinical Boards and the R&D Office. CVUHB has a falling WG research budget - £12.7m in 2009/10 to £5.7m in 2017/18. The number of research studies and recruitment to them is below Welsh Government Performance targets. The development and implementation of the R&D Implementation plan is imperative to reversing these trends and many of CVUHB's key clinical and reputational aims.

The Document has been renamed as the R&D Implementation Plan to sit under the overarching UHB Strategy document. The document supports Shaping our Future Wellbeing and CVUHB's IMTP by ensuring there is strategic direction for R&D at Clinical Board level.

BACKGROUND

One of the Welsh Government Key Performance Indicators for R&D is to have an up to date R&D Strategy specific to the organization. Each Clinical Board was requested to ensure it had an up to date R&D Strategy to be included in the overall document. Some Clinical Boards chose to devolve this responsibility to the Directorate level. In accordance with the autonomy given to Clinical Boards to set their own strategic direction for R&D, the R&D Office has collated the individual documents submitted and prefaced with UHB, R&D Office and Clinical Research Facility strategic aims.

The Implementation Plan is very comprehensive evidence submitted by the individual Clinical Boards/Directorates. Further discussion will take place with Welsh Government with regard to streamlining this report.

ASSESSMENT

Some Clinical Boards are more advanced in their strategic R&D plans than others. Overall their strategic aims fit with addressing both UHB strategic aims and WG Health and Care Research Wales strategic aims. Most Clinical Boards highlight issues in terms of staff resources and dedicated time in job plans for R&D. The failure to historically invest in R&D infrastructure within CVUHB and the reduction in the overall UHB R&D allocation from Welsh Government appears to be impacting on the ability of Clinical Boards to achieve their strategic aims.

The very recent performance meeting with Welsh Government will form the basis of an R&D Performance report to go to the next Board. This meets our Welsh Government requirement to submit a performance report twice a year.

Cardiff and Vale University Health Board Research and Development Implementation Plan

Contents

1. Executive Summary
2. Background
3. Approach to Developing a Research Strategy
4. Executive Strategic Aims
5. R&D Office Strategic Aims
6. Clinical Research Facility Strategic Aims
7. Clinical Board Research Strategies
   - 7.1 Children & Women's Clinical Board
     - 7.1.1 Paediatrics and Child Health Directorate
     - 7.1.2 Obstetrics and Gynaecology Directorate
   - 7.2 Clinical Diagnostic and Therapeutics Clinical Board
     - 7.2.1 Medical Physics and Clinical Engineering Directorate
     - 7.2.2 Radiology Directorate
     - 7.2.3 Therapeutics and Toxicology Directorate
     - 7.2.4 Laboratory Medicine Directorate
     - 7.2.5 Pharmacy Directorate
   - 7.3 Dental Clinical Board
   - 7.4 Medicine Clinical Board
   - 7.5 Mental Health Clinical Board
   - 7.6 Primary, Community and Intermediate Care Clinical Board

7.7 Specialist Services Clinical Board

7.7.1 Artificial Limb and Appliance Service (ALAS)

7.7.2 Cardiothoracic Directorate

7.7.3 Medical Genetics Directorate

7.7.4 Critical Care Directorate

7.7.5 Clinical Haematology and Immunology Directorate

7.7.6 Nephrology and Transplantation Directorate

7.7.7 Neurosciences Directorate

7.8 Surgery Clinical Board

1.0 Executive Summary

Cardiff and Vale University Health Board (CVUHB) has a strong Research and Development (R&D) track record. Ongoing changes to how R&D is funded and approved in Wales and the United Kingdom present major challenges but also major opportunities for CVUHB. To adapt to this changing funding landscape, key changes are recommended:

- Ring fence R&D monies – both Activity Based Funding (ABF) received from Health and Care Research Wales (HCRW) , Welsh Government (WG) and commercial for future investment

- Investment of the above funding to build research capacity.

2.0 Background

One of the core principles of the NHS is to bring benefits to patients through R&D and innovation. This has been central to the University Hospital of Wales since it opened in 1971, when it became Europe's first fully integrated hospital and medical school. Effective R&D performance is essential if CVUHB is to meet its objectives as it brings many benefits.

To patients:

- Access to latest therapies
- Access to latest diagnostic and prognostic tests
- Patients who are invited to participate in clinical trials show overall increased satisfaction and better outcomes when compared to patients not given this opportunity
- Hospitals with a strong R and D portfolio have better outcomes even for patients not in trials

To staff:

- A research-literate workforce is primed to participate in the process of continual change and service improvement required for meeting the challenges of modern healthcare delivery
- Staff development, which leads to increased enthusiasm, motivation, and high quality recruitment into the organization

To the UHB:

- Fulfils the UHB's statutory responsibilities
- Enables links with similar institutions in the rest of the world, sharing best practice and increasing the status of CVUHB
- Exemplar as the leading Health Care provider in Wales
- Financial
  - offset staff costs (through provision from R&D income)
  - drug savings through study participation
  - access to commercial income through research and trial participation
  - direct R&D income – Welsh Government

CVUHB has historically not ring fenced its HCRW Welsh Government (HCRW WG) research funding allocation and with the move from Culyer funding to activity based funding (ABF) this has contributed to over a £7m fall in research funding over the last 5 years down to £5.72m in 2017/18. Most of CVUHB's previous research monies from HCRW WG have been passed on to other NHS organizations within Wales who are investing this money directly in research. Previously, over many years, without specific separation of the R&D budget there has been inadequate investment in R&D infrastructure.

As part of the Welsh Government Health and Care Research Wales (HCRW) Performance Metrics, targets have been set in relation to number of research studies undertaken by the UHB:

- Increase of 10% per annum of the number of HCRW Clinical Research Portfolio (CRP) studies being undertaken within the UHB;
- Increase of 5% per annum of the number of commercially sponsored studies being undertaken within the UHB;
- Increase of 10% per annum of the number of patients recruited into HCRW CRP studies being undertaken within the UHB; and
- Increase of 5% per annum of the number of patients recruited into commercially sponsored studies being undertaken within the UHB.

Funding from HCRW is now received by the UHB in accordance with an ABF model. Funding is retrospective, based on previous year's activity. However, the assumption that an increase in activity – both in terms of number of studies or recruitment to each study – will necessarily result in an increase of income to the UHB is complicated by the fact that the total HCRW budget is unlikely to increase and other NHS organizations in Wales also have to deliver against the same performance metrics.

Strengthening and building the R&D culture within CVUHB is an Executive priority but there are challenges, which include:

- Competition for limited financial resources within CVUHB
- Difficulty in acting as Sponsor for complicated or multi-site research projects
- Difficulty in capitalizing on Intellectual Property (IP) discovery and patent protection
- Many new consultants have little research experience as now less likely that an MD or PhD is required to become a teaching hospital doctor
- Competition for consultants and nursing time from service work, management and educational commitments
- External competition for ABF allocation from other NHS organizations
- External competition for Higher Education Institutions for grant funding

In 2012 CVUHB set about a fundamental management restructuring with the over 40 clinical directorates being amalgamated into 8 Clinical Boards:

- Specialist Services
- Surgery
- Children and Women's
- Clinical Diagnostics and Therapeutics
- Dental Services
- Medicine
- Mental Health
- Primary, Community and Intermediate Care

The Clinical Boards are able to develop their own plans and operational priorities including their approach to R&D. During this same period as outlined above, HCRW WG has not only moved from a Culyer based funding model to an ABF model, they also insist on each directorate accounting for its ABF allocation spending. Traditionally the ABF allocation has been top sliced to provide structural support including the R&D Office, Pharmacy and Clinical Research Facility (CRF).

The R&D Office is headed by a Director and Business Manager who are managerially responsible to the Medical Director. HCRW WG principally funds the R & D Office to ensure

compliance with Regulatory, Legal, Clinical Governance and HCRW WG requirements including performance metrics

3.0 Approach to Developing a Research Implementation Plan

The Clinical Boards have been given the responsibility, with support and resources, to develop their own R&D Implementation Plans, with the assistance of the Medical Director's Office, R&D Office and other centrally funded research entities such as the CRF. The CVUHB R&D Implementation Plan therefore consists of Executive, R&D Office, CRF and Clinical Board/Directorate sections.

4.0 Executive Strategic Aims

The Executive R&D aims align to the UHB strategic themes as follows:

For Our Population:

- Improve the health and well-being of patients and the wider population by promoting and supporting innovation and research translation for the better understanding of diseases and human behaviours; and improved treatments, healthcare provision, and preventative programmes.
- Delivery outcomes that matter to patients especially in our Service Priorities notably
  - Population Health
  - Stroke
  - Long term conditions e.g. diabetes
  - Cancer
  - Dementia
  - Mental Health
  - Oral and Eye Health
  - Early years and Maternal Health

Other Service Priorities

- Building research capacity and strategically align research and service planning and delivery;
- Assist Clinical Boards and individual Directorates with their own R&D strategies and delivery;
- Improve the capacity of the CRF to undertake complex specialist studies e.g. Ophthalmology, Gastroenterology, Renal, Cancer etc; and
- Development of Paediatric Clinical Research Facility for Wales.

Sustainability

- Comply with HCRW metrics including use of its ABF allocation for research delivery;
- Build a skilled workforce capable of advancing high quality multidisciplinary research which is population and people centred and leads to quality improvements in healthcare and public health;
- Increase commercial income from its present level of just over £1m per annum towards the UK average for a UHB of £6m over the next 5 years with the aim of increasing research capacity;
- Contribute to economic prosperity, by developing existing and new partnerships with industry in the pharmaceutical and technical sectors to grow the commercial research portfolio; and
- Ensure patient safety by compliance with all Regulatory and Clinical Governance requirements.

Culture

- Create a culture and research environment to develop and sustain the reputation of the UHB for research excellence in clinical and translational medicine; and
- Add value and enhance impacts by creating new synergies between the UHB and Higher Education Institutions, especially Cardiff University, with the aim of increasing innovative development with possible commercial exploitation.

5.0 R&D Office and Delivery Team Strategic Aims

The priorities for the R&D Office during 2017/18 and beyond are to:

- Ensure readiness to implement the UK wide changes in NHS study set up
- Ensure readiness to switch to and implement the new All Wales Local Portfolio management System in CVUHB.
- Work closely with the Senior Project Manager appointed for 2 years to look at options for developing a joint R&D Office between the UHB and Cardiff University.
- Implementation of the All Wales Finance Policy
- Enhance Performance management of research studies, utilising the Delivery Team Leads to work closely with the Directorate R&D leads and Individual Principal Investigators (PIs) to ensure recruitment is timely and optimized and that failing studies for which a remedial plan is not agreed are closed in a timely manner
- Redirecting Delivery resource to those study activities which generate ABF or commercial income.
- To assist the newly appointed Chair of Nursing research to encourage more research from nurses and other allied health professionals.
- Develop a system of performance management of CVUHB R and D output and address any areas of underperformance eg lack of staff training
- Continue to develop the skill mix of Delivery staff.

6.0 Clinical Research Facility Strategic Aims

The priorities identified for the CRF in 2017-2018 are:

1. To work with the R&D department, investigative teams and other support departments to ensure efficient and high quality set up and delivery of trials on the CRF, prioritising early phase studies.

2. To work in partnership with the other parts of R&D, to maximise returns from available resource, to ensure high quality training and development of staff, and to maintain excellent governance standards. A focus in the coming year is the development and implementation of changes required as Wales adopts the coming new system of trial approval.

3. To work with R&D and finance to maximise returns from work conducted. An identified area for focus is cost recovery from commercial clinical trials

7.0 Clinical Boards/Directorates

7.1 Children and Women Clinical Board

Executive Strategic service priorities:

- Early years and Maternal Health

7.1.1 Directorate of Paediatrics and Child Health 2017-8

Background

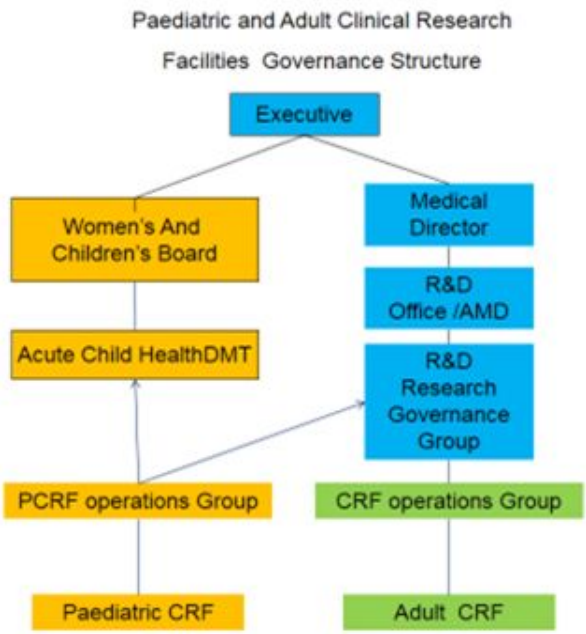
Since 2015 there has been a concerted effort by the Child Health Directorate to increase the total amount of research into childhood illnesses being undertaken at UHW.

Current Situation

Oversight

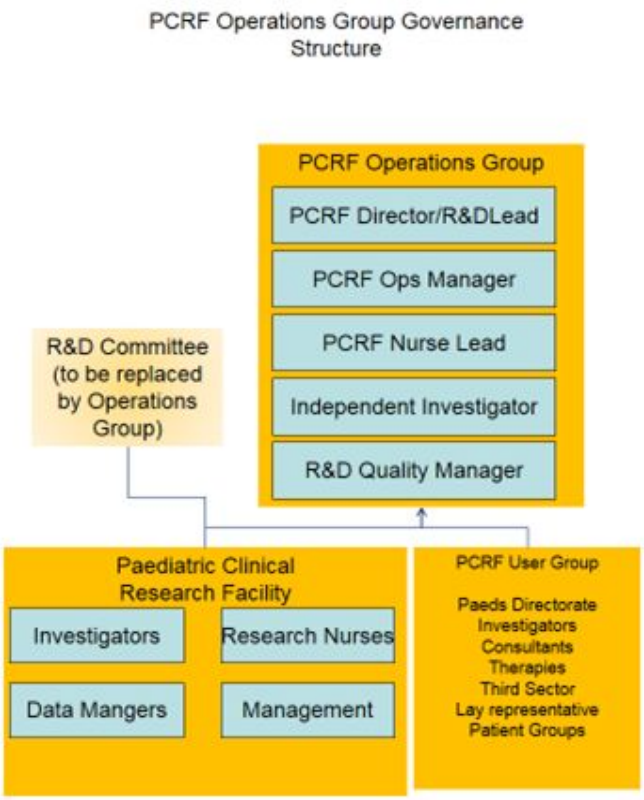
We have had detailed discussions with the Medical Director and the R&D Director to clarify the lines of responsibility and reporting of governance issues within the UHB

Fig 1



The day-to-day running of the research facility will be by the senior members of the team in the PCRF (Operations Manager, Lead Nurse, and PCRF Director). They will form an Operations Group and be joined by an Independent Investigator and the R&D Quality Manager. The Operations Group will take a more strategic perspective on PCRF activity.

Fig. 2



From Fig 1 it can be seen that the Operations Group (OG) will report to the R&D Research Governance Group (RGG) and the Acute Child Health Quality and Safety Committee. The OG will bring document and process review to the RGG and the RGG can be the forum in which Audit and incidents with corrective and preventative actions are reviewed.

The R&D Committee mentioned in previous Plans has been wound down and is now defunct.

Premises

Permanent premises for the PCRF have been secured on the ground floor of the Phase 1 Children's Hospital. This is the old Children's Admission Unit. Staff are now using the area for study related activities.

Permanent accommodation for an administration area has been found in the basement area of Phase 1 of the Children's Hospital (the old Sophie Pearson Room). This is in close proximity to the PCRF.

Personnel

A Band 7 Operations Manager has been appointed. There are 3 research Nurses for Rhino and one for CAP-IT. Additional Band 6 funding will be provided by two further studies, BATCH and SANDWICH. There is a directorate funded research nurse for a fixed period of 6 months coordinating and conducting studies. This post will end in October 2017. Link

nurses are being trained on every ward in the hospital and they will work alongside our research nurses to help with study recruitment and general research awareness.

Dr Connor has been appointed to the post of R&D Speciality Lead for Paediatrics by HCRW.

Equipment

Apparatus for the RHiNO study was transferred down from the University of South Wales to the UHW site and set up in the interim PCRF. It has now been moved to the permanent PCRF.

Following an equipment call from R&D, a refrigerated centrifuge, 5°C fridge and -20°C freezer, a pharmacy fridge and small temperature monitors have been purchased and installed. These are operational.

We are seeking further funding and have approached our third sector partners for the following:

2017/18 Financial Year Essentials List

1 Treatment Chair = £5400

Q Pulse= £6000

CRF manager = £5000

-80c Freezer and continuous monitoring system = £21,833.79

Weighing scales babies and children/adolescents = £570.00

Precision balance scales = £379.00

1 ECG Monitor = £10,800

Pulse Oximeter = £660

Infusion stand = £77.04

Notes trolley = £383.40

Resus trollies = £864.80

Portable suction = £470.40

Waiting room furniture for adults and children and toys/bookcase

= £579.00

2 Tablets = £472.76

Total for 2017/18 = £53,490.19

2018/19 Financial Year Essentials List

2 treatment chairs = £10800

Exam couch = £911.02

1 cot = £4266.00

Pharmacy Fridge = £1098.00

Height measurer = £66.00

1 ECG monitor = £10,800

Pulse Oximeter = £660

Dressing trolley = £198.60

1 Tablet = 236.39

Total 2018/19 financial year = £29,036.01

2019/20 Financial Year Essentials List

1 treatment chair = £5400

2 infusion stands = £154.08

Total 2019/20 financial year = £5,554.08

Funding

The PCRF does not currently have access to any core funding and therefore a limited budget is available until projects start to pay for the overheads of the PCRF. We have had to draw money from several different sources to achieve what has already been done. We have already been approached by PIs from other directorates within the UHB to host paediatric studies, in order to support these we will need to look at how such studies are funded as ABF will go to the PIs employing directorate. In relation to commercial studies the PCRF will need to be viewed as a support service, as with the Adult CRF, and we will need to fully cost recover staff time.

Logo

The theme of “Explorers” has been decided upon for the PCRF. The theme will tie in with the other themes in NACHfW (e.g. space, land and ocean explorers). The aim is to incorporate the PCRF in to the NACHfW as much as possible. Also in line with the rest of the Children’s Hospital we will refer to the Facility as a Unit (CAU, CIU) and it will become the CYA Research Unit (CYARU)

Future Plans

Governance

See figure 1 above.

The immediate task is to localise the SOPs used in the Adult CRF over to the CYARU. This will take some time

The aim is to purchase Q-pulse to help ease the workload of quality management within the CYARU.

Projects

PUMA, TRIAL NET, RIGD, SANDWICH, FEVER, CAP-IT and RHiNO are all recruiting or on the verge of starting. There are multiple other projects in initiation that will run through the CYARU.

All three of these studies will significantly increase research activity in Child Health over the next 2 to 3 years

Longer term aims are:

1. To join the early phase cancer network (Experimental Cancer Medicine Centres, ECMC Paediatrics). This is expanding from the 8 centres currently to 11 centres across the UK. The Adult unit at Cardiff is currently part of the Network.

2. To encourage more Cardiff and Vale sponsored research where the CI is based at NACHfW. To act as a hub to coordinate research in child health across other sites and assist in setting up and running other projects. We are currently exploring funding opportunities for this type of work. In addition the Chief Investigator of the GAPR-UKI http://www.bagp.org.uk/research-gapr-uki/ is based in Cardiff and hopefully we can collaborate in bringing more General Paediatric Studies to Cardiff and Wales.

Finance

Capital Funding

Capital for purchase of equipment should be coming from our third sector partners. It is intended to use as many of these sources as possible and so keep capital costs for the UHB down to a minimum. There is no specific money for this in the child health budget, so we are reliant on charitable donations for the large purchases (for which we are very grateful),

Recurring/operational income

The majority of the ABF income generated by ACH is allocated to funding the Paediatric Oncology research office. We recently looked at the ABF funding model and it does not fit these complex but low recruiting studies. In order to fund the office from ABF we would need to recruit 290 patients per year; luckily we do not have that many children to recruit in to these studies. ACH R&D team are exploring what options are available to us to support these studies in the future; ECMC Paediatric Centre membership (backed by Dr Meriel Jenny, Cancer AMD at Cardiff) is one of those avenues we are exploring.

We are also exploring what options may be available within Wales but believe such funding will not be available for 2 to 3 years.

In the interim period we are in discussions with the Clinical Board on how we ensure the CYARU functions without core funding. There are often small items of expenditure that have to be found (e.g. MHRA project fees). We will seek to clarify the role of the main R&D office in this.

7.1.2 Directorate of Obstetrics and Gynaecology

Executive Strategic service priorities:
- Early years and Maternal Health

Background

For women reproductive health is an essential component of their wellbeing. It is also recognised that pregnancy and childbirth provide the foundation for, and influence lifetime wellbeing. Many issues that form contemporary concerns of public health for all age groups have origins in pregnancy and children's early years. This is reflected in the Welsh Government Strategic vision for Maternity services in Wales (2011). The goal to strengthen the evidence base, through which care provided to women can improve their own health and wellbeing, and that of their children and families, is reflected in research activity within the Directorate. Current research activity within the Directorate incorporates studies reflecting the Directorate's portfolio of work: general gynaecology, gynaecological oncology and maternity.

Our strategy is to build on current strengths of delivering portfolio adopted trials, further expand research activity particularly in antenatal care and gynaecology, and encourage medical, midwifery and nursing staff to develop and lead their own research activities. Specifically we aim to 1) increase the number of portfolio studies open at site, 2) increase the number of participants recruited into portfolio studies and 3) increase the number of Directorate staff actively engaged in research activities.

1) The Directorate will continue to act as a study site for portfolio adopted studies and will proactively seek opportunities to do so. A particular challenge, for the medical staff within the Directorate is the lack of a linked speciality academic department within Cardiff University. The value of having good links with Cardiff University is recognised and we will continue to develop our links with the Division of Population Medicine, Centre for Trials Research and the School of Healthcare Sciences. We have staff members who are co-investigators on studies based in each of these departments and we would aim to continue and strengthen these relationships.

2) Many maternity based studies bring the benefit of the ability to recruit relatively high numbers of women compared to other specialties. Two open studies ANODE / HOLDS (ISRCTN 11166984 / 99841044) in combination have a combined target of recruiting a minimum of 40 women a month throughout 2017/18. In accepting a study in Cardiff & Vale the Directorate give consideration to the potential number of recruits, and whether this will justify efforts required for site opening and running. To date we have concentrated efforts on delivering studies with higher numbers of potential recruits, this strategy has served us well. Whilst it is recognised our portfolio should reflect our various specialties, overall our strategy will be to consider potential recruitment numbers when considering whether to participate in any given study.

3) The Directorate recognise the value of encouraging the maximum number of staff members to be research active. Over recent years Cardiff & Vale have demonstrated their ability to deliver challenging maternity based portfolio studies and trials, and in doing so have developed a national reputation to be able to deliver challenging trials,

including those of emergency obstetric care (OBS2 ISRCTN46295339). Many maternity based trials, and all trials of intrapartum care, require a site to be able to recruit participants over the 24 hour period. The approach taken within the Directorate has been to maximise research involvement and activity amongst all staff groups. Members of the Directorate team who are research active include midwives, nurses, obstetricians and anaesthetists. All are considered appropriate staff groups to be actively involved in the recruitment of women and contribute to the successful delivery of trials and other studies. In addition to encouraging all staff to take an active role in delivering portfolio studies we now need to further develop the research activity of senior medical and midwifery & nursing staff through the encouragement of roles of site Principal Investigator, Co-Investigator or Chief Investigator. Currently there is a dearth of Obstetric led studies, both in Cardiff and Wales. This is a particular challenge which will need to be addressed if reproductive health research is to thrive in Wales in the longer term.

7.2 Clinical Diagnostics and Therapeutics Clinical Board

7.2.1 Medical Physics and Clinical Engineering Directorate

1. Background

- Clinical facilities and expertise that can be applied to R&D e.g. vascular ultrasound, nuclear medicine, bone densitometry, body composition measurement etc.
- Technical facilities and expertise e.g. in radiopharmacy, electrical and electronic engineering, mechanical engineering, information technology
- Expertise in technology evaluation, health economics etc. through Cedar team
- Expertise in research study design, statistics, data analysis, systematic reviews etc. e.g. through Cedar team and contract R&D for medical device manufacturer (Getinge)
- Job descriptions (particularly for Clinical Scientists) include R&D but no protected time
- Income from several sources: Health and Care Research Wales allocation (including £20k for CD&T and Medical Physics R&D Lead roles), equipment manufacturer (contract R&D £37k p.a.), Cardiff University School of Engineering (£7k p.a.), non-commercial studies (~ £5k p.a.) and commercial trials (~ £2k p.a.)
- Income from NICE (£708k p.a.) and Welsh Government ETTF (£200k p.a.) and other ad hoc income for Cedar

2. Non-commercial study funding model

- Some clinical studies led by Medical Physics and Clinical Engineering (MPCE) staff
- Mainly collaboration with local CIs and PIs (usually in Cardiff University School of Medicine) for clinical R&D, generally Health and Care Research Wales portfolio studies, price per test, joint publication
- Supervision of PhD students in Cardiff University School of Engineering

3. Commercial study funding model

- Collaboration with local CIs and PIs (usually in Cardiff University School of Medicine) for clinical R&D, price per test

4. Strategic research priority areas

- Focus on expanding links with other institutions and departments to broaden opportunities and expertise
- Work with Finance and Procurement to provide timely response to R&D opportunities
- Expand links with medical device industry e.g. to facilitate clinical trials of their products
- Establish links with C&V UHB Clinical Research Facility, Academic Health Science Networks etc.

5. Strategic direction: non-commercial studies

- Put greater emphasis on our own R&D projects including grant application to funding bodies
- Apply for grants to renew and add to existing equipment and facilities, and establish dedicated research equipment
- Develop Pathway to Portfolio and eventually Health and Care Research Wales Portfolio studies
- Develop collaboration with Cardiff University School of Engineering

6. Strategic direction: commercial studies

- Seek new opportunities to provide services to those who recruit patients into studies

7. Investment needed to meet objectives and possible funding sources

- Freeing time for staff with expertise to engage in research activity, either by increasing numbers of clinical staff, or reducing other responsibilities
- Assistance needed for grant applications, and finding funding sources

7.2.2 Radiology Directorate

Background

Over the years, there has not been an active emphasis on radiology research related work in Cardiff and Vale UHB, due to intense pressures of clinical workload. There has been no dedicated research staff within the radiology directorate to support research work. There have been a few consultant radiologists who have managed to embed research within their working week but due to the aforementioned workload pressures, these have been the minority of the consultant workforce. The clinical radiology workload has increased considerably and is continuing to rise, which does not allow temporal space to undertake research. However, more recently several consultant radiologists have expressed interest in undertaking research.

There is also a need for more research related experience to be provided for the specialist radiology registrars to complete their training satisfactorily. The Royal College of Radiologists is emphasising this within the curriculum. Failure to be able to provide this could jeopardise the future of the South Wales Radiology Training Scheme.

It is recognised that in order to expand research activity within the Radiology directorate that improved infrastructure is required, most importantly research nurse and admin support, as well as job plans with protected SPA time.

Funding of research activity undertaken in the radiology directorate

Many research studies are run from other directorates but require radiology support within their protocols. Currently, this radiology research activity is not well recognised or funded. This has been the subject of a number of meetings over the past few years to try to identify how this level of research activity can be accurately and appropriately recorded and rewarded to the radiology directorate.

A proposal has been made to prospectively assess any trial requiring radiological support at the time that the trial is set up and to set a proportionate percentage level of ABF (Activity Based Funding) to be returned to radiology directorate to recognise the input from the radiology directorate.

Retrospective percentage ABF for trials already running was deemed to be too complicated to implement.

R and D have recently funded a 1.0 WTE band 4 administrator to assist with Radiology research activity for 12 months.

Research trials listed on the Health and Care Research Wales (HCRW – previously NISCHR) Portfolio attract ABF. Much useful radiological research can be done by retrospective analysis of images already acquired. However, as this is not 'patient facing' research work, it does not meet the criteria for inclusion on the HCRW Portfolio and therefore does not attract ABF.

If radiology support research work can be formally recognised and funded as detailed above, then this funding could be used to support radiology led research activity that does not meet Portfolio criteria currently.

Criteria for Portfolio inclusion needs to be reviewed and separate criteria for different specialties drawn up so that relevant research work can be better recognised and supported. This would help to support more radiology led research, increasing non-commercial studies undertaken in C&V UHB.

This needs to be discussed and addressed with HCRW.

Strategic Direction

Interested consultants will meet to discuss options to further research activity.

There are current research links with University Departments and these will be promoted to try to enhance research activity – e.g. CUBRIC, Cardiff University Engineering Dept, European Cancer Stem Cell Research Institute, School of Biosciences, Cardiff Metropolitan University cardiac physiology dept.

Current links with other radiology directorates across South Wales will be enhanced to try to develop research ideas that can therefore include larger target populations for improved research outcomes.

Over the past years, radiology studies for research trials have been conducted in the private sector due to lack of capacity in the C&V radiology department.

The current clinical director of radiology recognises this loss of research earning opportunity and is keen to find ways to address this and assess the feasibility of keeping C&V research imaging in house.

7.2.3 All Wales Therapeutics and Toxicology Centre Directorate

1. Background

The All Wales Therapeutics and Toxicology Centre (AWTTC) was established in 2012. The AWTTC (now a separate Directorate within CD&T) was created from the amalgamation of the Welsh Medicines Partnership, Welsh Medicines Resource Centre, Welsh Analytical Prescribing Support Unit, Yellow Card Centre Wales and the National Poisons Centre Wales. The AWTTC is responsible for providing information to the All Wales Medicines Strategy Group (AWMSG) to allow it to carry out medicines appraisals, provide prescribing guidance and to analyse prescribing trends in Wales. It is also responsible for developing educational bulletins, and promoting adverse drug reaction reporting via the MHRA Yellow Card Scheme. In order to provide this information the AWTTC employs medical writers, pharmacologists,

pharmacists and medical doctors. The Centre is well placed to carry out research projects into all aspects of therapeutics.

High quality research is important to demonstrate the effectiveness of the AWTTC to Welsh Government and to attract research funding. In 2014 a centralised process for developing research projects was adopted which included developing a research database and regular meetings of the AWTTC Research Group. The main goals for the department are the publication of research publications, involvement in portfolio studies and encouragement of research grant applications.

Over the past year the Directorate has been successful in presenting posters and abstracts at scientific meetings, publishing peer-reviewed research papers and has had involvement in a portfolio study. The Directorate plans to build on this. In order to support research within the department the AWTTC directorate has agreed to allocate NHS staff time for research activity. Medicines safety is a main focus of the work of AWTTC. Through collaboration with other organisations, AWTTC intends to research areas to improve medicines safety for patients in Wales.

2. Non Commercial Study Funding model

Health and Care Research Wales (HCRW) implemented a new funding model starting in 2012. Since AWTTC was founded in 2012 and due to the lack of historical commercial or grant-funded research, AWTTC is not currently allocated any activity based funding (ABF) funds for research activity. Due to the lack of ABF funding all research costs have to be borne by AWTTC. The current R&D funding model allocation is based on the number of HCRW Clinical Research portfolio studies and the number of participants recruited to these studies. AWTTC has actively encouraged participation in HCRW registered research portfolio studies.

Pathway to portfolio studies are also encouraged and proposals scrutinised for potential peer-reviewed grant funding. AWTTC also carries out audit and service evaluation studies.

3. Commercial Study funding model

Commercial income is distributed according to the R&D template. Money in Principal Investigator accounts is available until 18 months after the last assessment point and then money is transferred into a Legacy fund 20% centrally and 80% at Directorate level.
Many of the research proposals considered by AWTTC are concerned with medicines optimisation data rather than with direct clinical patient engagement. However clinical pharmacologists are an integral part of AWTTC and there is potential for involvement in commercial studies.

4. Strategic research priority areas

National Prescribing Indicators

Since 2003, AWMSG has been using prescribing indicators to promote safe, rational, cost-effective, quality prescribing within the primary care sector. These indicators are evidence based and are designed to be clear and applicable at practice level, addressing both efficiency and quality. National Prescribing Indicators are monitored quarterly by the **Welsh Analytical Prescribing Support unit (WAPSU)** within AWTTC, thus providing a tool with which

to benchmark prescribing performance of NHS Wales and individual health boards in key prescribing areas.

The AWTTC has received HCRW approval for studying the effect of these National Prescribing Indicators on prescribing "Changes in Medicines Usage in Wales Following the Introduction of National Prescribing Indicators and other Interventions".

AWTTC has published a paper showing the effectiveness of the National Prescribing Indicators (NPI) in changing prescribing behaviour (*Deslandes P et al A change in the trend in dosulepin usage following the introduction of a prescribing indicator but not after two national safety warnings. Journal of Clinical Pharmacy and Therapeutics 2016)* and is currently preparing a further paper on the effectiveness of making yellow card reporting a Welsh NPI.

AWTTC is committed to demonstrating improved health care outcome from the use of NPIs. This year two NPIs have been developed in collaboration with the National Wales Informatics Services. Using AUDIT+, which has access to 98% of general practice health care records in Wales, AWTTC can monitor the use of non-steroidal anti-inflammatory drugs in patients with renal failure and also the total anticholinergic burden of patients on anticholinergics. Through the use of Audit, AWTTC intends to demonstrate whether there are improvements in these health care outcomes for patients in Wales after specific interventions.

Toxicology and Hypertension

Dr Coulson and Dr J Thompson have been successful in obtaining C&V approval for involvement in a Portfolio study (*C&V UHB ref and study title 16/DHD/6369: Identification and characterisation of the clinical toxicology of novel psychoactive substances (NOS) by laboratory analysis of biological samples for recreational drug users -IONA study).*

Dr Coulson and his colleagues are leading research in toxicology and hypertension. AWTTC currently runs a national Adverse Drug Reaction (ADR) testing service and is currently exploring the possibility of appointing a Health Care Professional to take forward research in this area. Dr Coulson is currently applying for inclusion in two other HCRW registered research portfolio studies. (Appendix 1) It is hoped that the involvement in portfolio studies may lead to future grant-funded studies and possible collaboration in commercial studies.

National Poisons Information service

The NPIS produces service evaluation reports and through collaboration with other poisons centres is involved in producing journal publications.

Yellow Card Centre

The Yellow Card Centre is involved in carrying out audits and service evaluation to determine ways to improve adverse drug reaction reporting by the public and health care professionals using the yellow card spontaneous reporting system.

Medicines Safety and Big Data

AWTTC is committed to improving medicines safety. Collaborative partnerships have been made to access national databases CPRD/SAIL and national critical incident reports. AWTTC is working with its partners to research deprivation and antibiotic use and medication critical incident

reports. AWTTC is committed to analysing Big Data sets to develop projects for medicines optimisation in Wales. AWTTC is exploring the possibility of engaging with data scientists at Cardiff University to help with future projects.

5. Strategic direction in non-commercial studies

Research activity is focused on portfolio work and high quality pathway to portfolio studies

Aims

1. To increase the number of HRCW registered clinical research portfolio studies

AWTTC has been successful in gaining Cardiff & Vale approval for involvement in one portfolio study and is currently applying for inclusion in two other portfolio studies (see Appendix 1).

2. To encourage high quality pathway to portfolio studies

AWTTC is committed to becoming nationally recognized for a centre of excellence for research of medicines management in Wales and has allocated staff time to be involved in research.

6. Strategic direction in commercial studies

Clinical Pharmacologists at AWTTC are currently involved in hypertension and toxicology clinics at C&V and are open to involvement in appropriate commercial studies.

7. Investment needed to meet objectives and possible funding

The All Wales Therapeutics & Toxicology Centre is committed to developing high quality research. At present AWTTC has no funding allocation for research. For example, the costs of the IONA portfolio study will be absorbed by the department. AWTTC is currently investigating research areas that would be suitable for grant application.

AWTTC Publications 2016-17

Full Papers

1.**Deslandes PN, Jenkins KS, Haines KE, Hutchings S, Cannings-John R, Lewis TL, Bracchi RC**, **Routledge PA**. A change in the trend in dosulepin usage following the introduction of a prescribing indicator but not after two national safety warnings. J Clin Pharm Ther. 2016 Apr;41(2):224-8. doi: 10.1111/jcpt.12376. Epub 2016 Mar 2

2.Donnelly K, **Bracchi R**, Hewitt J, **Routledge PA**, Carter B. Benzodiazepines, Z-drugs and the risk of hip fracture: A systematic review and meta-analysis. PLoS One. 2017 Apr 27;12(4):e0174730. doi: 10.1371/journal.pone.0174730. eCollection 2017.

3. Alam MF, Cohen D, Dunstan F, Hughes D, **Routledge P**. Impact of the phased abolition of co-payments on the utilisation of selected prescription medicines in Wales. Health Econ. 2017 Jul 7. doi: 10.1002/hec.3530. [Epub ahead of print]

4. Waugh J, Najafi J, Hawkins L, Hill S L , Eddleston M, Vale J A, **Thompson J P**, and Thomas S H L. Epidemiology and clinical features of toxicity following recreational use of synthetic cannabinoid receptor agonists: a report from the United Kingdom national poisons information service Clinical Toxicology 2016 : 54 (6); 512-518

5. Marrs TC , **Thompson JP** .The efficacy and adverse effects of dicobalt edetate in cyanide poisoning Clinical Toxicology 2016:54(8):609-614

6. Day R, Eddleston M, Thomas S H L, **Thompson JP** ,Bradberry S M Vale J A .Toxicity from automotive screenwashes reported to the United Kingdom National Poisons Information Service (NPIS) from 2012 to 2015 Clinical Toxicology 2017:55(3):221-226

7.Day R, Eddleston M, Thomas S H L, **Thompson JP** , Vale J A . Exposures to traditional automatic dishwashing tablets and a comparison with exposures to soluble film tablets reported to the United Kingdom National Poisons Information Service 2008–2015 Clinical Toxicology 2017 :55(3);206-212

8.Day R, Eddleston M, Thomas S H L, **Thompson JP** , Vale J A . The impact of an international initiative on exposures to liquid laundry detergent capsules reported to the United Kingdom National Poisons Information Service between 2008 and 2015 Clinical Toxicology 2017;55(3):213-216

9.Henke D, Campbell A, Bradberry SM, Sandilands EA, Thomas SHL, **Thompson JP**, Vale JA. Toxicity from fluoropolymer-containing grout, tile and stone floor sealants reported to the UK National Poisons Information Service 2009-2015.Clin Toxicol (Phila). 2017 Jul;55(6):585-588. doi: 10.1080/15563650.2017.1296154. Epub 2017 Mar 28.

10.Kamour A, Crichton S, Cooper G, Lupton DJ, Eddleston M, Vale JA, **Thompson JP**, Thomas SH.Central nervous system toxicity of mefenamic acid overdose compared with other NSAIDs: an analysis of cases reported to the United Kingdom National Poisons Information Service. Br J Clin Pharmacol. 2017 Apr;83(4):855-862. doi: 10.1111/bcp.13169. Epub 2016 Dec 22.

11.Panchal B, Eddleston M, Thomas SH, **Thompson JP,** Vale JA.754 exposures to reed diffusers reported to the United Kingdom National Poisons Information Service 2010-2014.Clin Toxicol (Phila). 2016;54(4):333-8. doi: 10.3109/15563650.2016.1140772. Epub 2016 Feb 19.

12.Thanacoody RH, Gilfillan C, Bradberry SM, Davies J, Jackson G, Vale AJ, **Thompson JP,** Eddleston M, Thomas SH.Management of poisoning with ethylene glycol and methanol in the UK: a prospective study conducted by the National Poisons Information Service (NPIS). Clin Toxicol (Phila). 2016;54(2):134-40. doi: 10.3109/15563650.2015.1116044. Epub 2015 Nov 23.

13.Coulson J M, **CaparrottaTM** , **Thompson JP** The management of ventricular dysrhythmia in aconite poisoning Clinical Toxicology 2017:55 (5) ; 313-321

14.Crawford C, Anderson M, Cooper G, Jackson G, **Thompson J**, Vales A , Thomas S H L, Eddleston M, Bateman D N Overdose in young children treated with anti-reflux medications: Poisons enquiry evidence of excess 10-fold dosing errors with ranitidine Human and Experimental Toxicology 2017:1-7

15.Day R C, Bradberry S M, Sandilands E A, Thomas S H L , **Thompson JP** , Vale J A. Toxicity resulting from exposure to oven cleaners as reported to the UK National Poisons Information Service (NPIS) from 2009 to 2015 Clinical Toxicology 2017; http://dx.doi.org/10.1080/15563650.2017.1306070

Letters

Thomas AM, Routledge PA, Bracchi R, Carey E, Adams A. Yellow card champions to help increase reporting of adverse drug reactions. Clinical Pharmacist 3 FEB 2016

Abstracts

Islam Z., Deslandes R.E., **Haines K.E., Cannings-John R., Deslandes P.N. and Routledge P.A** . Benzodiazepine usage in Wales following the introduction of an educational pack encouraging appropriate prescribing in primary care PDS Pharmacoepidemiology & Drug Safety 2017;26(S1):3-20

Thomas C., Biswas R., Hathway C., Collier T., Craven C., Higgins L. & **Deslandes P.** A secondary care led deprescribing approach for care home patients in a health board in Wales PDS Pharmacoepidemiology & Drug Safety 2017;26(S1):3-20

On-going research projects

Lead/support	**Portfolio/ pathway/ other**	**Project**
Deslandes	Pathway	Changes in medicines use in Wales following the introduction of national prescribing indicators and other interventions
Coulson (PI) and Gray		The effects of antihypertensive treatment on the physiology of hypertensives
Coulson	Portfolio	ComparIsoN oF Optimal Hypertension RegiMens (Part of the Ancestry Informative Markers in Hypertension (AIM HY) Programme – AIM HY-INFORM) 16/EE/0294
Coulson and Thompson	Portfolio	Identification of *Novel psychoActive Substances* (*IONA*) *study*
Coulson	Portfolio	SPIRIT (**S**urvey of **P**at**I**ents with **R**es**I**stant hyper**T**ension

Recruitment for portfolio studies

Study	PI	Patients screened	Patients recruited	Overall Recruitment	
				Current	Target
IONA Study Identification of Novel psychoActive Substances	JC/JT	4	1	1	6
SPIRIT Survey of Patients with Resistant Hypertension	JC	20 NB: study now closed	9	9	9
AIM HY INFORM ComparIsoN oF Optimal Hypertension RegiMens	JC	0 NB: study awaiting R&D approval	0	0	40

7.2.4 Laboratory Medicine Directorate

R&D STRATEGY FEEDBACK 2017:

Lab Med	R&D Income generated within Lab Medicine 14/15	R&D Income generated within Lab Medicine 15/16	R&D Income generated within Lab Medicine 16/17
Genetics	£400k	£323,568.68	*£769k
Biochemistry	£115k	£99,929.36	£89,602.3
Haematology	£0	£9,055.96	£23,923.24
Cell Pathology	£50k	No data	No data
Total	**£565k**	**£432,554.00**	**£883,525,54**

*Various Laboratory Genetics R&D projects have been ongoing for a number of years (e.g. CRUK, WCB, Focus4) but the additional projects that contribute to the increase in income include RfPPB (SIGNAL) £120K and ETTF (various sub-projects including NIPT and LIMS) £184K

- Current clinical job plan R&D sessions within directorate = 0.1wte (Clinical Job Plans).
- Current Clinical Scientist/ Biomedical Scientist R&D protected time awards = various (e.g. 1 WTE Band 5 for commercial trials support funded via commercial clinical trials for Factor VIII replacement therapy within Haematology)

It is pleasing to report that the total R&D income generated by Lab Med in 16/17 **is £883,525,54 which is a substantial increase from that generated in previous financial years.**

In addition to testing of clinical samples, the main focus for Laboratory Medicine Directorate in 2016-2017 **has been the attainment of UKAS accreditation** across ALL laboratories. This has been an intensive process, requiring extensive staff time and commitment. Nonetheless the Laboratory Directorate has contributed to key R&D activities.

Commercial R&D Activities

The Directorate, notably via Haematology and Biochemistry continue to support commercial trial activity. This is both by on-site sample analysis and by processing samples for central laboratory analysis.

Expanding commercial trial activity in Clinical Haematology has resulted in increased demands on laboratory Haematology support.

Non-Commercial R&D Activities

In general non-commercial R&D activities are performed in collaboration with clinical teams and colleagues outside the Directorate. A new collaborative project, the ObsPlus study, activity within

the Haemostasis& Thrombosis Section of Laboratory Haematology via collaborative studies with Obstetric Anaestheology has been initiated.

As previously noted Laboratory Genetics continues to undertake a substantial amount of the total directorate R&D activity with ongoing projects e.g. CRUK, WCB, Focus4 and in addition new projects, RfPPB (SIGNAL), ETTF (comprised of various sub-projects including NIPT and LIMS) and BEVAN (various projects funded 2016-2017).

Note the directorate is unique in that it employs a high percentage of Clinical Scientists. Indeed, senior members of this staff group are expected to undertake R&D (within job descriptions) although there is little provision to 'protect' staff time to do this

Liaison with UHW Finance Department

The Directorate R&D has sought clarification from UHW Finance and their advisers regarding the VAT status of goods bought with grant funded research monies. (Meeting on 24th May: Task group = James Cassley; Jane Jones; Vince Jenkins; Paul Emmerson; Dan Ryan; Sian Morgan) Academic institutions such as Universities are able to use such monies with VAT exemption. HMRC guidelines suggest "*Generally research is outside the scope of VAT when it is funded, either by the public sector or by the charitable sector, for the wider public benefi*t (HMRC VAT information sheet 11/13: supplies of research between eligible bodies published 10.07.2014). The group sought clarification as to whether transactions by NHS laboratories involving funding for research are VAT exempt. This has significant financial implications for the Directorate

OUTCOME to date: There are NO written processes currently in respect of VAT exemption around trials and R&D funding with C&V UHB. It was recognised documented processes are required. The possibility/potential for using costs centres/subjective codes and analysis codes to identify costs for individual projects was discussed. Finance is to devise a method to improve in house VAT compliance in these areas.

What should the Clinical Board focus on going forward?

The accredited laboratories comprise highly qualified staff providing specialised testing services. The expertise of staff and variety of specialist testing services offers opportunities for improved knowledge of disease, improved development of tests and services. Scientific staff and areas should be encouraged to participate in Publications, Improving Outcomes and Efficiencies to improve patient care.

Additionally there are significant opportunities to generate income potential to the Directorate from both commercial and non-commercial research studies; and to researchers both within the C&V UHB and external to the organisation.

The potential to improve financial and non-finance outcome are not mutually exclusive however there is a lack of relevant commercial experience and administrative infrastructure within the Directorate to fully exploit this latent potential.

- Improved and easy to use records of income and expenditure of research funds is required as a matter of urgency. Research funding expenditure must be easy to identify and fully auditable.
- Formation of a directorate based Review Body to identify 'new' income within and outside the UHB.
- Support by a part time business administrator with a remit to identify potential R&D income would facilitate a streamlined approach for all laboratories.
- Protected R&D time for Clinical and Scientific staff should be facilitated.
- Laboratory management should be encouraged to discuss R&D as an item at regular management and staff meetings.
- Cross-disciplinary CD&T and specialist services meetings; to determine what opportunities are being 'missed'.

Sian Morgan, Laboratory Medicine Directorate R&D Lead

Dr P.V. Jenkins, Laboratory Medicine Directorate R&D member

Scott Gable, Laboratory Medicine Directorate R&D member

Fiona Campbell, Laboratory Medicine Directorate R&D member

Rachel Butler, Laboratory Medicine Directorate R&D member

Dr Stefan Dojcinov, Laboratory Medicine Directorate R&D member

Gaynor Chase, Laboratory Medicine Directorate R&D member

Dr Andrew Goringe, Laboratory Medicine Directorate R&D member

Dr Mike Badminton, Laboratory Medicine Directorate R&D member

Sarah James, General Office / Clinical Trials Biochemistry and Immunology Dept

Michaela John, Laboratory Genetics Business Manager

7.2.5 Pharmacy Directorate

Current Position

Summary

Pharmacy departments engage with the NHS research agenda in a variety of ways:

1. Provide support services to researchers (commercial and non commercial) e.g.
    a. Manufacture of Investigational Medicinal Products (IMP's)
    b. Dispensing of Clinical Trial medicines (IMP's and non IMP's)

2. Act as independent research leaders

1. Support Services

The Pharmacy dept provides a variety of support services for researchers. These services are primarily associated with the manufacture or supply of medicines for clinical trials. These medicines may be IMP's or non IMP/licensed products. Medicines used for research must be manufactured/purchased, stored, dispensed and reconciled according to Clinical Trial regulatory legislation and approved protocol guidelines. Commercial clinical trials have a costed manufacturing and/or dispensing charge levied. Non-commercial trials are supported by establishment staffing resource. Considerable income and prestige for the HB is generated from these activities.

a. IMP

Saint Mary's Pharmaceutical Unit (SMPU) holds an IMP license from the MHRA. SMPU manufacture IMP's as a contractual service, mainly to sponsors for non commercial clinical trials e.g. Cardiff University. The cost of sourcing an IMP will be part of any CTIMP grant application and as such SMPU are often engaged early on in this process. A pharmacist also sits on Cardiff and Vale Research Review Service (CaRRS) and has the opportunity to review pharmacy involvement and costings prior to UHB approval. Robust invoicing procedures are in place for reimbursement of IMP costs to pharmacy once manufacture and distribution has taken place.

b. Dispensing

Any medicine used within the UHB, including those for Clinical Trials, will be managed by the main dispensaries. Pharmacy input will have been reviewed at CaRRS and appropriate costing of these activities is based on a costing template agreed with the commercial R&D office.

2. Pharmacy professionals as independent research leaders

Wales

The pharmacy profession has recently recognised the need to develop a clinical academic workforce. England has established an Integrated Clinical Academic Scheme (ICAS) for allied healthcare professionals, with pharmacy recently gaining access to this. Wales must explore the provision of equal opportunities for pharmacists practicing in Wales. There has been no clear academic leadership or career pathways for pharmacy clinical researchers to date.

A Pharmacy Research strategy for Wales is being developed with an aspiration to develop a supported clinical academic workforce and develop closer working arrangements with relevant HEI's.

The overall Mission statement is to:

"Develop a lasting research culture within the Pharmacy Profession which will create a step change improvement in the quality and quantity of multidisciplinary research that influences practice and policy to benefit the health of the people of Wales and beyond."

There are four themes within this strategy:

Culture

Create a culture in which pharmacy professionals recognise the importance of pharmacy research to the health of the nation and the future of the profession

Workforce

Develop a flexible and future proof workforce where research and evaluation for patient benefit are at the centre of practice.

Knowledge Mobilisation

Support the transfer and mobilisation of knowledge through the development of communication infrastructures and lasting partnerships.

Research Priorities

Identify and prioritise emerging research themes for Pharmacy Wales which improve patient outcomes.

The strategy has 17 recommendations, a high level delivery plan and a list of performance measures which will be used to assess progress over the 5 year plan.

Cardiff and Vale UHB

Cardiff and Vale UHB pharmacy department intend to develop a local strategy which is aligned with the All Wales Pharmacy Research Strategy. Therefore, aspects of the strategy, delivery plan and performance measures which are appropriate for local action will be assimilated together with any additional local aspirations. Attached are the draft local delivery plans and performance measures. As the All Wales strategy evolves so will these documents.

Minimal time is identified for pharmacy led research activities within the pharmacy department (includes the Directorate lead role at 0.2WTE). Despite this there has been some robust research, service delivery and audit activity (see attached activity summary sheet).

Key research summary points are: 1 portfolio registered study with Pharmacist as Chief Investigator (recruited patients =20), 1 Clinical Research Time Fellowship and grant incomes of approx £115K (over 3 years: 2012-2016 extension). Some of these research projects have the potential to earn income through the development and licensing of medicinal products at SMPU (GabaGel). Others are setting UK standards for the use of novel technologies (Rapid Microbiological Methods).

Key service evaluation and quality improvement activities respond to service pressures, quality improvements identified by the senior management team or external stakeholders and

provide generalisable new knowledge for the profession. Eg Electronic Prescribing for Hospital Out-Patients: Has it Reduced Expenditure and Improved Quality and Safety of Prescribing?
Key audit summary points being that identified staff of the pharmacy department in training positions are required to carry out audit. These often have an impact on safety and quality of medicines use and may have cost implications for the UHB.

Conclusion
The Pharmacy and Medicines Management Directorate has a strong track record for both supporting and undertaking high quality research. Recent development of Advanced to Consultant Practice through the pharmacy professional body (RPS Faculty) and credentialing of practice (including a research and evaluation cluster) will support a related increase in activity. Engagement across Wales and within the Health Board in the evolving Pharmacy Practice Research strategy will help maintain and strengthen this focus.

Making it happen: A High Level Delivery Plan (All Wales)

Cardiff and Vale UHB – local delivery plan

	Recommendation	Who		When
		Driver	Delivery	
1.1	Communicating the value of pharmacy research, in enhancing patient outcomes and service productivity, to pharmacy professionals and the wider audience	Chief Pharmacists @ HB level		On-going
1.2	Establish local R&D leadership roles	Chief Pharmacists @ HB level		Partially completed
1.3	Establish Professorial leadership position for pharmacy research Wales	Research Strategy Board	Uni of Wales. NHS Wales	2017. Prof appointed at CSPPS
2.1	Establish vision and career pathway for the research active workforce	Research Strategy Board	MPC II E&T Ops Consultant Pharm Steering Gp	On-going
2.2	Establish competency framework for clinical researchers	Consultant Pharm Steering Gp	Consultant Pharm Steering Gp with invited specialists	Done REET @ RPS

2.3	Develop training opportunities for audit and quality improvement which complements the research strategy.	Local R&D lead Local E&T lead		Partially completed as per 1.2
2.4	Establish ways to allow career flexibility to enable combination of research and clinical practice Link with 2.1	Chief Pharmacists @ HB level		On-going
2.5	Establish well articulated systems of mentoring and peer support for clinical researchers and educators	R&D leads in partnership with relevant HEI		24 months
2.6	Establish a co-ordinated range of integrated research training opportunities	Research Strategy Board	HEE/WEDS	On-going. Re new HEIW
2.7	Work with appropriate providers to identify current and new research training programmes. Link with 2.2	E&T Ops		Current done. New being developed
2.8	Establish career pathways for clinical researchers			
	Amalgamated with 2.1			
2.9	Establish joint appointment positions for clinical researchers	Chief pharmacists in partnership with relevant HEI		24 Months: Joint PhD's
3.1	Establish a robust, interactive mechanism for research collaboration and communication.	R&D leads in partnership with relevant HEI		www.pharmacy.research.wales
3.2	Establish an interactive live pharmacy research activity database for Wales	Research Strategy Board	WCPPE	Reviewed. www.pharmacy.research.wales
3.3a	Encourage and support publication of research activity	Chief Pharmacists @ HB level Local R&D leads Local E&T leads		On-going
3.3b	Translate published data into practice or policy where relevant	Chief Pharmacists @ HB level R&D leads		On-going

3.4	Establish a Research Strategy Board to determine governance arrangements for future research and management of the strategy implementation.	AWCPC	Research Steering Gp	RSIG established 2016
4.1	Introduce process to identify and prioritise emerging research themes for Wales	R&D leads and Chief Pharmacists Use process ID by strategy board to establish local priorities		All Wales Pharmacy vision doc completed

Pharmacy Research Wales – Performance Measures (5 year plan)

Cardiff and Vale UHB performance measures – plan

Being reviewed 2017

Key Metric		2015	2016	2017	2018	2019
Demonstrating benefits of doing research. Annual report		x	x	x	x	x
Appointments of R&D leads per HB and Velindre – 100%			100%			
Membership of HCRW Faculty – 100% researchers			50%	100%		
Establish professorial researcher leader post for Wales (1)				x		
Benchmark against APF : R&E – 100% researchers		50%	100%			
Internship posts - establish			x			
MSc – ↑100%			50%	100%		
PhD – ↑100%				50%	100%	
Post doc positions – ↑ 100%					50%	100%
Prof positions - ↑ 100%						x
Integrated clinical academic training scheme – established				x		
Research joint appointment posts established				x		
Resource mapping - % researchers ↑ by 20% per year		x	x	x	x	x
Funding from grants – ↑ 50%				x		
Publications – by ↑ 50%			x			
Number of quality research studies –↑ by 50%			x			
Publication impact –↑ by 20%				x		
Review of Welsh research priorities (annual)		x	x	x	x	x
Review of C&V UHB research priorities (annual)		x	x	x	x	x
Research included in departmental operational plans and agendas			x	x	x	x

R&D activity log 2013-2017 - Cardiff and Vale UHB Pharmacy

Type of activity	Site	Title	Funding
Research	Llandough	The Public's View Of Community Pharmacists Receiving An Electronic Hospital Discharge Advice Letter	PhD (CSPPS)
	SMPU	Evaluation And Assessment Of Nutritional Status In Home Parenteral Nutrition (HPN) Patients	PhD (CSPPS)
	SMPU	Parenteral Nutrition: Nutritional abnormalities in long term homecare patients	PhD (CSPPS)
		Parenteral Nutrition: Nutritional abnormalities (selenium) in long term homecare patients	4th yr (CSPPS)
	SMPU	To Evaluate Topical Gabapentin Gel for the Treatment of Neuropathic Pain	PPDS £12K
	SMPU	Optimise formulations for the topical delivery of NHS "special" pharmaceuticals and investigate models to exploit NHS IP	NISCHR fellowship 0.4 WTE 3 yrs £93K.
	SMPU	Exploring novel bases for topical gabapentin	4th yr CSPPS student
	SMPU	Transfer disinfection validation for TPN bags and cytotoxic products	ERSMUS students
	SMPU	A preliminary investigation into the ability of three rapid microbiological methods to detect microorganisms in hospital IV pharmaceuticals	PPDS £10K
	SMPU	Investigating rapid microbial detection methods as an alternative to total aerobic microbial counts for non-sterile bioburden assessments.	
	SMPU	Validation of a rotary vial washer for terminally sterilised product manufacture	
	Llandough	The Public's view of community pharmacists receiving an electronic hospital discharge advice letter	MSc tuition and expenses:NHS Wales Informatics Service
	SMPU	Production and permeation of topical gabapentin formulations across various diffusion barriers	4th yr CSPPS student

Service Evaluation	Llandough	To evaluate and develop a safe and clinically appropriate local infiltration anaesthetic (LIA) formulation for total knee replacement surgery	ERASMUS/4th yr students. CSPPS
	Llandough	Electronic Prescribing for Hospital Out-Patients: Has it Reduced Expenditure and Improved Quality and Safety of Prescribing?	4th year and MSC students
Audit	C&V UHB	An Evaluation of the Secondary Care Initiation of Oral Antipsychotic	
	C&V UHB	Compliance with Intrathecal Guidelines, supply and admin of Chemotherapy at UHW	
	C&V UHB	Audit of compliance with dose banding of chemotherapy in Wales	
	C&V UHB	Audit to determine the compliance of chemotherapy doses with All-Wales dose bands in Llandough Hospital and Velindre Cancer Centre	
	C&V UHB	Audit into Management of Diabetic Patients Undergoing Elective Orthopaedic Procedures	
	C&V UHB	Compliance of Pabrinex prescribing in line with the Good Prescribing Guide	
	C&V UHB	Audit of anti-infective sticker use within specialist services (C&VUHB)	
	C&V UHB	Audit into the management of diabetic patients undergoing elective orthopaedic procedures	
	C&V UHB	Audit of medicines reconciliation in frail elderly patients	
	C&V UHB	Time to undetectability on Antiretroviral Treatment	
	C&V UHB	Audit of prophylactic antibiotic use in cardiac and enhanced recovery colorectal surgery	
	C&V UHB	Audit of choice and assessment of use of patients' inhaler device in the treatment of asthma	
	C&V UHB	Developing and piloting a system for internal audit of pharmacy clinical trials folders	
	C&V UHB	Hospital prescribers use of the out-patient prescription/referral form	
	C&V UHB	Are recommended treatments for acute ischaemic stroke being prescribed	
	C&V UHB	An audit of compliance with NICE guidance for Bortezomib in adult haematology patients	
	C&V UHB	Reporting of Adverse Drug Reactions to MHRA using sticker as an identification aid	
	C&V UHB	Audit to establish whether Cardiff and Vale UHB complies with local and national protocols on the storage, record keeping and destruction of controlled drugs	

7.3 Dental Clinical Board

Executive Strategic service priorities:

- Early years and Maternal Health

Background

Historically the R&D budget for the Dental Clinical Board (and predecessor organisations) has been low, rising to a maximum of just above 1% of total income 2014/15 (Table 1). Dental Clinical Board (DCB) has 403wte establishment and 389wte in post as at March 2017, the NHS R&D forecast budget for DENTL 2015-16 supports 18 hours SPA Research across 9 consultant job plans. It is not envisaged that this trend will change in the foreseeable future. In part because the DCB main areas of activity are undergraduate education and clinical service, but also because the current funding mechanisms do not reward the activities that our research currently under pins.

Table 1

Dental Clinical Board					
R&D Income 2012/13 to 2016/17					
	2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**
	£000	**£000**	**£000**	**£000**	**£000**
R&D Income	0	75	214	155	98
R&D Income commercial trials	27	11	0	0	0
R&D Legacy fund	0	14	11	6	5
Dental SIFT	11,686	11,686	11,686	11,686	11,686
Medical SIFT	1,003	1,003	1,003	1,003	1,003
PGMDE income	690	690	690	658	658
Other service	6,016	6,567	5,923	6,063	6,789
Total Gross income	19,422	20,046	19,527	19,571	20,239
Percentage of income stream against total					
	2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**
	%	**%**	**%**	**%**	**%**
R&D Income	0.0	0.4	1.1	0.8	0.5
R&D Income commercial trials	0.1	0.1	0.0	0.0	0.0
R&D Legacy fund	0.0	0.1	0.1	0.0	0.0
Dental SIFT	60.2	58.3	59.8	59.7	57.7
Medical SIFT	5.2	5.0	5.1	5.1	5.0
PGMDE income	3.6	3.4	3.5	3.4	3.3
Other service	31.0	32.8	30.3	31.0	33.5
Total Gross income	100.0	100.0	100.0	100.0	100.0

Research in the School of Dentistry has developed in a multidisciplinary environment with basic scientists, academic clinicians and NHS staff in DENTL, MEDIC and other Schools working together. While the research is generated within the DCB many of the clinical benefits will not specifically be for dental patients and the translational work will therefore not directly benefit the DCB although research income is recorded by Cardiff University. Current areas of research which are being performed in collaboration with the NHS and translated into patient care include advanced therapeutics and wound healing;

1. Research undertaken with industry (Algipharma AS) and funding agencies (Norwegian Research Council, MRC, Wellcome, EU) has developed novel polymer therapies (e.g. OligoG) for a range of infective/inflammatory diseases. These agents are currently at all stages of development, from in-vitro screening to a portfolio registered Phase 2b multi-centre trial (across the UK and EU). In the first applications of these technologies the clinical trial phase involves cystic fibrosis patients. Whilst this work clearly benefits the wider NHS community and Cardiff & Vale UHB it will not therefore initially be of direct financial benefit to the DCB. Use of OligoG was granted Orphan drug Approval by the US FDA in March 2016.
2. Collaborations with School of Dentistry and Critical Care investigating biofilm biology and pneumonia in intubated patients recruit patients from another clinical board within C&V. The work is underpinned by competitive grant funding based on work undertaken within the School of Dentistry but the translational research in not on dental patients.
3. Research is ongoing to investigate the involvement of specific bacteria in denture biofilms that promote the pathogenicity of the fungus, candida albicans in denture associated stomatitis. This work is supported by an industrial case award and the EPSRC.
4. Collaborative work on the use of oral progenitor cells for repair of kidney damage (Life Science Bridging Fund). This involves collection of oral mucosal biopsies from patients in the School of Dentistry but the project centres on administration of the oral progenitor cells to animal models of kidney damaged in collaboration with colleagues at the MRC Centre for Inflammation Research, University of Edinburgh.
5. Research is ongoing into the development of a new injectable antimicrobial hydrogel for endodontics. This uses teeth obtained from the School of Dentistry Toothbank and is funded by Health and Social Care Research Wales.
6. Studies are progressing into the development of nanocarriers for antimicrobials for incorporation into clinical dental cements to generate antimicrobial restorative materials. This project, funded by the MRC Confidence in Concepts Scheme uses tissue obtained from the Toothbank.
7. Industrial collaboration with Renishaw PLC, has facilitated research into the development of novel antimicrobial coatings for dental implant abutments and investigating the development of a standard for bacterial attachment to implant abutment surfaces. This uses tissue obtained from the toothbank.
8. Arthritis Research UK has confirmed renewed funding of its Centre of Excellence in Cardiff for a further 5 years up to 2020 (£2M) to support translational research. The Centre is a major cross-disciplinary initiative of researchers across the University and the clinical service in orthopaedics and rheumatology to address the 'big questions' in the area of osteoarthritis. The School of Dentistry leads on the biomarker development program that works on new diagnostic procedures that identify rapid onset of degenerative joint disease after acute injury, and patient stratification for different forms of intervention. Over the past 5 years, over 3500 biological fluid samples have been collected, processed and stored to enable the biomarker discovery and evaluation work.
9. Collaborative research with Sheffield University (Coeliac UK & BRET funding) has provided molecular evidence that neurological dysfunction is a distinct form of presentation of gluten intolerance associated with the development of an autoimmune response to transglutaminase 6. Cardiff University researchers led the development of diagnostic tests based on these findings that allow for rapid and accurate diagnosis of patients that previously were difficult to diagnose due to the absence of enteropathy (http://zedira.com/Blog/Transglutaminase-antibodies-in-ataxia_73). Being able to

diagnose and consequently treat patients without delay has major ramifications for the NHS. Further work in collaboration with industry (Zedira) and the Ryder Briggs Trust

The potential to undertake clinical trials in dental patients is limited and the opportunities to secure funding for dental studies are similarly limited. A number of current Dental Portfolio studies recruit general dental practitioners (GDP) in primary care and staff in the School of Dentistry have secured grants as part of portfolio multi-centre clinical trials as collaborators, for example FiCTION. However, Cardiff & Vale GDPs are not part of DCB, so the patients recruited via the practice route do not bring funding to the Dental Clinical Board, although the research income is recorded by Cardiff University.

Commercial Funding Model

The UHB continues to encourage commercially sponsored and funded research, in order to develop more effective treatments for future use within the NHS and, in collaboration with university and industry partners, to be recognised as a centre of research excellence internationally. To this end in 2012 the UHB introduced a formula to ensure that any excess income generated is protected to support R&D and enhance the UHB's strategic goals. The new system distributes income from commercial studies which reflects the work done by the R&D Office, fairly compensates Directorates for their involvement, builds R&D capacity and continues to incentivise principal investigators (PIs).
Costs for commercial research studies are calculated using an agreed UK wide costing template. Total template staff costs comprise standard hourly rates, 20% of these for capacity building and 70% of the standard hourly rates for overheads. All costs are multiplied by the *All Wales Multiplier* (AWM) of 1.09429 to reach the final figure.

Strategic Direction Commercial Funding Model

Staff within the Dental Directorate have in the past successfully undertaken a number of commercial clinical trials. The activity was reliant on two research active consultants; one NHS consultant in Oral Surgery the other an Academic professor in Oral Medicine. Clinical Trials investigating pain relief with wisdom tooth surgery and management of herpes simplex, where the DCB have adequate patient numbers to support studies, have in the past been commercially and academically rewarding.

However, with the retirement of the oral surgeon and the increased managerial responsibility of the Academic colleague commercial trial activity within the DCB effectively ceased in 2012/3. Further, companies undertaking oral and dental clinical studies are increasingly moving clinical trials overseas. Basic scientists and clinicians within DCB and the School of Dentistry are still undertaking funded laboratory based research with these companies which may bring opportunities in the future.

Currently DCB are involved in a single Commercial Study (adopted to Oral and Dental Portfolio) and are in discussions about a further trial. The clinical lead for these studies is a NHS Maxillofacial surgeon, supported by research dental nurses trained to act as R&D support staff with support from assistance from Health and Care Research Wales. The DCB are therefore well placed to support new commercial trial activity.

Actions	Timescale
• Recruit and train Dental Nurses to support current Commercial Studies (Band 5; 4WTE)	complete
• Work with industrial / Commercial partners in laboratory settings to develop links for future clinical studies (Infection, Immunity and oral microbiology research group)	Ongoing
• Continue to support multidisciplinary laboratory research in advanced therapeutics and wound healing	Ongoing

Non Commercial Funding Model

C&V UHB receives an annual allocation from HCRW WG which is based on an Activity Based Funding model.

Since 2012/3 there have been three funding streams:

- NHS Research Support and Governance (RS&G)
- NHS Support Costs (NHS SC)
- NHS Researcher Support and Portfolio Development (RS&PD)

NHS RS&G is centrally managed and not based upon research activity at clinical board level. The clinical board can however attract funds via both NHS SC and NHS RS&PD streams by leading portfolio based clinical trials or recruiting patients for trials registered on the portfolio. Full details are available on the HCRW website. (1)

The HCRW NHS Support Costs (NHS SC) activity based funding model is based on:

- A two year rolling average of recruitment to studies on the Clinical Research Portfolio (CRP), with each study allocated to a complexity band
- Multiplied by the average tariffs associated with the relevant complexity band
- With the average tariffs for each complexity band adjusted proportionately to fit the budget for NHS SC

Complexity Bands

These are used in the model when using recruitment data to allocate costs based on complexity of study, there are three levels:

- *Band 1*: Interventional studies tariff £492
- *Band 2*: Observational studies tariff £117
- *Band 3:* Large Sample Size tariff £36

In other words funding comes to the clinical board based on the number of participants recruited and the complexity of the study. Only patients recruited within the Dental Hospital and School or the Community Dental Service would reward the DCB with recruitment premiums.

The HCRW NHS Researcher Support and Portfolio Development (RS&PD)

There are two separate premiums intended to support researchers to participate in and lead research these are:

- *Activity Premium:* incentivise NHS organisations and researchers to host and participate in high quality research
- *Leadership Premium*: incentivise NHS organisations to lead research and reward CI's to win grant funding.

Ratios are applied based on complexity bands:

- Band 1: Interventional studies Ratio Value 14
- Band 2: Observational studies Ratio Value 3
- Band 3: Large Sample Size Ratio Value 1
- Patient Identification Centres (PICs) Ratio Value 0.5

Funding is therefore closely aligned to recruiting participants to portfolio registered studies, both as lead organisation or as a host site. The funding is related to recruitment only. From 2012 the UHB has been in a transitional phase moving towards the activity based funding

system. From April 2015 the UHB funding model ensures that with the exception of funding allocated for R&D management, research funding received will appear in the budget of the Directorate that undertook the research.

Strategic Direction Non Commercial Studies

Leading studies:

Given the potential financial benefits to the DCB participation in HCRW Clinical Research Portfolio (CRP) studies is an activity that should be encouraged but to date relatively few clinicians within the DCB have experience of leading these projects. Further because of the complexities of these studies it is unlikely that clinical staff would have capacity to lead more than a single study at any point in time.

To date Dental Clinical Board has a single project on HCRW CRP. This was based on a competitive grant (Seal or Varnish, SoV) lead by researchers in DENTL and undertaken in the Community Dental Service. SoV recruited 1016 children to an interventional study lasting 5 years. The recruitment period predates the UHB activity based funding model and the funds that accrued to the UHB as a result of the trial were not, in the main, returned to the directorate. However, this single study was worth

- £450K to the CDS Directorate (approx. £50 per child visit)
- £800K to UHB (not to dental clinical board)
- £1.3M to Cardiff University at 80% FEC

The R&D funding for this study was related to recruitment during 2011 – 2012, but the study was successfully completed until late 2016 and the results presented in 2017. It is however clear that participation in these studies should be encouraged and supported. Opportunities to undertake clinical trials in community settings will be explored by the Chief Investigators if future studies are commissioned by the NHS. The opportunity to follow the cohort beyond the trial was rejected by the funders.

Hosting studies:

Details of all studies open to recruitment on HCRW Clinical Research Portfolio (CRP) are circulated monthly by HCRW Support Centre, and sent to clinical board R&D leads. Professor Ivor Chestnutt as the Welsh representative on the NIHR Oral and Dental clinical network is well positioned to ensure the DCB receives regular updates of all studies based within the UK that are actively recruiting studies. Acting as a host site, recruiting patients to a multicentre study has the potential to bring additional funds into the DCB.
Over the last 2 years none of the studies registered with the NIHR Oral and Dental clinical network were open to recruitment to additional sites. Those that are likely to do so in the short term are looking for General Dental Practices who are not part of DCB but are currently part of PCIC.

Actions	Timescale
• DCB R&D lead to regularly review Portfolio to identify multicentre studies looking to recruit dental patients	Ongoing
• Explore possible collaborations with PCIC to enable closer working with GDP networks	Ongoing
• Chief Investigators to review Seal or Varnish study to identify possible follow on clinical trials based on the study rejected	Completed

References

1. R&D funding policy accessed 7 April 2016
http://www.healthandcareresearch.gov.wales/nhs-randd-funding-policy/

7.4 Medicine Clinical Board

Executive Strategic service priorities:
- Population Health, Stroke, Long term conditions (Diabetes)

1. Background

Significant changes have occurred to the way in which commercially and non-commercially funded research income is distributed within the UHB. The new system is designed to reflect work undertaken by the R&D office, compensates Directorates for their involvement, builds R&D capacity and incentivises Principal Investigators (PIs). This came into effect in April 2012, with the goal that any excess income generated will be protected to support R&D and enhance the UHBs strategic plan to become an internationally recognised centre of research excellence.

2. Non-commercial study funding model

The new funding model is activity based with allocations being made on the basis of a formula which takes into account the:

- Number of Health and Care Research Wales Clinical Research (HCRW) Clinical Research Portfolio (CRP) studies
- Number of participants recruited to these studies
- Number of portfolio studies where the Chief Investigator (CI) is associated with the UHB
- Number of HCRW Academic Health Science Collaboration (AHSC) Clinical Research Fellows employed by the UHB

Complexity bands have also been introduced into the NHS R&D funding formulae in order to differentiate between study complexity and associated costs. The three bands are:

- Band 1 (Interventional studies). A study where the participants' exposure to a particular intervention is influenced by participating in the study (e.g. whether or not a participant receives a particular treatment is determined by the research protocol). Ratio value 11.
- Band 2 (Observational studies). A study in which the participants' lifestyle or care pathway is not affected by being part of the study. Ratio value 3.5.
- Band 3 (Large sample studies). A study where the total UK planned sample size is equal to, or greater than 10,000 participants. Ratio value 1.

This funding can be used to support:

- HCRW Clinical Research Portfolio studies i.e. those studies funded through an open, peer-reviewed, nationally competitive funding stream and accepted onto the Portfolio.
- Pathway to Portfolio studies i.e. work undertaken to inform the development of a portfolio study or a grant application for a portfolio study.

Spending plans and budget management

The Directorate R&D budgets are managed by the Directorate R&D Leads in conjunction with the Directorate Management Team. Each Directorate will be responsible for producing an annual spending plan, and providing reports against this to ensure that the funding is being spent on eligible activity. The spending plan will include the costs of all posts (clinical and non-clinical) that contribute to non-commercial research. This will include all medical Consultant sessions allocated to non-commercial research, Clinical Research Fellow time allocated to portfolio studies, nursing time used to support non-commercial research and administrative support. Directorates will be expected to have systems in place to account for and report on spending against the budget.

Budget lines have been introduced to the Directorates based on their activity (1st October to 30th September before the financial year) and average historical R&D project costs. Future R&D Directorate budgets will change according to activity compared with other Directorates and other NHS organisations in Wales. This is subject to a cap of either 20% of the previous year's budget or £40,000 if higher.

3. Commercial study funding model

Commercial studies are costed using a UK-wide costing template which generate set-up, per patient and additional costs based on standardised staff hourly rates and price lists for investigations. Overhead, capacity building and location cost weighting (the All Wales Multiplier) elements are added to reach the final figure. Commercial income is now distributed according to a new template which depends on whether the PI is a Cardiff University or UHB employee. For UHB PIs, 40% of total UHB template staff costs will return to the Directorate to cover commercial research costs to the directorate including the staff costs of individuals involved and overheads. Twenty five percent of total UHB template staff costs are returned to a specific PI UHB account and can be used for defined activities to support research e.g. staff training, pathway to portfolio work, staff salaries, equipment. Money in PI accounts is available until 18 months after the date of the last major assessment point (usually the last patient, last visit), after which residual funds are transferred into the Research Legacy Fund, 20% centrally and 80% at Directorate level.

4. Strategic research priority areas

The strategic direction for R&D within Medicine reflects local and national strengths and priorities for research and development in Cardiff and in Wales. Research aligns with Welsh Assembly Government/HCRW, Cardiff University (College of Biomedical and Life sciences) and South East Wales Academic Health Science Partnership (SEWAHSP)[2] priorities.
Welsh Assembly Government policy priorities are:

- Health inequalities
- Chronic diseases
- Cancer
- Mental health
- The health of children and older people
- Service delivery and organisation

The strategic priority themes of SEWAHSP are:

- Cancer
- Cardio-respiratory and diabetes
- Genetics and genomics
- Health Services and Delivery Research
- Infection, inflammation and immunity
- Neuroscience and Mental health
- Primary care and public health
- Regenerative medicine and healthcare
- Healthcare education and healthcare education research

The Directorate R&D Leads thus assume greater responsibility in ensuring that only Portfolio studies and high quality pathway to portfolio work which meets these priority areas will be supported. The amount of pathway to portfolio work that can be supported will depend on the Directorate R&D budget and strategy.

HCRW has also developed a policy document for industry engagement in Wales[3]. This sets out a vision:

- For the NHS to play a pivotal role in delivering research, development and innovation and develop a business friendly culture where engagement with industry is a core organisational activity.
- For engagement between academia and industry to become a natural process of innovative collaboration which results in addressing unmet clinical needs and economic growth.
- For Wales based researchers to play a greater role in securing funding from UK and European translational research schemes in order to meet future clinical unmet needs and carry forward new and innovative ideas.
- For patients in Wales to be consistently offered the opportunity to participate in clinical research and play a greater role in global drug discovery programmes, new technologies and medical devices.
- For NHS R&D offices to build on existing strengths and consistently deliver commercial research studies in a competitive, global environment.
- For government to work together to promote Wales as a distinctive brand within UK PLC.

This represents a fundamental change in policy to place engagement with commercial partners at the heart of R&D activity in Wales.

5. Strategic direction: non-commercial studies

R&D income in Medicine is significantly less than our historical baseline and is likely to fall further in the short-term as the Transitional Funding component of the HCRW allocation comes to an end. It is clear that the historical model of adopting all new non-commercial research proposals is no longer viable. With the development of a transparent funding stream which has at its core an activity based model dependent on portfolio studies, research activity within the Medicine Board will need to be streamlined to focus on portfolio work and high quality pathway to portfolio studies. The new funding formula presents an opportunity to increase our non-commercial income year-on-year if we are able to focus our activity along the following lines:

a. **Increase the number and proportion of HCRW registered clinical research portfolio studies.**

There is anecdotal evidence that many PIs are (a) unaware of the benefits and importance of portfolio adoption, (b) unfamiliar with the process of adoption onto the HCRW Clinical Research Portfolio, and (c) unaware that the adoption process is slightly different from that in England. In addition to the list of automatically eligible funders, studies in Wales (but not in England) may be eligible for portfolio adoption if funded in open national competition from a non-automatic funder, if supported by high quality external peer review.

In addition to increasing R&D funding, adoption onto the HCRW portfolio also offers the following benefits:

- Local research activity is registered on the UK database and is visible UK-wide, thereby raising awareness of research activity in Wales across the UK and to Industry. This also promotes research studies to potential collaborators.
- PIs are able to apply for HCRW Research Network support
- Staff working on a portfolio study will have access to HCRW training courses

Portfolio adoption, whether applied for via the mechanism outlined above or whether conferred automatically by grant award from an automatic funder, is therefore key to the process of enhancing research quality and R&D income within the Medicine Board.

b. **Maximise recruitment and data upload for portfolio adopted studies**

The Medicine Board Directorate HCRW returns show a low number of participants recruited into the majority of the portfolio studies registered. A strategic priority must therefore be to

engage with PIs to ensure that all opportunities for recruitment have been explored and that appropriate support is made available to help with this.
There may also be issues with recruitment upload which need support. Data from portfolio adopted studies must be collected and uploaded accurately and in a timely manner in order for the HCRW formula to correctly reflect activity. Whilst it is the responsibility of the Chief Investigator (CI) to upload the portfolio data, when the CI is not based locally this may not happen automatically leading to a failure to accurately capture all local recruitment into a study.

***c.* Increase proportion of studies with CI associated with the organisation**

Studies where the CI is associated with the organisation are associated with a higher tariff. Where possible, studies with a Medicine Board CI should be prioritised. This has the added benefit of enhancing the reputation of the Board for research excellence.

***d.* Prioritise interventional studies in the Translational gaps**

The improvement of research translation is a key aim of most UK research funders, a focus which stemmed from the Cooksey report. He highlighted two bottlenecks in the translation process:

- Gap 1 relates to the process of taking basic science ideas and developing them into products that can be commercialised or taken into healthcare practice.
- Gap 2 relates to the evaluation and identification of those new products and interventions which are appropriate for everyday use by the NHS, and the process of their implementation into routine clinical practice.

The SEWAHSP report[2] identifies two other gaps:

- Gap 3 concerns the failure of evidence to progress into clinical practice because of the barriers created by everyday clinical encounters (implementation science).
- Gap 4 relates to population based data, both biomedical and psychosocial, being available to feed into the translational process.

Investigators within the Medicine Clinical Board are very well placed to develop a strong portfolio of research studies covering these translational gaps since the clinical disciplines in medicine lend themselves very well to experimental research (early phase clinical trials covering Gap 1) and later phase studies. Interventional studies come with a significantly higher tariff (Ratio value 11), reflecting the greater complexity of these studies, and have the potential to enhance R&D income accordingly. The higher complexity demands careful planning in study design (including extensive statistical support in establishing sample size and analysis) and execution (to include robust processes for research governance). The infrastructure needed to support such studies should be developed and embedded within the Medicine Board R&D structure.

***e.* Meet and exceed HCRW targets covering non-commercial research**

HCRW has set challenging targets for non-commercial and commercial research.
For non-commercial research, these can be summarised as:

- Increase the number of Clinical Research Portfolio (CRP) studies and recruitment into them by 10% per annum over the next 3 years.
- 80% of studies to receive NHS research permission within 40 calendar days
- 80% of studies to recruit the first patient within 30 days of approval/initiation
- 80% of studies recruiting 80% of target
- Reduce percentage of non-recruiting studies to less than 10%
- Increase the number of CIs leading a HCRW CRP study (no target set) and the number of CRP studies being sponsored by the organisation (no target set)

These are ambitious targets but within our grasp if we are able to develop a strong and supportive research infrastructure for non-commercial research in Medicine. We should aim

to establish ourselves as the lead R&D Board within the UHB in delivering on these performance metrics within the next 3 years.

6. Strategic direction: commercial studies

It is important that the Medicine Board is active in commercially sponsored and funded research, in order to:

- Develop more effective treatments for future use within the NHS
- Be recognised as a centre of research excellence internationally
- Save on drug costs
- Support the R&D infrastructure (Clinical Research Facility, Pharmacy, staff training)

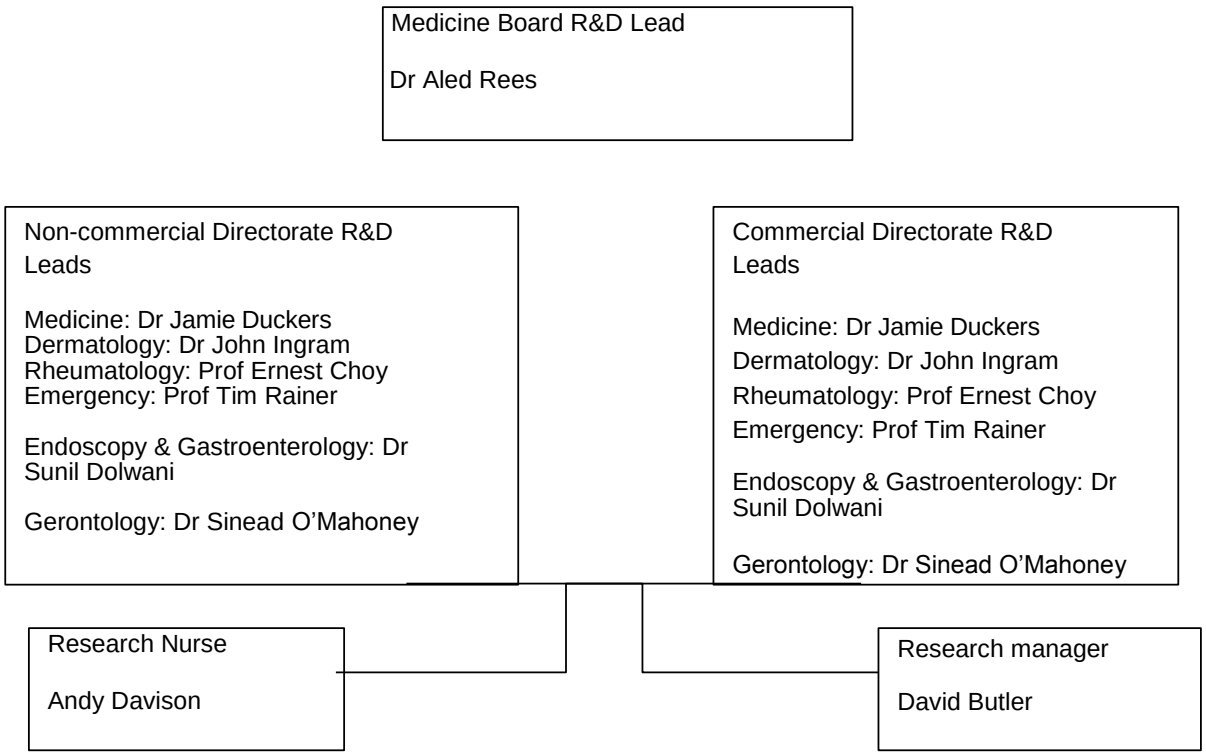
We need to enhance our reputation with industry by accelerating approval processes for commercial trials, improving recruitment rates by incentivisation of staff to refer eligible patients, ensuring that industrial partners are able to link quickly with high quality PIs within the Medicine Board, and by ensuring high quality study data. Commercial partners need to have confidence that the expertise and facilities available are of the highest quality and that we have access to the relevant patient populations.
Clinicians find it challenging to deliver on these goals because of difficulties in securing protected time from clinical duties, in overcoming regulatory hurdles and in accessing manpower support to deliver trials.

Establishing a commercial clinical trial unit within the Medicine Board

In order to deliver on C&V and HCRW targets for commercial studies we recommend establishing a commercial clinical trial unit to provide a clearly identifiable point of contact for companies. The trial team would build on established infrastructure, and coordinate activity between Industry, PIs and partner Institutions (Universities and Health Boards). They would ensure quick identification of new sites by disease area and would help to meet HCRW targets for trial capture and recruitment.
In order to ensure effective study delivery, the Medicine Board commercial trial centre would need to:

- Engage with HCRW Registered Research Groups of relevance to Medicine.
- Develop a close working relationship with R&D and the HCRW Permissions Coordinating Unit (PCU) to ensure timely delivery of study approval
- Involve research teams at an early stage
- Incentivise clinical colleagues to maximise recruitment
- Coordinate training of study staff

7. Investment needed to meet objectives and possible funding sources
The organisational R&D structure for the Medicine Clinical Board is set out below.



In order to support the objectives outlined in sections 5 and 6, income from the HCRW R&D allocation has been used to pump-prime the establishment of 2 new posts in the Medicine Board in the appointment of a Research Manager and Research Nurse. The Medicine Board aims to secure these posts in the long term and further add to the team with anticipated R&D income growth.

Funding

The creation of these key positions is central to our goal to establish the Medicine Board in Cardiff & Vale as a centre of research excellence. The change in R&D funding approach, whereby money flows to Directorates based on the extent of high quality portfolio and commercial trial activity, provides an opportunity for a significant uplift in research quality, quantity and income within the Medicine Board. The anticipated uplift in research activity arising upon these appointments thus has the potential to increase R&D income to an extent that these posts will be self-funding in the near future.

Future considerations

Support from the Board is requested in the first instance to secure the new positions on a permanent basis. These are currently 1-2 year fixed term appointments, extendable on a permanent footing dependent on performance against key activity measures.

1 Uplift in non-commercial income from the HCRW allocation by increasing the number of portfolio adopted studies, overall recruitment and recruitment to target, and proportion of studies with Cardiff & Vale CIs.
2 Uplift in commercial income which will include savings on expenditure for high

cost drugs. Commercial studies which target expensive drugs should thus be prioritised.

With the anticipated uplift in R&D income within Medicine, opportunities will also emerge to create new research nurse positions in Medicine in 2017/18 or beyond. This would:

1 Encourage the development of a cadre of research nurses possessing *generic* research skills and capability.
2 Facilitate access to *all* PIs within the Medicine Board who are actively engaged in non-commercial or commercial clinical research.
3 Replace the historical model of speciality-specific, PI-employed research nurses in Medicine
4 Reduce the risk to individual research nurse posts by allowing flexibility of PI/trial allocation, dependent on which studies are open and recruiting within Medicine. Current PI-specific posts are vulnerable if commercial trial activity falls within that speciality.
5 Reduce research governance risks by ensuring that training in research skills is maintained on a regular basis.

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7.5 Mental Health Clinical Board

Executive Strategic service priorities:
- Dementia and Mental Health

Professor Ian Jones

Background

Significant inequalities exist between physical and mental health care, including preventable premature deaths, lower treatment rates and an underfunding of healthcare and research relative to the scale and impact of mental health problems. Mental illness is a major cause of suffering and contributes greatly to the social and economic burden of disease in Wales, and beyond. The economic cost of mental illness to Wales is considerable, estimated to be £7.2 billion (2007/08). Given the suffering that results from these disorders there is a significant funding gap in the money spent on mental health research compared to other conditions. For these reasons supporting mental health research is a vital activity for the NHS and increasing research activity in the mental health division of the Cardiff and Vale University health board is a key target in the coming years. Mental health research in the Health Board takes place in the context of the National Centre for Mental Health (NCMH) operating out of Cardiff University and this leads to some opportunities from which we must ensure we maximise the benefit.

NCMH (http//www.NCMH.info) was established in 2011 as Wales' NISCHR funded Biomedical Research Centre (BRC) forming the interface between Cardiff University's Medical Research Council (MRC) Centre for Neuropsychiatric Genetics and Genomics (CNGG) and the NHS in Wales. It has made considerable progress in supporting and undertaking mental health research, and in involving and engaging patients, carers, health and social care professionals and the wider public. NCMH funding has recently been renewed for the next five years.

The NCMH overarching aims are:

- To advance mental health and learning disability research in Wales – to support areas of excellence and develop capacity in new areas of excellence.
- To engage with patients, their families, the wider public and third sector organisations in Wales to increase understanding of mental illness and LD and the need for research in these areas
- To change the research culture in health and social care services in Wales with the ultimate goal of all individuals accessing care being invited to participate in research.

In the next phase, NCMH will develop in a number of key ways including extending to include Principal Investigators (PIs) from Swansea and Bangor in addition to Cardiff University. As a portfolio study recruiting large numbers of participants (6,000 to date) and covering all health boards in Wales, it is important that we maximise the benefit to the Cardiff and Vale health board by ensuring adequate support is given to recruitment here.

We have world leading Mental Health and Neuroscience work in Cardiff, reflected in the performance in REF 2014 where Cardiff was ranked second in the UK in this area. The funding of NCMH from Heath and Care Research Wales (HCRW) gives us great opportunities to take advantage of this infrastructure support and build mental health research that will result in a number of advantages to the health board, not merely financial,

including a more educated and research focused workforce and leading to better clinical outcomes for patients. Despite the world leading mental health research being led from Cardiff, historical divisions between the University and health board have meant that that this has not translated into health board R&D activity. We have an opportunity to overcome these historical issues. The directorate lead for R&D, Professor Ian Jones, is Director of NCMH and aligning the Mental Health Directorate research and development strategy with the activity of NCMH has the potential to result in numerous benefits.

In addition to the strengths in biological research in Cardiff and work in NCMH, the UHB has a long history of significant other research activity including, but not limited to:

1. The Traumatic Stress Research Group (TSG), founded and led by Professor Jonathan Bisson and group including several members of staff from the MHCB (Dr Mat Hoskins, Dr Neil Kitchiner, and Dr Neil Roberts). This group is internationally recognised for its work on the treatment and prevention of PTSD and through its publication of a number of systematic reviews, particularly with the Cochrane Collaboration. The group has worked closely with NCMH since its development and enjoys strong collaborative relationships with Wales-based experts in Health Economics, Neuroimaging, Oral and Maxillofacial Surgery, Research Design and Statistics, and a range of other national and international researchers. The All Wales PTSD Registry is a portfolio study closely aligned with NCMH and recruiting throughout Wales. As with NCMH it is important that we maximise the benefit to the Cardiff and Vale health board by ensuring adequate support is given to recruitment to current and future TSRG portfolio studies.

2. Mental health services research, including in studies led by researchers in Cardiff University's School of Healthcare Sciences. Findings from projects of this type help managers and practitioners understand how mental health systems work, and how care and its organisation can be improved. Examples of mental health services studies are investigations into care planning and care coordination, the use and effects of triage, the work and impact of community crisis teams, services to meet the needs of people with comorbidities, responses to treatment refusal in people with dementia, and the management of risk for young people using mental health services. Studies are often informed by social scientific ideas and use qualitative and/or mixed methods, and increasingly are coproduced by research teams including people with lived experience of mental illness and of service use.

Non-commercial study funding model

Our goal will be to maximise research activity in the mental health directorate. Specifically this will be to increase

1) the number of portfolio studies in mental health

2) the number of participants in portfolio studies

3) the number of Cardiff and Vale University Health Board staff and services actively engaged in research

It is worth noting that the number of studies registered, while important, is not the most important metric. Many studies registered in the health board (approximately 25%) recruit only one or fewer participants. Therefore studies which may potentially recruit hundreds of participants are more financially important to support than those which may only result in small numbers. The NCMH and PTSD cohorts provide an ideal opportunity for us to

maximise recruitment into portfolio studies and strategies to significantly increase participation from Cardiff and Vale University Health Boards must be explored. In order to maximise financial benefits the Health Board should actively support involvement in intervention studies as these attract a higher participant premium.

It is vital to the success of this strategy that clinical services are fully engaged in research. Far too often in clinical services, informing potential participants about opportunities to participate in research is not considered to be important and indeed at times services have seen their role as protecting people from being approached. In other areas of medicine the situation is very different, for example in the UK 1 in 3 cancer patients are actively participating in research – in mental health services participation is one or two order of magnitudes lower. Engagement with research has well recognised benefits for clinical services. Research involved clinicians are likely to encourage research informed services by facilitating the dissemination and implementation of evidence based approaches, with obvious benefits for patients and service effectiveness. Active engagement in research can also enthuse and motivate staff with consequent benefits to recruitment and retention and service culture.

Other Health Boards in Wales have already taken the opportunity to maximise portfolio study recruitment that the NCMH cohort affords and have invested in this regard. For example, funding has been provided to free up clinical staff to focus on recruitment in AB Health Board and this is paying off with significant increased recruitment figures. Similar strategies should be considered in Cardiff and Vale.

It will also be important to develop novel approaches for recruitment including making invitations to participate in research a routine part of the assessment of those in contact with services in the health board. Examples being piloted in other health boards include Cwm Taff HB bringing in routine ascertainment for all CAMHS referrals. Taking a lead from the Traumatic Stress Service where routine ascertainment is already embedded, we must begin to explore similar approaches in other services across Cardiff and Vale.

The existence of the NCMH and PTSD cohorts will not just bring benefits in the initial recruitment of participants but the fact that participants are consented for further contact means that they are a resource that we can then go on to take advantage of in further grant applications and new portfolio studies.

NCMH will also enable staff who are developing ideas for research studies to link in with a portfolio study. Whenever possible new areas of research activity in the health board should be developed linked in with NCMH activity and in this way pathway to portfolio and even studies not classed as pathway to portfolio can be supported and will generate income for the health board.

Commercial study funding model

There has been less commercial funded mental health research than other areas of medicine, not just in Cardiff and Vale Health Board but throughout the UK. The reasons for this are multiple and include both a withdrawal of pharma from mental health drug development and also a culture in mental health services, as discussed above, which is suspicious of research in general and commercial activity in particular. Developing commercial funded research, however, is a key strategic aim which aligning with NCMH activity will be key to deliver.

NCMH provides an essential resource for developing NHS-industry-academia partnerships

important for growing the Welsh economy and improving health. Critical to this effort are the unique resources developed through the NCMH cohort. These include participants consented for collaborative studies with industrial partners, and critical banked bio-resources including DNA, cellular and imaging samples. The NCMH biobank provides the bedrock for a range of ongoing and future commercial collaborations aimed at patient stratification, biomarker development, the development of medical devices and novel therapies based on behavioural/imaging approaches or the development of new drugs.

To achieve our goal of maximising NHS-industry academia partnerships we will continue to link closely with relevant agencies including Health Research Wales (http://www.healthresearchwales.com/), the Life Science Wales Knowledge Exchange Project, and the Life Sciences Research Network Wales. We will ensure our plans are consistent with HCRW's broader industry engagement strategy. In particular we aim to work closely with the full range of HCRW funded infrastructure to ensure a coordinated approached to commercial engagement.

NCMH has already established a broad range of collaborative interactions with major global companies. For example NCMH PIs are actively engaged in collaborations with major industrial partners including: (i) Janssen via the Severnside Alliance for Translational Research (SARTRE; www.sartre.ac.uk – development of novel drug target validation strategies); (ii) Lilly via our membership of the Lilly Centre for Cognitive Neuroscience (targeting cognitive enhancement in conditions including dementia and schizophrenia) and (iii) Astra Zeneca through a programme of joint PhD studentships. In addition, NCMH members also work closely with smaller and non-pharma companies. We believe it is vital that we develop a broad range of collaborations that include small and medium sized enterprises.
Over the past few years there has been increasing interest in mHealth (health care delivered through computers and mobile devices such as smart phones and tablets) with more individuals becoming aware and keen to receive treatment, including psychological intervention, through these means. Therefore, in addition to collaboration with pharmaceutical companies we should also consider collaboration with IT based partners when the opportunity arises.

We have identified a number of areas that show great potential for further integration and development with commercial partners including: (i) neural stem cell biology (eg with ReNeuron); (ii) brain imaging and neuromodulation (eg with Magstim and Neuradaptix Ltd); (iii) medical diagnostics and devices (eg with Siemens Healthcare and GE); (iv) drug development (eg with Penn Pharmaceuticals, Albany Molecular Research Inc. and Quay and Quotient Bioresearch). Engagement in major post-genomic consortia with major industry partners such as Lilly through vehicles such as the Innovative Medicines Initiative (IMI). Through our links with NCMH we have specific plans to further develop industry integration and will be able to take advantage of developments such a major industry stakeholder meeting and more regular meetings with potential partners. It will be vital for the health board to ensure that it is well placed to benefit from these developing industrial collaborations established by NCMH.

Public and Patient Involvement

The Mental Health Clinical Board and its research partners have a good record in involving people in research both as advisors, co-applicants and as researchers. The NIHR funded COCAPP-A is a good example of a multi-centre study involving service users in the design of the study and as paid researchers. NCMH working with the clinical board needs to develop structures and approaches that enable patients and carers to participate in setting

research questions and priorities as well as engaging the design and delivery of research.

Investment needed to meet objectives and possible funding sources

The mental health clinical board needs to work with the NCMH to create capacity for high quality research. Firstly by maximizing research income and reinvesting these funds in research activity. Secondly recruiting and developing clinical researchers, and engaging all NHS staff and patients with research activities.

1. Maximising funding from research.

Aligning our strategy with NCMH activity is key and will enable us to maximise the benefit of the HCRW investment in this infrastructure. However, NCMH is a Wales wide initiative and we in the health board must act to ensure that we maximise the benefit in our health board. Other health boards have already seen the potential benefits from investing in staff time to aid recruitment to the cohort and in working towards the routine ascertainment of patients. As the models of R&D funding become clearer we must work towards a more transparent relationship between R&D time in individual staff job plans and activity that results in income generation for the Health Board by leading studies and through recruitment to portfolio studies.

Specific examples will include support from staff time the health board for initiatives run from Cardiff such as the trauma registry and allocating staff time to recruitment for NCMH.

We also need to build support in clinical services for recruitment and explore models whereby patients can be routinely approached as part of their clinical work up about research. Many of our competitors – for example the “consent for consent” initiative at the South London and Maudsley Trust are already doing this and we risk slipping further back if we do not introduce similar procedures here.

2. Developing research active clinicians and engaging all staff and patients in research.

The mental health board has a key role in attracting promising or established researchers as members of the clinical teams. The board should place emphasis on research in its employment practices relating to recruitment and progression. To assist progression the board working with the NCMH needs need to support clinicians to apply for Health Research Awards through the HCRW Research Fellowship program and other similar programs. The Mental Health Clinical Board has a role in supporting trainee doctors, psychologists, nurses, OTs and other professions to complete research studies as a part of their training programs. Projects which form part of a professional award play a valuable role in enabling service evaluation and in addressing novel academic questions. However, these projects are often small in nature and have limited generalizability in terms of their findings. Studies that have not achieved portfolio or pathway to portfolio status can no longer be supported through the Health Board’s R&D allocation and smaller projects will therefore need to be funded and resource supported through their academic institution. The Health Board should encourage clinical and academic supervisors to develop projects that are either linked to existing portfolio studies, or which are likely to contribute to future portfolio study applications.

Our workforce and the public we provide a service for need to be engaged in our research and benefit from the work of our researchers. The clinical board working with the NCMH will extend the impact its research makes by developing partnerships between NHS staff the NCMH other agencies, institutions, industry, service users and carers that provide benefit for the local community. The board will create a mental health clinical research network with which to engage clinicians in research activity, research findings and applications.

7.6 Primary, Community and Intermediate Care Clinical Board

Research & Development (R&D) Strategy
2015 to 2020

Contents

1. **Introduction**
2. **Purpose**
3. **Definitions**
4. **Duties**
5. **Non-commercial study funding model**
6. **Commercial study funding model**
7. **Prioritisation of Work**
8. **Strategic direction**
    - Maintain a support and governance function
    - Raise the profile of PCIC in promoting research and develop further capacity to undertake high quality research
    - Initiate innovation by leading on research activity within the PCIC directorate
    - Commercial studies
9. **Investment needed to meet objectives and possible funding source**
10. **R&D programme development**
11. **References**

Appendices

Introduction

Cardiff and Vale University Local Health Board (the C & V UHB) is a statutory body that was established on 1st June 2009 and became operational on 1st October 2009 under The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778 (W.66)), "the Establishment Order". The 'Primary Community & Intermediary Care' (PCIC) Clinical Board was formed formally on the 2nd December 2013 following formal feedback from the PCIC Clinical Board authorisation process (round 1), and approval to Clinical Board status, and in line with the C & V UHB organisational strategy Organising for Excellence

The PCIC Clinical Board Vision can be seen through the locality vision statements for each of the three localities representing the communities of Cardiff and the Vale of Glamorgan.

Vale Locality Vision Statement:

'To plan, deliver and enhance integrated accessible, community based health and social care services that keep you as independent, well and content as possible'.

South East Locality Vision Statement:

'Enabling equitable access to care from a wide range of (culturally sensitive) services based upon the diverse needs to the local population and high levels of deprivation.'

North West Locality Vision Statement:

'Provision of health and social care in a collaborative integrated structure, based on prevention and on needs with adequate resource'.

Additionally, Palliative and Supportive Care research has been highlighted as a priority area for development by both 'National Institute for Health Research' (NIHR) and 'Health and Care Research Wales' (HCRW) over the last decade following the NCRI Strategic Report of 2004. In Wales it is embedded within Welsh Assembly Government Strategies including 'Together for Health: Cancer Planning for the NHS to 2020' (2017) and 'The End of Life Care Delivery Plan' (2017).

As health-care services modernise to meet the growing demand placed on it, the policies must be underpinned by highest quality of evidence which research can provide. Research has been identified by the PCIC board as a crucial component of evidence-based care provided within primary care and research development and performance constitute core components of the UHB's end of life strategy for 2017 -2020. This document declares the intended 'Research & Development'(R & D) strategy for the PCIC board for the period 2017 to 2020, reflecting the continued commitment to the Cardiff and Vale UHB R & D policy and in delivering key services that are ultimately based on sound evidence.

Purpose

This document sets out the intended plan for the continued advancement of 'Research & Development' (R & D) activity in the PCIC directorate during the next four years. The strategy aim is to improve health outcomes for patients and carers by generating and using sound information on which decisions about service provision can be based. In meeting this aim the objectives are to:

- Ensure that high quality research is undertaken.
- Ensure equitable access to research and information for all patients across all care settings
- Maintain support and governance functions for primary-care and palliative care staff undertaking research.
- Improve research environment
- Deliver on engaging multiple professionals in research, in collaboration with academic settings
- Develop an integrated palliative research strategy to allow studies to cross care settings
- Improve on capability to undertake high quality research within the board that informs and improves patient care
- Strengthen collaborations with research partners i.e. other clinical boards, HCRW and higher educational institutes like Cardiff University leading to development and or uptake appropriate research projects.
- Assess the impact of research activity on after-care at the end of research study in primary-care practices of C & V UHB
- Promote and raise the profile of the PCIC research culture.

Definitions

Research: Clinical research activity is about objectively looking at proposed new ways of working or new treatment options in order to inform service developments and improve patient outcomes and evidence-based practice.

Research Support Services: a framework of good practice and standard procedures to simplify and speed up local research management as well as managing operational risk proportionately. Within PCIC this function will be led by the 'Research Lead'.

Good Clinical Practice: set of laws, guidelines and frameworks which govern the set up and conduct of clinical research.

Clinical Research Portfolio studies **(CRP):** Funded through an open, peer-reviewed, nationally competitive funding stream

Pathway to portfolio studies: Undertaken to inform the development of a portfolio study or a grant application for a portfolio study – Includes feasibility and pilot activity along with work to develop a platform for future portfolio studies

Commercial studies: Funded by profit-making organisations such as pharmaceutical companies and medical devices

Duties

The responsibility for R & D within the PCIC Clinical Board is over seen by the 'Research Lead' for primary-care. Strategic development will be guided by 'Head of Medicines Management PCIC' (HoMMP), 'Head of Primary-Care Operations' (HoPC), lead for Palliative Care research and monitored by the PCIC clinical Board (Appendix 1).

The 'Research Leads' will be members of the Cardiff and Vale Research Review Service (CaRRS) and will review all potential primary care and palliative care research applications and provide feed-back to the Cardiff and Vale University Health Board 'R & D Director'. All research applications that receive a favourable feed-back at the CaRRS review process will receive final approvals from the 'R & D Director'.

Local site applications will be dealt with within the PCIC Clinical Board. The 'HoMMP', 'HoPC' and Palliative Care and Primary-care 'Research Leads' will review site specific applications and make final joint decision on research site approval. This will be fed back to the Health Board R & D office who will then liaise with the study teams and the research site to proceed with the research activity. Research log will be maintained by the 'Research Manager' (see Appendix 2 & 3).

Strong links with other departments, research sites and quality initiatives across primary care/palliative care research activity within the UHB must be developed and maintained. This is the key requirement of the primary-care 'Research Lead' role.

Non-commercial study funding model

The new funding model from HCRW is activity based with allocations being made on the basis of a formula which takes into account the:

- Number of HCRW Clinical Research Portfolio (CRP) studies
- Number of participants recruited to these studies
- Number of portfolio studies where the Chief Investigator (CI) is associated with the UHB
- Number of HCRW Clinical Research Fellows employed by the UHB

Complexity bands have also been introduced into the NHS R&D funding formulae in order to differentiate between study complexity and associated costs. The three bands are:

- Band 1 (Interventional studies). A study where the participants' exposure to a particular intervention is influenced by participating in the study (e.g. whether or not a participant receives a particular treatment is determined by the research protocol). Ratio value 14.
- Band 2 (Observational studies). A study in which the participants' lifestyle or care pathway is not affected by being part of the study. Ratio value 3.
- Band 3 (Large sample studies). A study where the total UK planned sample size is equal to, or greater than 10,000 participants. Ratio value 1.

This funding can be used to support:

- HCRW Clinical Research Portfolio studies i.e. those studies funded through an open, peer-reviewed, nationally competitive funding stream and accepted onto the Portfolio.
- Pathway to Portfolio studies i.e. work undertaken to inform the development of a portfolio study or a grant application for a portfolio study.

Spending plans and budget management

The Directorate R&D budgets are managed by the Directorate R&D Leads in conjunction with the Directorate Management Team. Each Directorate is responsible for producing an annual spending plan, and providing reports against this to ensure that the funding is being spent on eligible activity .The spending plan will include the costs of all posts (clinical and non-clinical) that contribute to non-commercial research. This will include all medical Consultant sessions allocated to non-commercial research, nursing time used to support non-commercial research and administrative support. Directorates will be expected to have systems in place to account for and report on spending against the budget.

Budget lines have been introduced to the Directorates based on their activity (1st October to 30th September before the financial year) and average historical R&D project costs. Future R&D Directorate budgets will change according to activity compared with other Directorates and other NHS organisations in Wales. This is subject to a cap of either 20% of the previous year's budget or £40,000 if higher.

In 2012, National Institute of Social Care and Health Research (NISCHR is currently rebranded as HCRW), Welsh Government published a NHS R&D Funding Plan 2012/13-2014/15 which set the policy context and outlined the vision for establishing NHS funding streams to support high quality studies taking place in the NHS, as well as the development of a activity based funding model for NHS R&D.

Activity based funding (ABF) was introduced in 2012/13 and was implemented through a three year transition period, with 2014/15 being the third and final year of transition. The ABF formula incorporates a needs based assessment of R & D Office costs, a Leadership Premium based on the number of Chief Investigators and Clinical Research Fellows as well as an Activity Premium based on the number of studies and recruits. The fairness of the ABF funding methodology is inherently dependent on the relationship between the activity measures incorporated within ABF formula and the actual costs of R &D.

Cardiff and Vale UHBs allocation has fallen each year since 2013/14 following the introduction of the ABF approach as follows:

2013/14 funding £6.467m

2014/15 funding £5.851m

2015/16 funding £5.576m

2016/7 funding £5,446m

HCRW has recently developed a non commercial R & D study costing template which has similarities to the commercial R & D costing template. The level of resource required to populate the template for each new study will depend on the complexity of the study. The template could potentially influence future HCRW allocation policy as well as providing useful information to determine whether or not an R & D study can be supported by the UHB.

It is unclear at this stage whether HCRW allocation policy will change from 2016/17 onwards

Commercial study funding model

Commercial studies are costed using a UK-wide costing template which generate set-up, per patient and additional costs based on standardised staff hourly rates and price lists for investigations. Overhead, capacity building and location cost weighting (the All Wales Multiplier) elements are added to reach the final figure. Commercial income is now distributed according to a new template which depends on whether the principal investigator (PI) is a Cardiff University or UHB employee. For UHB PIs, 40% of total UHB template staff costs will return to the Directorate to cover commercial research costs to the directorateincluding the staff costs of individuals involved and overheads. Twenty fivepercent of total UHB template staff costs are returned to a specific PI UHB account and can be used for defined activities to support research e.g. staff training, pathway to portfolio work, staff salaries, equipment. Money in PI accounts is available until 18 months after the date of the last major assessment point (usually the last patient, last visit), after which residual funds are transferred into the Research Legacy Fund, 20% centrally and 80% at Directorate level. If the

PI is a Cardiff University employee the R&D department and directorate still have the same percentages of template costs but none of the money goes to a PI specific count, rather it goes to Cardiff University.

Prioritisation of Work

The Cardiff and Vale UHB's Vision is ***"to be the recognised leader"*** providing highest quality of health care to its resident population and further to contribute more widely to the development of evidence based at a national and international level. Research knowledge and activity within the PCIC directorate will contribute to the C & V UHB's vision for the provision of future health care. PCIC's main R & D objectives are set out as below:

Strategic Objective 1: Research activity is closely linked with quality of care provision. This first and foremost strategic objective aims to promote a research friendly environment and maintain the provision of effective and timely governance function.

Strategic Objective 2: This aims to further develop research skill and capacity within the primary-care and palliative care workforce within the UHB. Key communications with primary-care practices, palliative care organisations and other research organisations will help to raise the profile of PCIC as a research active organisation and encourage practices to contribute to its developing research culture.

Strategic Objective 3: Changing service models should be evaluated and underpinned by an evidence-base. This developing research strategy will aim to evaluate existing and new models of care pathways within primary care in C & V UHB thus informing future primary-care services.

Strategic Objective 4: To build on objectives one and two to ensure that PCIC undertakes high quality supportive and palliative care research. This will align with UK and Welsh priorities for palliative and end of life care research, as guided by initiatives such as the Palliative and End of Life Care Priority Setting Partnership led by the James Lind Alliance.

Strategic direction

Maintain a support and governance function

This Strategy continues PCIC's commitment to supporting a culture of research excellence by observing the requirements set out in legislation and NHS policy i.e. *NHS Research Governance Framework for Health and Social Care in Wales 2009; Standards for Better Health 2004; Best Research for Best Health 2006.* The Framework applies to everyone involved in research in a health and social care setting and includes: clinical research; non-clinical research; any research undertaken by NHS staff using NHS resources. A new UK research policy framework for Health and Social Care has been drafted and issued by the 'Health Research Authority' (HRA) and the individual devolved administrations for early comment. A formal consultation period has taken place and the document is due for release this year.

Research Support Services will guide research projects through the Research Governance process and function as a gatekeeper where appropriate. A system of recording all research activity will continue to be maintained in order to ensure compliance with research governance requirements, and to log progress of research projects. Financial and resource implications of all research projects will be considered by the board to ensure its best use for patient benefit.

Ensuring high quality research is undertaken:

PCIC will seek to undertake research that will ultimately improve patient outcomes, in line with local, regional and national priorities. We will aim to have a balanced approach in promoting different type of research studies with this directorate incorporating portfolio and non-portfolio based projects, commercial projects and projects funded by charities.

All research undertaken within the UHB will be robust and of a high standard, and must be conducted in accordance with the Research Governance Framework for Health and Social Care in Wales (2009), HCRW, NIHR and other relevant UK legislation.

From a palliative perspective, providing access to research for vulnerable patients in the appropriate settings is a significant challenge and a specific threat to delivery of the UHB's end of life strategy if not appropriately resourced. Key developments include the NIHR response to the Neuberger Report on End of Life Care and the Palliative and End of Life Care Priority Setting Partnership (PeolcPSP) led by the James Lind Alliance. These initiatives will heavily influence and shape the future research agenda in palliative care from health, social and cultural perspectives. Grant capture will require a breadth of methodological, trials process and clinical expertise which is available in South East Wales, but which requires a coordinated alliance across institutions and care settings.

The development of the Marie Curie Palliative Care Research Centre (MCPCRC) at Cardiff University has resulted in significant grant capture and inward investment, and unprecedented recruitment of patients to palliative portfolio studies across Wales, in particular within the Cardiff and Vale UHB area (Wales Cancer Trials Network NSAG Report 2012). This performance has allowed consistent engagement with the wider NIHR portfolio, attracting external UK studies into the UHB, and providing clinical academic leadership in the development of UHB based CI-led studies. Palliative and Supportive care research is also a dedicated workstream within the Wales Cancer Research Centre with linked collaborations with other Centres such as PRIME and the new Wales School for Social Care Research.

Given the limited funding opportunities, including lack of a meaningful commercial portfolio in the UK, the nurturing of these collaborations has been crucial to the viability and sustainability of palliative care research within PCIC division, and represents efficient sharing of resource and expertise. The proposed operational strategy seeks to build on this, aligning itself to changes in Health and Care Research Wales infrastructure and strengthening the clinical-academic interface.

Raise the profile of PCIC in promoting research and develop further capacity to undertake high quality research

PCIC will continue to promote awareness of relevant research and evidence-based practice, and encourage staff to embrace these principles and participate in research activities as part of their Continuous Professional Development. This will be facilitated by on-line access to the Cardiff University and Cardiff and Vale UHB Research Support Services. Primary-care work-force participating in research activity will be encouraged and supported by the research lead and UHB R & D office. Specific support in uptake of research projects and to enhance recruitment within projects will be provided in a timely manner.
We will encourage practices uptake the HCRW primary-care research incentive scheme and to contribute practice data for research purposes by signing up to research databases such as secure anonymised information linkage (SAIL) and the clinical practice research data-link (CPRD).
There will also be ongoing engagement with Trials Units (e.g. WCTU/MCPCRC) and across Health and Care Research Wales infrastructure which will bring added value to the UHB including:

- research training of clinical staff
- engagement across care settings – including the third sector
- methodological support for multi-professional clinical staff developing studies.

Initiate innovation by leading on research activity within the PCIC directorate

This developing research strategy will aim to evaluate existing and new models of care pathways within primary and unscheduled care in C & V UHB thus informing the future of primary-care services. Collaborations with sister organisations for joint projects will be sought to share knowledge, expertise and experiences of patient care pathways.
The main Supportive and Palliative Care research themes will be funded from non-commercial open calls via NCRI and NIHR funding streams (HTA, RfPPB streams), as well as national calls by funders such as Marie Curie and Tenovus. Byrne and colleagues have already been successful with NCRI funders and the HTA and these will remain the main target for future funding. We will utilize the MCPCRC and Health and Care Research Wales funded Wales Cancer Research Centre (WCRC) to develop funded studies, attract NIHR portfolio studies and hence investment into the UHB, engage with multi-professional clinicians and support patient recruitment using HCRW CRC resource.

- Our Supportive and Palliative Care objectives will be achieved by:
- clinical leadership from Byrne to develop local CI led studies
- access to NIHR portfolio projects from outside Wales with associated inward investment, building on track record
- increase in PIs and engagement of other disciplines in the research process, particularly outreaching to the third sector and non-acute settings
- research champions in 3rd sector and support for research governance in 3rd sector settings: specifically a research governance toolkit, development of standardized templates for SLAs and contracts between UHB and third sector
- consolidation of innovative engagement with Health and Care Research Wales CRC staff which ensures skilled approach to vulnerable patients and accessibility across all UHB settings: home, hospital, hospice
- leadership within WCRC to ensure high profile for palliative care research and the UHB within HCRW Centre
- dissemination: understanding preferences for learning, having a single point of contact for research queries; collaborate with Cardiff University and WCRC to develop a repository for best practice evidence in palliative care, easily accessible to UHB staff and third sector partners.

Commercial studies

Commercial R&D activities in health are funded by profit-making organizations such as pharmaceutical companies and medical devices. The PCIC board regards such research activity as fundamental to the development of beneficial treatments and technologies for NHS patients and to the future of UK science and innovation and the wider economy. In the interests of improvement in patient care and service delivery, possibilities of collaborative working with such organizations where appropriate will be explored with assistance from the C & V R&D department.
PCIC will engage with the commercial sector and aim to bring in more high quality research activity within the directorate. Financial and resource implications of this research will be addressed and reports produced yearly. These reports will inform future strategies in getting outcomes that mutually benefit the C & V UHB, PCIC and the commercial sector.
There is very little commercial funding opportunity within palliative care, but Byrne is a member of the NCRI Industry Liaison Panel for Palliative Care, providing an opportunity to identify potential collaborations. The Marie Curie Research Centre will also provide links to commercial partners.

Investment needed to meet objectives and possible funding sources

The allocation of HCRW R & D income to Clinical Boards & Directorates is based on the ABF activity that informed the UHB's HCRW allocation. The income and associated expenditure budget are embedded within the Clinical Boards overall budget. A small deficit or surplus may accrue against the R & D income budget dependent on how the Clinical Boards contribution to the overall UHB ABF allocation has moved between years. The deficit or surplus arising is capped at the lower of 20% of the allocation or £40,000.

Funding associated with PCIC R & D activity was identified with the Cardiff and Vale UHB allocation as follows over the period 2013/14 to 2015/16.

2013/14 funding £0.134m
2014/15 funding £0.203m
2015/16 funding £0.175m

Where the associated NHS Treatment Costs during a research study are greater than the cost of standard treatment the difference between the cost of the study intervention and the cost of the standard treatment is referred to as the NHS Excess Treatment Costs (ETC). If a non commercial R & D study incurs Excess Treatment costs an application for additional funding should be made to HCRW via the established ETC process**.**

R&D programme development

This document sets a clear vision for research and development within PCIC for the next 3 years (2017-2020). It has four main strategic objectives that support the development of a research culture within the organisation which will ensure that research becomes an integral part of the PCIC's core business. The strategy also shows that the partnerships with other organisations and universities will be maintained and further developed to enable the PCIC to make the best use of available R & D resources. Over the next 4 years PCIC will enhance the support offered to primary care organisations within its remits to increase competence and optimise research activity within the directorate.

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1. Research Governance Framework for Health and Social Care in Wales, Second Edition, 2009.
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4. Best Research for Best Health: Implementation Plans, September 2006
5. Health and Social Care Act (Community Health Standards) Standards for Better Health, HCC, 2004
6. Together For Health – Cancer Delivery Plan. A Delivery Plan up to 2016 for NHS Wales and its Partners. Welsh Assembly Government. Cardiff. 2012.
7. Together for Health –Delivering End of Life Care. A Delivery Plan up to 2016 for NHS Wales and its Partners. Welsh Assembly Government. Cardiff. 2013.
8. Palliative Care Studies NSAG Report. Wales Cancer Trials Network, NISCHR CRC. Cardiff. 2012.
9. More Care, Less Pathway. An independent review of the Liverpool End of Life Care Pathway. Dept of Health. London. 2013.
10. Research Governance Toolkit for Hospices. http://www.nischr-cancerrrg.org/research/

Appendix 1

Reporting responsibilities and arrangements within PCIC Clinical Board

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
High quality research activity and governance is undertaken	Research lead and Clinical directorate	Research Register captures all research activity and governance	Annual Research Report will be prepared	Evidence of research governance and permissions granted	PCIC Board and report will be sent to the R & D office	Research Lead and Clinical Board	Research Lead will inform necessary system changes through Clinical Directorate
Improve research environment		Research register captures time taken to grant permissions for each application					
Improve on capability to undertake high quality research	Research lead and Clinical directorate	Research report of studies undertaken with major contribution form or chief investigator from PCIC board and/or Cardiff and Vale Primary Care staff	2 yearly report will be prepared	Evidence of research findings and how this informed patient care Register of PiCRIS practices and practices signing up to SAIL & CPRD databases	PCIC Board	Clinical Board and Primary Care staff	Report on strategy for implementation of research finding and plans for future evaluation
Strengthen collaborations with research partners	Research lead	Record of collaborative work		Evidence of joint collaborative projects completed or in progress	PCIC Board	Clinical Board and Primary Care staff	Identified new areas of work in collaborations
Assess the impact of research activity on after-care	Research lead and Clinical directorate	Record of post research monitoring of practices for improvement in care, prescribing costs etc.	2 yearly report will be prepared	Evidence of changes in practice	PCIC Board Report to be sent to R & D office	Directorate, R & D office and NISCHR	Report on examples of both good and adverse effects of research and its

					and NISCHR		type and recommendations made
Promote and raise the profile of the PCIC research culture.	Research lead	Record of research active PICRIS practices	Annual Report	Evidence of more practices signed on to PICRIS scheme and increase in research activity	PCIC Board and report will be sent to the R & D office	Research lead	Identified strategies to increase quantity and quality of research
Initiate innovation by leading on research activity within the PCIC directorate e.g. in evaluating existing and new models of patient care pathways	Clinical Director and various departmental leads.	Record of research activity originating within the PCIC teams.	Annual Report	Evidence of research initiated and carried out by PCIC staff members.	PCIC Board	Relevant PICIC staff	The research results will inform the implementation of policies and patient-care pathways within the trust.

Appendix 2

Cardiff & Vale University Health Board R&D Office

Proforma for the assessment for GP/Dental Practices participating in primary care research

The Practice below has indicated that it would like to participate in the following primary care research study.

Practice:
Study Title:
R&D Reference:
RMG Reference:

Historic Research Activity

(R&D Department to detail the number of commercial and non-commercial trials undertaken in the practice within the last 18 month period)

Commercial:
Non-Commercial:
Ratio (Commercial vs Non-commercial):

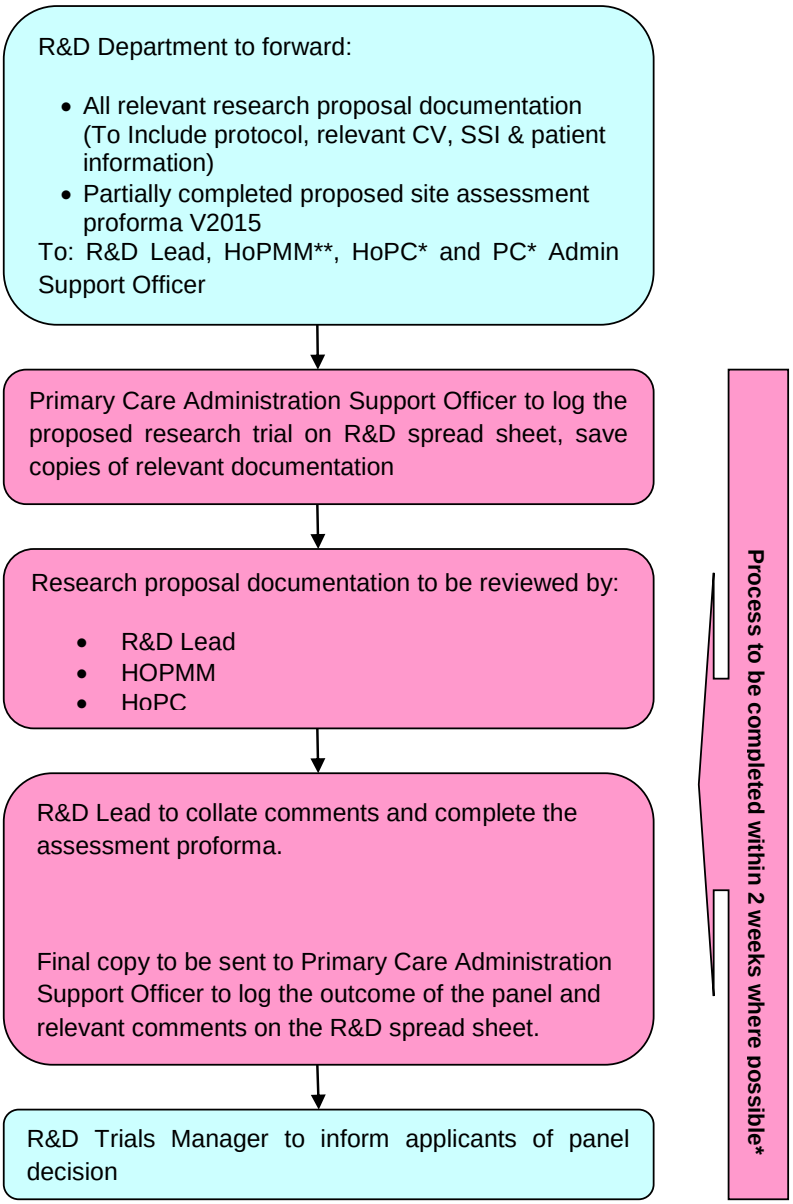
Assessment Panel Review

Date of Panel:
Panel Members Present:

The panel have reviewed the research proposal and assessed the suitability of the above Practice as a participating research site by answering Yes or No to the questions below. And an overall decision is detailed below based on this assessment

Assessment:	**Yes/No**
Does this research answer a scientific question that needs an answer?	
Does this research raise any concerns with regard to potential impact on routine patient care and/or prescribing practice, including practice specific concerns?	
Are there any relevant clinical governance or resource issues at this Practice that would prevent authorisation of suitability?	
Does the practice have a track record as a participating research site and/or does the practice have HCRW Primary Care Research Incentive Scheme funding?	
If the study involves an Investigational Medicinal Product, are there satisfactory pharmacy arrangements in place?	
From a pharmacy perspective, is the protocol and the information in the Participant Information Sheet appropriate?	
Overall Assessment (Does the panel consider the research proposal and participating research site suitable for this study?)	
Comments	

Appendix 3 Flowchart outlining responsibilities of the PCIC Clinical Board and R&D Office



* where a site visit is needed the process may take longer
** HoPMM – Head of Prescribing and Medicines Management
HoPC – Head of Primary Care

7.7 Specialist Services Clinical Board

7.7.1 Artificial Limb and Appliance Service (ALAS)

Executive Strategic service priorities:

- Population Health, long term conditions, Stroke

Professor Colin Gibson, Head of Rehabilitation Engineering – December 2013

1. Background

The Artificial Limb and Appliance Service (ALAS) delivers assistive technology services to the people of Wales. The origins of ALAS are in the 1980s when the management of the Artificial Limb and Appliance Centres moved from the Department of Health and Social Security to the Welsh Health Common Services Authority. Currently, ALAS is hosted in North and South Wales by Betsi Cadwaladr and Cardiff & Vale UHBs respectively with Cardiff ALAS providing six regional/national assistive technology services (see note 1), namely, the Electronic Assistive Technology Service, Limb Prosthetics Service, Orbital Prosthetics Service, Orthotics Service, Posture and Mobility (Special Seating) Service and Posture and Mobility (Wheelchair) Service, to in excess of 50,000 service users.

The Cardiff Rehabilitation Engineering Unit (REU) was established at Rookwood Hospital in the 1980s as an outpost of South Glamorgan Health Authority's Medical Physics and Bioengineering Department. In common with other equivalent units across the UK, Cardiff REU's role is to 'break new ground' via the research, design and development of novel devices and techniques which are not otherwise available and to apply sophisticated engineering solutions to complex clinical problems in the delivery of NHS services (Cardiff REU Clinical Service Improvement Strategy - June 2009).

Cardiff REU merged with Cardiff ALAS in September 2010 bringing together complementary resources that, if appropriately combined, offer substantial potential for useful and productive research, development and innovation (RD&I). The purpose of this strategy is to set out a means to achieve that potential.

2. Current projects (December 2013)

The resources available to the ALAS Directorate range from external funding to internal staff time and include a variety of options for collaboration with others. An illustrative cross section of current projects that have received formal UHB approval is outlined below.

2.1 A Knowledge-based Engineering Technique for Special Seating and Wheelchair Systems Design and Manufacture (EPSRC CASE studentship)

The objective of this project is to demonstrate the feasibility of creating technology that will design and manufacture custom contoured seating as effectively and safely as that hand crafted by clinical engineers with substantial knowledge, skills and experience. As such expert skills are becoming rarer and more difficult to replace if lost, the overall aim is to make that technology widely available so as to ensure that clinical needs continue to be met.

Commencing in 2006 as a collaboration between Cardiff REU and the University of Glamorgan Faculty of Advanced Technology, the project attracted Engineering and Physical Sciences Research Council (EPSRC) funding a condition of which was that the collaborating partners

make both cash and in kind contributions to the project.

Currently planned to continue until December 2014, the project has received in excess of £100,000 funding (the majority from EPSRC) with further external funding being sought to extend the work until 2017. As ALAS's only NISCHR Clinical Research Portfolio study (UKCRN ID 12406) it was the sole contributor to the ALAS R&D allocation from the UHB in 2013/14 which, in turn, was used to fund REU staff time on this project and the cash contribution towards 2.1.1.

2.1.1 Automated Postural Management Device (KESS MRes studentship)

As a specific branch of 2.1, the object of this project is the proof of concept that hardware and software can be developed to undertake clinical and functional assessments of clients with complex postural needs that would otherwise need to be undertaken by highly qualified, trained and experienced healthcare professionals.

Commencing in November 2013 and currently planned to continue until October 2014, this Knowledge Economy Skills Scholarships (KESS) project has received in excess of £20,000 funding (the majority from KESS). In addition to staff time as described in 2.1, the UHB's cash contribution to this project was funded from the 2013/14 ALAS R&D allocation.

2.2 Rehabilitation Engineering into Telecare Services (Consultancy contract)

This multi-centre collaboration between Birmingham Telecare Service, Coventry University's Health Design Technology Institute (HDTI) and Cardiff REU was funded by the Skills for Care Workforce Development Innovation Fund. The objective of the study was to determine what added value (if any) rehabilitation engineering professionals could bring to telecare (and possibly telehealth) services.

Commencing in August 2012, Cardiff REU's contribution to date has been staff time purchased via a consultancy agreement with HDTI worth more than £12,000. Currently, the project is planned to continue until March 2014 with the public report 'What Can Rehabilitation Engineering Offer Telecare Services?' now available.

2.3 Applying the equipment library approach to posture and mobility equipment with life support systems (WEDS funded supernumerary trainee project)

Commencing in September 2013, this project forms the basis of a dissertation to be submitted in January 2014 under the Cardiff University MSc course in Clinical Engineering by a WEDS funded Trainee Clinical Engineer. For the duration of the project, that funding will amount to more than £14,000.

The aims of the study are: to gather evidence regarding the efficacy of the equipment library approach applied to posture and mobility equipment with life support systems; to determine the feasibility of establishing a similar approach based at the Intensive Care Unit at University Hospital Llandough in order to improve outcomes in spinal cord injury and neuromuscular disease patients and to facilitate their transfer to less resource intensive settings.

3. Future resources and themes

The cross section of projects outlined above illustrates the sort of collaborations and resource streams available for assistive technology related RD&I activity across ALAS. In order to realise potential future RD&I themes, the following resources will need to be effectively and appropriately utilized.

3.1 ALAS Advanced Practitioners

'Advanced Practice' delivered by those working in Allied Health Professions (AHP) and Healthcare Science (HCS) combines, among other things, roles in training and research (NLIAH 2010, ALAS 2013 and Hill 2013). Qualified to masters level and working at NHS Career Framework Stage 7, such staff provide an invaluable RD&I resource.

3.2 ALAS non-commercial R&D allocation

The NISCHR non-commercial R&D allocation to ALAS for 2013/14 is £28,680. This is the smallest allocation of any directorate within the Specialist Services Clinical Board, the largest being £366,395 to Haematology & Clinical Immunology. In future years, allocations will be calculated by means of an activity based funding formula thereby presenting ALAS with the opportunity to 'grow' its allocation by increasing relevant RD&I activity.

3.3 ALAS based students and supernumerary trainees

Currently, the Cardiff Training Centre of the All Wales Medical Physics and Clinical Engineering Training Consortium is funded by WEDS to support supernumerary trainees undertaking the Modernising Scientific Careers (MSC) Practitioner Training Programme (PTP), Scientist Training Programme (STP) and, in future years, the Higher Specialist Scientific Training (HSST). Each of these programmes include undergraduate, masters and doctoral level projects respectively (Hill 2013). Training of those specialising in the delivery of assistive technology services such as those provided by ALAS is co-ordinated by the Cardiff REU.

In addition, the University of Bradford have approached Cardiff REU with an offer to fund the placement of students on its Healthcare Science - Clinical Engineering (BSc Hons) course who wish to specialise in rehabilitation engineering and, thus, undertake an assistive technology related undergraduate project.

3.4 Commercial and non-commercial funding

Having in excess of 50,000 service users across six assistive technology services makes ALAS both an ideal source of new ideas and an ideal testing ground in which to explore new and better ways of doing things.

Key themes that have already attracted the attention of potential funders are: substantial knowledge base of historical clinical data; wide ranging opportunities to undertake robust and well planned clinical trials of new devices, systems and techniques; innovative design and manufacture which, in relation to posture and mobility, has already led to the creation of a spin-out company, namely, Rookwood Rehabilitation Solutions (RRS) Ltd.

4. Strategic Vision

4.1 Advanced Practitioners take the lead in exploring potentially useful and productive RD&I themes via student/trainee projects.

4.2 RD&I themes which demonstrate promise are developed further using the ALAS R&D allocation with the aim of attracting additional project funding and increasing the ALAS R&D allocation in subsequent years.

4.3 All those involved in RD&I activity contribute to the development of an ALAS RD&I 'community' by sharing knowledge, experiences and ideas with the aim of highlighting potentially useful and productive RD&I themes.

5. Implementation

Given its direct relevance to Standards for Health Services in Wales (WAG 2010) HCS 21: Research Development and Innovation, the implementation of this strategy will be planned and co-ordinated by the ALAS Quality and Safety Group.

Notes

1. Not including War Pensioners service.

Glossary

ALAS	Artificial Limb and Appliance Service
CASE	Co-operative Awards in Science and Engineering
EPSRC	Engineering and Physical Sciences Research Council
HDTI	Health Design and Technology Institute, Coventry University
KESS	Knowledge Economy Skills Scholarships
MRes	Master of Research
MSC	Modernising Scientific Careers
NISCHR	National Institute for Social Care and Health Research
NLIAH	National Leadership and Innovation Agency for Healthcare
PTP	Practitioner Training Programme
RD&I	Research, Development and Innovation
STP	Scientist Training Programme
REU	Rehabilitation Engineering Unit
UHB	University Health Board
WEDS	Workforce Education and Development Services (NHS Wales Shared Services Partnership

References

Cardiff REU Clinical Service Improvement Strategy (June 2009)

Doing Well, Doing Better - Standards for Health Services in Wales. Welsh Assembly Government, April 2010

Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales (NLIAH 2010)

ALAS Workforce Strategy 2013 to 2018 – Healthcare Science (June 2013) – Appendix A

'Modernising Scientific Careers: the story so far and future direction' presented to the International Conference on Medical Physics by Professor Sue Hill, Chief Scientific Officer for England, on 3rd September 2013.

What Can Rehabilitation Engineering Offer Telecare Services? Final Report of the Rehabilitation Engineering into Telecare Services (RENTS) Project. HDTI (November 2013)

Appendix A

ALAS Workforce Strategy 2013 to 2018 – Healthcare Science

Professor Colin Gibson, Head of Rehabilitation Engineering – June 2013

Background

Opportunities for Cost Reduction, Service Improvement and Service Development

As identified in the November 2010 and March 2012 ALAS healthcare science workforce planning reports, there is a need to develop the knowledge, skills and experience of the healthcare science workforce within ALAS whilst maintaining sufficient flexibility to adapt to the changing circumstances likely to be encountered over the next few years. By adopting a strategic approach to this, opportunities for cost reduction, service improvement and service development will emerge.

For example, the use of Healthcare Science Associates/Assistants based in one service to provide cover and support to other services as and when the need arises will go a long way to addressing recruitment, retention and sickness issues across all the ALAS services. It may also present personal and professional development opportunities to staff which would not otherwise be available. Furthermore, roles previously undertaken by registered professionals may in future be undertaken by appropriately educated and trained Healthcare Science Associates (HCSAs) under the supervision of a registered professional.

In addition, extending the role of Healthcare Science Practitioners (HCSPs) to include areas of advanced service delivery previously undertaken by Healthcare Scientists (HCSs) will not only reduce costs but will also free up HCS time to be applied specifically to service improvements and/or developments.

Respective roles

The Modernising Scientific Careers (MSC) programme is transforming healthcare science careers and training. In response, RESMaG and IPEM (in collaboration HDTI) have produced a series of booklets describing the respective roles and competencies of healthcare science professionals working in the delivery of assistive technology services such as those provided by ALAS. An outline of respective roles and activities is reproduced in Fig. 1.

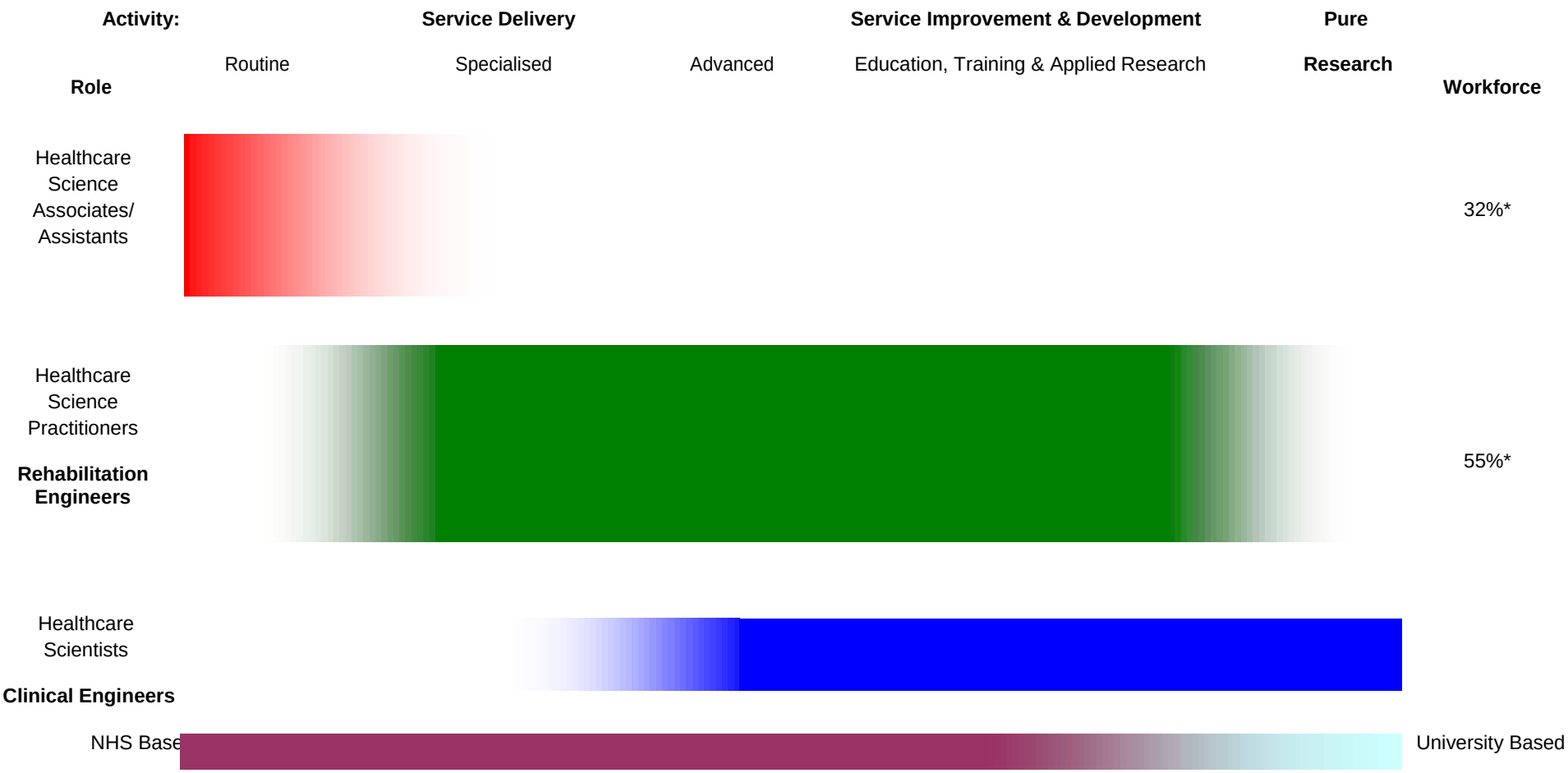
Although there is overlap between and variation within each of the different groups, in general terms, the RESMaG Workforce Planning Survey (January 2012) identified that associates and assistants mostly deliver routine services by working to protocol, while practitioners mostly deliver specialist services requiring the freedom to act independently to address complex needs and scientists mostly deliver advanced services that cannot be provided by other healthcare science professionals. Scientists, in particular, are expected to be active in service improvements and developments and cost reduction

Education and Training

Currently, the Cardiff Training Centre of the All Wales Medical Physics and Clinical Engineering Training Consortium is funded by WEDS (formerly NLIAH Workforce Development) to support HCS and HCSP supernumerary trainees via the MSC Scientist Training Programme (STP) and Practitioner Training Programme (PTP) respectively. Training of those specialising in the delivery of assistive technology services such as those provided by ALAS is co-ordinated by the Cardiff Rehabilitation Engineering Unit (REU).

At present, there is no formal provision for the training of Healthcare Science Associates/Assistants, however, Cardiff REU is working with Coventry University and others to develop suitable training programmes that may be eligible for various funding initiatives including those related to apprenticeships.

Figure 1 Outline of Respective Activities and Roles in Healthcare Science (Rehabilitation Engineering)
(reproduced from 'Rehabilitation Engineering Services: Functions, Competencies and Resources' RESMaG/IPEM/HDTI Issue 3.1 March 2012)



- RESMaG Workforce Planning Survey (January 2012)

Strategic Vision

1. To develop a generic assistive technology manufacturing and 'medical equipment management' capability across ALAS delivered by Healthcare Science Associates/Assistants with HCSAs leading day to day operations in line with defined aims and objectives.

2. For HCSPs to work closely with Allied Health Professionals (AHPs) and other healthcare professionals as members of multidisciplinary teams to develop, improve and deliver holistic client centred assistive technology services that fall within the remit of ALAS.

3. Alongside any service commitments, for HCSs to lead change by identifying and ensuring service improvements/developments and cost reduction as approved by the ALAS Management Team.

Implementation

Healthcare Science Associates/Assistants

Career pathways under MSC for associates/assistants are still under development and, as such, no formalised training programmes and funding streams are available currently. Although this may change in coming years, there is an immediate need to support the continuing professional development (CPD) of the existing associates/assistants within ALAS and to put in place education and training plans for new staff in order to realise the strategic vision.

In addition to existing qualifications such as NVQ, City & Guilds or BTEC in technical subjects, a useful option in this regard is the Assistive Technology Foundation Degree which is a wholly distance learning course provided by Coventry University. The course runs over two or more years with a 'step off' possible at the half way point which would lead to a qualification equivalent to a level 4 certificate as opposed to the full Foundation Degree (level 5). Also, modules are available individually including those offered as second year options such as Telecare and Telehealth, Fundamentals of Wheelchairs & Seating and Management of Assistive Technology Equipment.

Under MSC, HCSAs are expected to have attained knowledge, skills, understanding and proficiency relevant to their role that is equivalent to level 5. The levels of attainment for assistants vary according to role and range up to and including level 4.

Healthcare Science Practitioners and Healthcare Scientists

Career pathways under MSC for HCSPs and HCSs are clear with those emerging from the PTP and STP able to specialise in any of the assistive technology services falling within the remit of ALAS. In addition, opportunities for existing ALAS staff to demonstrate equivalence will emerge via the Academy for Healthcare Science (AHCS) over the next few years.

HCSs and HCSPs have important roles to play in the realisation of the strategic vision which will be promoted at an individual level by the Personal Appraisal Development Review (PADR) process and at a Directorate level by the service and workforce planning processes.

HCSs, in particular, will be expected to take an ALAS-wide perspective putting forward service improvement, service development and/or cost reduction proposals to the ALAS Management Team for approval. Such proposals should not only account for their own time but also inform service and workforce planning and demonstrate the most effective and efficient use of resources.

Glossary

AHCS	Academy for Healthcare Science
AHP	Allied Health Professional
CPD	Continuing Professional Development
HCS	Healthcare Scientist (HCPC registered Clinical Scientist)
HCSA	Healthcare Science Associate
HCSP	Healthcare Science Practitioner (currently VRCT registered Clinical Technologist)
HDTI	Health Design and Technology Institute, Coventry University
IPEM	Institute of Physics and Engineering in Medicine
MSC	Modernising Scientific Careers
NLIAH	National Leadership and Innovation Agency for Healthcare
PADR	Personal Appraisal Development Review
PTP	Practitioner Training Programme
RESMaG	Rehabilitation Engineering Services Management Group
STP	Scientist Training Programme
REU	Rehabilitation Engineering Unit
WEDS	Workforce Education and Development Services (NHS Wales Shared Services Partnership)

References

ALAS Workforce Planning 2011 to 2017 – Healthcare Science: Colin Gibson (November 2010)

ALAS Workforce Planning 2012 to 2017 – Healthcare Science: Colin Gibson (March 2012)

'Rehabilitation Engineering Services: Functions, Competencies and Resources' RESMaG/IPEM/HDTI Issue 3.1 March 2012

Protocol for Implementation of the ALAS RD&I Strategy (agreed by the ALAS Q&S Group - January 2014)

Purpose

The purpose of this protocol is to facilitate the implementation of the ALAS Research Development & Innovation Strategy 2013 to 2018 (Dec 2013).

RD&I projects

Those who wish to secure approval and, if appropriate, resource, in order to undertake projects in line the ALAS RD&I Strategy should first present their ideas to the ALAS Q&S meeting for discussion.

That presentation may take a number of forms ranging from an informal verbal description to a formal written project proposal. Should the presenter wish to seek the endorsement of the meeting to seek formal approval and authorisation then the latter is preferred.

Project proposals

These should adopt the following format:

Project Brief – general outline (usually less than one page A4)

Project Specification – detailed description of what is to be achieved Project Plan description of objectives with associated resource requirements and timeline

Resources Justification – explanation of the net resource benefits to the Directorate, Clinical Board and/or UHB.

Approval and authorization

Project proposals endorsed at an ALAS Q&S meeting will be directed to the ALAS Management Team for formal approval and authorisation.

Feedback

Progress against Project Plans will be fed back by project leaders/teams to the ALAS Q&S meeting for the duration of any projects implemented under this protocol.

Dissemination

Results and lessons learned will be disseminated by project leaders/teams within the Directorate and beyond.

7.7.2 Cardiothoracic Directorate

Aims and Goals

- **To increase research activities within the whole cardiothoracic directorate (surgery and cardiology)**
- **To improve patient outcomes through innovative cutting edge research**
- **Increase research related incomes**
- **Increase Portfolio related study recruitment**
- **Increase our research team infrastructure with new appointments of another research nurse and data collection administrative support.**
- **Maximize and enhance continuing professional development for consultants and increase institutional prestige through increased involvement in clinical research studies and publications in high quality peer reviewed journals.**
- **Increase academic research time protection for clinical consultants**
- **Re-establish Cardiff University link for local research university network**

What do we have?

Current Infrastructure

- 3 research nurses, 2 band 7 nurses and 1 band 6 nurse
- New appointment of band 5 data collection administrator
- 1 Regius Professor of Cardiology – Alan Fraser
- 2 Honorary Professors, Z Yousef – University of East Anglia, N Ossei-Gerning Trinity St Davids University.
- 1 Honorary Senior Lecturer Keele University – Tim Kinnaird
- 8 different PI on trials locally and 3 UK Chief Investigators studies - UK Z Yousef, R Anderson, T Kinnaird
- 2 Research fellows at SpR level involved in MD projects
- 1 NISCHR fellow appointment for 0.2 WTE for 3 years (T Kinnaird)

Uplift in HCRW (portfolio related) income.

Participation in 15 major trials with 6 major multicentre trials

4 new clinical trials starting in the next 4 months

4 NICOR study approvals with data acquisition occurred and analysis undertaken with

6 major peer reviewed manuscripts accepted and published in high impact journals. Three further manuscripts in review at present.

1 SpR research fellow

August 2017		Current status	Overall Recruitment	
			Current	Target
ENVISAGE- AF	Richard Anderson	Initiation Aug 2017		
Explorer HCM	Zaheer Yousef	Proposal		
SMART CRT	Zaheer Yousef	In set up		
PIONEER III	Richard Anderson	In set up		
PARADISE MI	Richard Anderson	Proposal		
ENTRUST AF	Richard Anderson	Initiation Aug 2017		
TALENT	Anirban Choudhury	In follow up	67	70
FAME	Richard Anderson	Open to recruitment		30
MILES UK	Richard Anderson	Open to recruitment	50	50
RELAX*	Zaheer Yousef	In follow up	11	10
Liberty HCM*	Zaheer Yousef	Study discontinued	1	4
UKTAVI	Peter Groves	Open to recruitment	10	24
S-FLEX	Anirban Choudhury	closed data input only	49	30
IDEAL	Richard Anderson	In follow-up	26	10
e-Ultimaster	Rito Mitra	closed data input only	99	100
TRANSFORM	Malgorzata Kornaszewska	In follow-up	10	10
LIBERATE	Malgorzata Kornaszewska	In follow-up	2	8
BRADYCAREII	Zaheer Yousef	In follow-up	14	N/A
TARGET	Richard Anderson	In follow-up	56	100
MASCOT	Tim Kinnaird	closed data input only	11	10
REVEAL	Ian McDowell	In follow-up	144	100
GLOBAL LEADERS	Richard Anderson	In follow-up	204	200
ODYSSEY	Nick Ossei-Gerning	In follow-up	2	N/A
ROX	Nick Ossei-Gerning	closed data input only	1	N/A

BHF Clinical Study Applications submitted

1. A clinical trial of routine DEFERral of stenting vs. standard care with immediate stenting in higher risk STEMI patients undergoing emergency PCI: the DEFER-STEMI Phase 3 trial.

2. To examine the efficacy and mechanism of periodontal disease treatment in patients with type 2 diabetes mellitus after acute coronary syndrome.

Development of clinical research

Encourage departmental research projects (Investigator lead, commercial, national and multinational multicentre trials).

This has resulted in 2 new Chief Investigator appointments (RAA/TK) in the last 6 months on 2 multinational trials

Specific research priority areas include

Interventional Cardiology

Heart Failure

Cardiovascular pharmacology

Thoracic Surgery

Strategic direction: Non commercial studies.

Continue Heart Failure MD projects (2 ongoing)

Continue investigator led Cardiovascular pharmacology MD projects (Finished in writing up phase).

Build a better proactive relationship with Cardiff University for the department to facilitate this direction.

Increase manuscript and publication outputs – Increase reputational aspects

Increase grant and NICOR submissions.

Increase clinical research fellow staff (SpR's/CRF's) numbers where possible.

Assist new investigators to develop into principal investigators. (pathway to portfolio studies)

Foster further HCRW clinical research time applications by consultants (1 planned).

Maximize links with Cardiff University will be attempted to ensure good REF returns and expand clinical translational research and rebuild the clinical academic cardiology infrastructure.

Ongoing discussions with the Dean of the medical school in terms of co-locating research back into the Wales Heart Research Institute and potential honorary research appointments locally rather than have to look to England to facilitate clinical/University linkage

If this strategy fails then looking for research links with other Welsh Universities may be the only other option.

Governance

Ensure directorate complies with UHB R+D governance arrangements, CaRRS reporting etc.

Ensure directorate response to HCRW portfolio reporting.

Clinical board interface with other directorates (Specialist services) to participate in C+V UHB specialist services research hub.

Financial

Current sources

1. Research legacy funds
2. Individual commercial research funds
3. Portfolio income from HCRW
4. Possible British Heart Foundation money
5. University funded SPA research time money (Univ of E Anglia)

Maximize income via portfolio studies

Maximize income via commercial studies

Ensure departmental R+D financial transparency

Formalize an annual R+D spending plan.

Plan and achieve targets for rest of 2017

Re-employment of 2 renewal posts in 2017/18 through the directorate structure

Secured

Increase portfolio studies and recruitment

Maintain our position as a high recruiter in our cutting edge technology trials including the UK TAVI trial continuance

Commence 2 further innovative heart failure studies

Investment required to meet objectives 2017-8

Set aside monies from trial income to support for consultant SPA sessions to allow further trial work to be taken on.

7.7.3 Medical Genetics Directorate

Background

The directorate is made up of -

- 12 consultants and 1 associate specialist (job planned between 0.04-0.1(WTE) research time/week)
- 16 genetic counsellors (job planned between 0.01-0.02 (WTE) research time/week)
- ANC staff - Bands 3 and 4 (0.01 (WTE) research time/week)
- 1 Band 4 R&D Admin support (0.6 WTE)

The All Wales Medical Genetics service has a long history of outstanding research and national and international collaborations. The service has been actively involved in promoting and facilitating medical genetics and genomic research studies. The spectrum of research activities not only focuses on developing new genetic tests, but also on translation research looking at more effective treatments in various disorders like Tuberous sclerosis, Ectodermal Dysplasia, Cancers and Huntington Disease.

Musketeers Memorandum (MM)- is an agreement between the UK's 23 genetic centres to link as one consortium to benefit rare genetic disease research by reducing the length of time taken to receive approval for a research proposal. Cardiff and Vale University Health Board signed up to this agreement on 13/11/2013, thereby facilitating national agreement applicable to non-CTIMP rare disease projects with minimal local hospital costs. The Medical Genetics service in Wales has been facilitating recruitment into many national studies via this memorandum. The key metrics of number of patients recruited in to these has been increasing. There is also at least 2 Wales led MM studies recruiting patients with rare diseases from other regional Genetic centres.

Genomics for Precision Medicine Strategy- has been developed by a Welsh Government-led genomics taskforce and aims to create an internationally competitive environment for genomics and precision medicine to support the delivery of prudent healthcare for the population of Wales. The aim of the All Wales Medical Genetics Service based at the Institute of Medical Genetics with clinical and non-clinical academics from Cardiff University is to support the implementation of this strategy by:

- Promoting and facilitating high quality genetic and genomic health research in Wales.
- Creating a focus for translational genomic research initially into specific rare diseases and cancer.
- Establishing mechanisms of engaging with patients to drive service developments and will continue to capture patient experiences to improve service delivery.
- Reviewing models of consent within All Wales Medical Genetics Service and develop a proposal for routine research access to surplus clinical genetics samples and data, laying the foundations for a unique platform for precision medicine and genomics research.

The Wales Genomic Medicine Centre is envisaged to be developed as a virtual centre, built upon close working between the Wales Gene Park and All Wales Medical Genetics Service. The Genomic
Medicine Centre will support Wales' involvement in the 100,000 genomes project and act as a focus for the translation of genomics research into NHS Wales. The rapid advancement in genomic technologies coupled with the anticipated increase in demand for genomic services and research activities will impact on the existing workforce with increase in clinician research time.

Highlighting some of the research studies the department is participating in:

1. **TRON Study** (Trial code- ISRCTN09739757) –

- A randomised, double blind, placebo-controlled study of RAD001 (Everolimus) in the treatment of neurocognitive problems in tuberous sclerosis. This is an interventional study led by Professor Sampson.
- Tuberous sclerosis is a genetic disease that causes the growth of benign tumours in lots of different places in the body. This includes the skin, kidney and brain. In the brain, these tumours, known as tubers, are associated with epilepsy and problems in learning and information processing (known as neurocognition).
- Several studies in people with tuberous sclerosis have found that a medicine called Everolimus can reduce the size of TSC tumours and seizures but it is unknown if there is an effect on learning and executive function in patients. The TRON trial is designed to find out of treatment with Everolimus can improve the neurocognitive problems in people with Tuberous sclerosis.
- In the trial, participants are randomly allocated to take either Everolimus or placebo for a total of six months. Their neurocognition is measured before they start taking the drug and again when they have stopped taking the medication.
    - **Recruitment-**
        - Revised Recruitment Target - 38
        - Number of participants recruited to date - 34
        - Date first participant recruited - 15/10/2012
        - Date last participant recruited - 24/05/2017
        - Number of participants screened - 64
        - Of the 34 participants still in the trial, 32 have completed all visits, with 2 still participating. Four of the active participants have stopped taking the IMP. The next participants expected to complete will do so in July 2017 and the completion date of the latest recruit will be March 2018. Should recruitment continue until August 2017, earliest expected completion of trial would be May 2018.

2. **CaPP3 (Cancer Prevention Programme)** (Trial code - ISRCTN 16261285)-

- A randomised double blind dose non-inferiority trial of a daily dose of 600mg versus 300mg versus 100mg of enteric coated aspirin as a cancer preventive in carriers of a germline pathological mismatch repair gene defect, Lynch Syndrome. Project 3 in the Cancer Prevention Programme- Principal Investigator- Dr Mark Rogers.
- Primary objective- To determine whether the cancer preventive properties of enteric coated aspirin in Lynch syndrome are dose sensitive by comparing overall cumulative Lynch syndrome cancer incidence rates annually from 5 years in people who took 100mg, 300mg or 600mg enteric coated aspirin for at least 2 years.
- Once randomised blinded treatment ends after 2 years, all the participants will be un-blinded and treated for a further 3 years with the allocated 75mg, 300mg or 600mg enteric coated aspirin (unblinded phase)
    - **Recruitment**-
        - Recruitment Target- 20
        - Number of participants recruited to date -32
        - Date first patient recruited into the study – 02/09/2015
        - Study closing date - 31/08/2021
        - At 2yrs (Sept 2018) we will start to unblind patients who will then continue on their trial dose of aspirin. The study will continue to monitor patients annually for a further 5 years.

3. **Genetic mechanisms in polyposis of the bowel** (REC ref: 12/WA/0071, IRAS ID: 87399, CPMS ID: 14774)-

- This is an observational study led by Professor Sampson.
- Colorectal cancers (CRC) have a considerably strong heritable component, recognition of which is important for precise diagnosis and patient and family management. High-penetrance germline mutations predisposing to CRC include those affecting the adenomatous polyposis coli (APC) gene, which causes familial adenomatous polyposis (FAP). MUTYH associated polyposis (MAP) is a recessive inherited condition that accounts for ~1% of all CRCs. It is caused by genetic alterations in the MUTYH gene which is involved in repair of DNA damage.
- Patients with clinical features of MAP/FAP are referred to the Institute of Medical Genetics and other UK regional genetics centres (Musketeers Memorandum study) for genetic diagnostic analysis of the APC/MUTYH genes and clinical genetic management.
- First Welsh study to join the MM, approved.
  - **Recruitment**-
    - Recruitment target- 300
    - Number of participants recruited to date- 281
    - Date first patient recruited into the study- 02/06/2012
    - Study closing date- 31/08/2018

4. **Whole genome/exome sequencing to identify additional Tuberous Sclerosis Complex (TSC) disease causing gene(s) in no mutation identified (NMI) TSC patients (**REC ref: 11/WA/0276, IRAS ID: 86757, CPMS ID: 13635)-

- This is an observational study is led by Professor Sampson.
- TSC is an autosomal dominant condition, and two causative genes have been identified: TSC1 (encoding hamartin, chromosome 9), and TSC2 (encoding tuberin, chromosome 16). Mutations in TSC1/TSC2 are known to underlie at least 80% of TSC cases. It is expected that advanced methods of genetic variant detection such as genome wide or exome sequencing may allow for the identification of high penetrance variants, which are associated with the clinical features in some NMI patients.
  - **Recruitment**-
    - Recruitment target- CLOSED TO RECRUITMENT
    - Number of participants recruited to date- 199
    - Date first patient recruited into the study- 11/11/2011
    - Study closing date- 31/08/2018

5. **Molecular genetic analysis of duodenal polyposis in the inherited colorectal adenoma and cancer predisposition syndromes (Familial Adenomatous Polyposis and MUTYH-Associated Polyposis)** (REC ref: 15/WA/0075, IRAS ID: 158519, CPMS ID: 19065)-

- This is an observational study is led by Professor Sampson.
- This study aims at providing evidence in determining whether the natural history of duodenal polyposis is the same or different in FAP and MAP and to further investigate genetic factors, inherited and somatic, that are associated with growth and progression of duodenal adenomas to cancer in MAP and FAP.
  - **Recruitment-**
    - Recruitment target- 80
    - Number of participants recruited to date- 26
    - Date first patient recruited into the study- 16/10/2015
    - Study closing date- 31/08/2018

6. **A Study of the Natural History of Renal Disease in TSC2/PKD1 Contiguous Gene Deletion Syndrome-**

- This is an observational study is led by Professor Sampson.
- MM Study.
- Many TSC patients also have kidney problems, but not all. We hope to investigate TSC patient with changes in both the genes TSC2 and PKD1 and how it affects their kidneys and compared the symptoms to patient who have only changes in the gene TSC 1 or 2.
- This research project hopes to further understanding of the connection between kidney disease and Tuberous sclerosis (TSC).
    - **Recruitment**-
        - Recruitment target- 255
        - Number of participants recruited to date-151
        - Date first patient recruited into the study- 08/03/2010
        - Study closing date- 31/08/2018
          Historical research projects that Medical Genetics was previously involved in like the *Deciphering Developmental Disorders* (DDD) Study, Childhood Overgrowth (COG) Study, Genetics of Learning Disability (GOLD) Study and SIGNAL (Studying the Implementation of GeNomics in wALes) Study have started to generate individual genomic test results, leading to increase in consultant MDT working with the laboratory team in particular for clinical interpretation and translation to the clinic. This is bound to increase much more in the future.

Research studies planned in near future-

- **100, 000 Genome Project in Wales**- In 2016, as part of the aim to develop the 100,000 Genomes Project into a UK-wide initiative, Genomics England Ltd. invited the Welsh government to join the 100,000 Genomes Project. Wales' participation in the UK 100,000 Genomes Project will be underpinned by the development of the Wales Genomic Medicine Centre that will grow from the current joint clinical and lab genomics MDT and act as a focus for the translation of genomics research into NHS Wales. The Wales Genomic Medicine Centre will work closely with the Wales Gene Park, All Wales Medical Genetics Service and LHBs and Trusts across Wales and will be strongly aligned with Genomic Medicine Centres established in participating UK regions. Initially, the Wales Genomic Medicine Centre will recruit patients from across Wales with rare diseases who stand to benefit from precise genomic diagnosis through research-based whole genome sequencing provided by Genomics England. Genetic variants that appear likely to be causative will be interpreted by Wales Genomic Medicine Centre and confirmed for NHS Wales by All Wales Medical Genetics Service. The Project will be used as an exemplar towards the integration of genomic medicine into clinical care pathways in Wales. This aligns with the Welsh Government Genomics for Precision Medicine Strategy.
  We hope to start recruiting by September 2017. Recruitment target is 420 participants with rare genetic disease (mostly trios). Recruitment end date is 19.9.2019. Referrals to the project team will come via genetic counsellors and consultants with impact on clinical staff research time and activity.

- **Prenatal Assessment of Genomes and Exomes (PAGE) Study**- is a UK wide study that aims to improve prenatal diagnostics and parental counselling in the future. This study uses NGS technology to analyse the genetic material of babies and parents where structural

abnormalities became apparent on antenatal scans. The study started in 2014 in England. Following discussions with the All Wales Genetics Laboratory and the UHW Fetal Medicine team, the plan is to offer this study to appropriate patients seen in UHW Fetal Medicine unit from September 2017. According to the research policy, results of the NGS analysis will be sent back to the clinician only after the current pregnancy. The Clinical Genetics team will work closely with the Fetal medicine team to ensure that the patients are informed of any findings identified via this study and are provided appropriate counselling.

Strategic research priority areas-

1. Implementation and implications of new genetic testing technology.
2. Improved variant interpretation.
3. Research into the genetic causes, natural history and targeted treatment of inherited rare disease and cancer.

Strategic direction-

- Review of funding model to ensure recruitment-derived NHS R&D funding is identified and used by the department to facilitate ongoing and future research.
- Biannual R&D meeting to review patient recruitment, trial completion and research/recruitment assistant availability
- Encourage all NHS staff to support research activity and for more staff to act as PIs and Chief Investigators

Constraints identified as limiting R&D Activity in Medical Genetics

1. Infrastructure – the current Institute of Medical Genetics does not provide suitable clinic accommodation for clinical research. CRF under pressure. Long term plans to rehouse Medical Genetics needs to include provision for R&D.
2. Staffing needs - research genetic counsellor/recruitment assistant embedded within the AWMGS to facilitate recruitment. Protected genomics MDT time in staff job plans. Applications to clinical research time competition with HCRW to be promoted. Clinical Research Fellowship applications to be promoted.
3. Recruitment figures for existing studies- Being an All Wales service need to ensure that the recruitment figures of consultants and genetic counsellors recruiting patients in peripheral hospitals and North Wales is reflective of the numbers recruited in Cardiff and Vale UHB

7.7.4 Critical Care Directorate

The past

The first research strategy document for Critical Care was set out in June 2010 and followed a benchmarking exercise against eleven similar metropolitan hospitals. Three of these were based in London, four in metropolitan areas of the UK and three University teaching hospitals in Hong Kong and Australia. Citations on PubMed were collated over a five-year period.

It was clear that Cardiff had performed poorly over the preceding period compared to similar institutions. Cardiff had far fewer original publications and these were mostly collaborative manuscripts initiated by investigators outside of Cardiff. All but one of the original research papers were published in journals with an impact factor around five and none above ten. The majority of PubMed citations were reviews, letters, editorials or viewpoints.

Despite Cardiff being one of the biggest critical care units in the UK, it suffered from a poor publication record, poor research staffing structures and was unable to recruit patients into clinical trials.

The present

Following a major restructuring of staff and services in 2016, the situation is now radically different. This is thanks to the hard work of the whole research team and colleagues in the allied departments.

Dr Matt Wise and Dr Matt Morgan have led this transformation in conjunction with a strong and committed nursing team as below. A new Band 7 role working across R&D and Critical Care is in the final stages of development.

	Band	WTE
Jade Cole	6	1.0
Jacqueline Curtin	6	1.0
Eve Cocks	6	0.8
Jenny Brooks	6	0.6
Chris Whitton	5	1.0
Rhys Davies	5	1.0
Helen Hill	5	0.3
		5.7 WTE

A stable research infrastructure that has led to the publication of high impact manuscripts has been developed with the potential to generate changes in clinical practice and research
income either through grants, commercial sponsors or recruitment into major international studies.

Aims

- Improve the academic and clinical profile of Cardiff nationally and internationally
- Attract and retain quality, committed staff
- Improves clinical practice and patient outcomes
- Access to new drugs (often free of charge) and interventions
- Attract commercial and non-commercial income for workforce development and clinical studies

In order to achieve these aims, we need to invest in the following:

- Environment
- Visibility
- People
- Resources
- Outcomes

Environment

Dedicated office space for R&D leads, R&D nurses and other research staff was acquired in 2010 but a number of elements are still to be delivered. In 2017 the factors that would help develop our environment further include:

- A secure fire-proof space for storage of documents with archive facility
- Space to undertake processing of biological samples in accordance with current health and safety standards
- Appropriate non-clinical areas for refrigerators and ambient storage of drugs used in clinical studies

Visibility

Increasing research visibility to other staff, patients and relatives enhances engagement and facilitates performance of research. This has been accomplished through notice boards in relative and clinical areas. Staff guides which outline studies and are available in clinical areas. Generic information on research from NIHR and the Intensive Care Society is displayed in addition to research outputs. A generic poster was developed from Cardiff in association with the NIHR Critical Care Specialty Group in 2014 which is now available in critical care units throughout the UK. An updated version is currently being developed.

The National Health Service: Frontline in research

NHS National Institute for Health Research

Innovation and research in the NHS

The National Health Service (NHS) was founded in July 1948 with the ideal of bringing 'good healthcare to all regardless of wealth or social background'. The NHS remains a unique organisation at the frontline of healthcare research, innovation and delivery.

As a result of research in the NHS over the past 60 years, there have been great advances in medical treatments.

This poster is being displayed to explain the importance of critical care research and to tell you that this critical care unit is involved in patient research. Many of the studies are part of the National Institute of Health Research (NIHR) Clinical Research Network Portfolio which only accepts clinical research studies of the highest quality.

In 1954 Sir Richard Doll and Sir Austin Bradford Hill studied lung cancer in London hospitals and made their landmark discovery linking this disease to smoking

Sir John Charnley performs the world's first full hip replacement in 1962. In an effort to improve the design he meticulously follows up patients for years after their surgery

In 1971 Sir Godfrey Newbold Hounsfield developed the CT scan. This was first used on a patient at London's Atkinson Morley Hospital – he won the Nobel Prize for Medicine in 1979.

Why conduct healthcare research?

The treatments and drugs currently used to look after NHS patients all result from medical research. Clinical studies transform new scientific knowledge into direct patient care and healthcare systems that are active in clinical research demonstrate better patient outcomes.

What does this mean for NHS patients?

An important example of successful NHS research is the treatment of cancer. Survival for many types of cancer has improved hugely in recent years as a result of new treatments looked at in clinical trials. More patients take part in cancer trials now than ever before. Ten years ago the number of NHS patients with a newly diagnosed cancer taking part in medical research was 4 out of every 100 now this has increased to 18 out of every 100. The majority of patients with cancers affecting the blood now take part in clinical trials. In the financial year 2012-2013 more than 630,000 NHS patients were involved in a clinical research study.

The challenge of research in critical care

Undertaking research to help people that become critically ill is challenging. Doctors and nurses need to make rapid decisions about the best treatments. Whilst most of the treatments provided in intensive care have come from the results of previous research, there is a continual need to explore potentially better treatments.

As most people in intensive care are too sick to be able to make informed decisions for themselves about whether to take part in research, it is common for doctors and nurses to speak to a patients relatives or next of kin to try to find out what the person would have wanted if they were able to express their wishes.

We understand that this is a difficult time for you and it may appear inappropriate that you are approached at this time, however, the very nature of research in critical care means that there is no appropriate time to speak to you about involving your relative in a research study.

How can you help?

If you are approached by the doctors and nurses about research, take time to think about what they have to say, consider what your relative or friend may have wanted if they were able to communicate. Feel free to ask questions.

Success in critical care research

In 2000 the ARDSNet study doctors published the results of a study comparing ventilating patients using small volumes of breath (tidal volume) with large breaths (traditional tidal volumes) in patients with the severe lung condition Acute Respiratory Distress Syndrome. Patients treated with low tidal volumes had better outcomes than those receiving the large breaths. This type of ventilation has become standard practice in critical care, saving thousands of lives.

The Swine Flu Triage (SwiFT) study was rapidly established in response to the swine flu outbreak. The aim was to monitor the impact of the outbreak on critical care services, in real time, with regular feedback to inform ongoing policy and practice.

The CRASH-2 investigators showed that in trauma patients with haemorrhage (heavy bleeding) administering the drug tranexamic acid reduced deaths. Importantly this therapy had to be given within three hours or it became harmful.

Participating in research

You may wish to ask staff what studies are currently being undertaken or you may be approached about your relative taking part in a study.

Version 1.0 December 2013

Research income is funding nursing and junior medical professionals to attend a major international conference in 2017. We also support pathway to portfolio research projects for allied health professionals including physiotherapists.

Investment in new technology and mobile platforms for research delivery will continue after purchasing three iPads to ensure efficient and accurate data entry.

In 2017, the factors that would help develop our visibility further include:

- It is disappointing that despite approaches to Welsh Universities, little support for the development of a critical care academic department has been offered.
- This is despite the impressive REF returns available and IMPACT statements available
- There are also huge opportunities to develop undergraduate and postgraduate teaching courses as yet untapped.

People

Success thus far has been dependent on motivated, enthusiastic and competent staff. Starting from one R&D lead and one R&D nurse in 2010, the expanded team above are funded by a combination of ABF allocation and commercial income.

An innovative and unique staffing structure was developed to maximize recruitment into studies taking place in the already challenging specialty. This structure has led to high recruitment into studies and led to Cardiff leading for several international multicentre portfolio adopted clinical trials.

This structure provides robust research governance which allows recruitment to studies 7 days a week, 24 hours a day. Cardiff is the only critical care unit in the UK which has this model.

In total, Cardiff has recruited over 1800 patients into clinical trials in the last 5 years, 66% of which are interventional trials, to our knowledge, this is one of the best performing units in the world.

In 2017, the factors that would help develop our people further include:

- Realisation of the plans in places to protect, promote and support this staffing structure including the development of a new band 7 critical nurse specialist role.
- Develop rotational staffing model to help foster relationships between clinical and research nursing.

Resources

Resources required for an effective research department require space, equipment, IT, appropriately trained staff and income stream. The issue of space and equipment has been discussed above.

In 2017, the factors that would help develop our resource further include:

- Implementation of the Health and Care Research Wales activity based funding model within the institution is less than ideal but change was necessary as it moved from Culyer funding to an ABF model. The activity cap of £40,000 placed on directorates prevents rapid growth of research amongst the more successful groups.

- The income allocated to critical care is significantly less than the amount generated by ABF. It also has the effect of encouraging specialties to work in silos, whereas diseases often encompass several specialties especially in the acutely ill. Income is required to facilitate this process. Rather unfortunately, most meetings focus on research income as the primary objective rather than the quality of the research.

- Finally, the complex nature of the interventional studies in our environment are not adequately recognised by the generic funding formula.

Outcomes

The primary objective was to generate a stable research infrastructure that led to the publication of high impact manuscripts with the potential to generate changes in clinical practice and research income either through grants or commercial sponsors.

There was also an intention to engage with successful international critical care trials groups. This has subsequently been achieved with established collaborations with the esteemed Scandinavian Critical Care Clinical Trials Group, Australian and New Zealand

Intensive Care Society (ANZICS). A successful partnership has also been created with the University Medical Centre Utrecht who are leading the pioneering RGNOSIS and COMBACTE programs following grant funding from the European Commission and the Innovative Medicines Initiative (IMI).

Generating commercial income if these studies complemented our other work streams has been limited due to the restricted availability of commercial trials within the specialty of critical care. In a commercial influenza study, however, Cardiff was the only site in the UK to recruit patients with documented influenza over three years. We are now developing these commercial links with 3 trials in set-up and 1 currently recruiting.

In the last 4 years critical care has had a PI or CI for 13 NIHR portfolio studies.

In the last four years we have published 46 original research manuscripts. The quality of publications has increased substantially with one citation classic (865 citations since December 2013) published in the NEJM (impact factor 72.40). Thirty of these manuscripts were published in journals with an impact factor above 5.

Successful co-applicant on HTA funded grant (£2,269,038) with around $7,000,000 support funding from industry.

Results from the Target Temperature Management trial, which was led in the UK by Cardiff, were a major contributor to international consensus guidelines on resuscitation following cardiac arrest published in 2015.

Building on the successes

Many challenges exist, to build on the successes of the critical care team which need addressing often at institutional or national level.

- Income generated by activity based funding needs to be delivered by HCRW which can then be distributed in an equitable manner. The set percentage of income allocated over the last 5 years has not allowed high incomes to be fed into further department development.
- Research staff need to have their jobs recognised within a governance and management structure in C&V UHB and be protected whenever possible from service work
- We have no funding for formal trial administration support.
- There needs to be increased understanding of the role of medical research and how this fits into clinical practice and patient well being
- Ideally HCRW and the UHB needs to consider what happens to successful HCRW AHSC Clinical Research Fellows when they come out of the programme
- With no formal University academic representation, consultant time is derived from SPA time only. Only good will has allowed the trials to be organised, conducted and ultimately published. This is not sustainable and needs commitment.

Future

The objectives set out in the first strategy document remain valid with the primary aim of establishing a sustainable research infrastructure and generating high quality outputs.

- Continue links with international trials groups: Cardiff UK lead for SPICE III, RGNOSIS, SUP-ICU, ASPIRE-ICU, TTM2, TAME – all these will generate high impact (IF>30 publications in the next five years).
- Develop a phase 1 First in Man area within the critical care footprint and obtain accreditation. This would be unique in the UK to the pharmaceutical industry.
- Establish a sustainable model with regards to funding, staff structure – including remuneration appropriate to individual's role

- Maintain our existing research team structure to create a fit for purpose structure that would facilitate the continual development of the department
- Establish footprint and access to resources fit for purpose
- Continue to develop unique collaboration with Cardiff University Dental School on oral care and pneumonia.
- Continue to develop commercial links for funding investigator initiated studies.
- Adopt an institutional approach to research in the acutely ill.
- Develop translational science and academic pathways through collaboration with PhD clinicians, scientists from Cardiff University and industry.

Our Vision

Cardiff's Critical Care research department can become three things:

- A World-leading clinical trial site with expertise in planning, implementation and publication of major clinical trials.
- A translational science hub with formal university representation attracting both undergraduate and post-graduate students to do world-leading research.
- A centre for innovation collaborating with industry through the new innovation structure within the UHB.

Ultimately, realising this potential will bring huge benefits for UHB income, patient care, and staff retention. Achieving these things needs dedicated staff with vision and a structure that supports them. The research team has dedicated staff with vision as shown by the rapid improvement over the last 5 years. Now this team needs Board and UHB support:

Fair recognition of trial recruitment reflective in income with seed-corn funding for future trials when needed. Staff support for clinical research nurse, consultant, and trial administration time. Matched funding for successful fellowships to support future expansion would be welcomed. Resources and infrastructure improvements including physical environment and academic representation.

Summary

The Critical Care research department has undergone a remarkable transformation in the last 5 years. It has moved from being a poorly performing, low-output unit to a world-leading critical care academic department.

2017 is an exciting year for realising current opportunities leading international unscheduled care clinical studies, developing translational science research pathways, and embracing innovation.

However, there remain a number of glass ceilings to international excellence due to the current funding model, research-nursing support, trial administration support, protected research consultant funding, and formal university representation.

The research team will work tirelessly to overcome these issues in conjunction with support from Cardiff and Vale University Health Board. Research matters to us, to our patients, and to Cardiff and Vale.

7.7.5 Clinical Haematology and Immunology Directorate

Haematology Directorate research includes both the Haematology Clinical Research Group (HCRG) and Haemostasis and Thrombosis (H&T)

Background

The Haematology Directorate is made up of 14 consultants

- 10 consultants are job planned for a total of 5.0 SPAs research time / week
- 3 Cardiff University Senior Lecturer posts, each have 5 research sessions / week
- The Haematology chair was appointed in 2015 – Professor Oliver Ottmann

There are currently **65 studies** in the Haematology Directorate

HCRG

- 10 studies in set up
- 19 open and in active recruitment
- 21 open and in active follow up

H&T

- 2 studies in set up
- 5 open and in active recruitment
- 8 open and in active follow up

Haematology Clinical Research Group :

Band 7	Clinical trials nurse manager 0.8 wte – post appointed 2015 Emma Williams		
Band 6	Research Nurse	1.0 wte	Hilary Benney
Band 6	Research Nurse	1.0 wte	Patricia Carter
Band 6	Research Nurse	0.9 wte	Katja Williams
Band 6	Research Nurse	1.0 wte	Marcia Short (Business case August 2017)

Administration:

Band 5	1.0 wte	Catrin Truan
Band 3	1.0 wte	Hannah Boon
Band 3	1.0 wte	Julie Mort

The haematology department is 1 of 13 LLR funded Trials Accelerated Program (TAP) centres in the UK which funds a 1.0 wte clinical trials nurse within the Clinical Research Facility. In addition we are also an Experimental Cancer Medicine Centre (ECMC).

The haematology department has a well-respected national and international reputation for performing high quality commercial and non-commercial research studies. Although a single directorate, haematology consultants within C&V UHB sub-specialise and have areas of clinical expertise and research interests, as well as sitting on a number of National and International trial management groups and disease specific working groups including:

Myeloid and lymphoid leukaemia (acute and chronic)

- In collaboration with Cardiff University, co-ordination and sponsorship of UK AML studies
- C&V UHB is one of the major recruiting centres in the UK for Acute Myeloid Leukaemia studies
- Several studies with C&V Chief investigators (AML, CLL)
- All adult patients with Acute Lymphoblastic Leukaemia are screened for suitability to enter one of the non-commercial portfolio studies (~80% enrolment)
- Membership of Paediatric and Adult ALL UK Trial management groups

CLL

  - UK CLL working group,
  - Trial management group,
  - Trustee National Charity (UK CLL forum)

Lymphoma (Non-Hodgkins and Hodgkins)

- In excess of 150 new cases / year, but only 3 non-commercial studies and 1 commercial lymphoma study
- Patients referred to Velindre for clinical studies - but services may not remain long-term
- Significant number of commercial studies historically declined because second lymphoma consultant post previously unsecured (new post appointed Q3 2017)

MDS

- MDS Foundation Center of Excellence
- National Cancer Research Institute (NCRI) working group membership

Myeloproliferative Neoplasms

- Only centre in Wales performing studies in this patient group
- C&V is lead site for new national CMML study (MONOCLE)
- (NCRI) working group membership

Myeloma

- New consultant in post Q4 2014
- (NCRI) working group and Myeloma UK trials network

CML

- NCRI working group

Bone Marrow Transplantation

- The South Wales BMT Programme provides specialist transplant services for the population of South Wales
- Significant proportion of patients referred for BMT are participating in a clinical trial and BMT is an integral part of many haematology trials including NCRI AML / ALL and UK myeloma studies
- Participation in European Blood and Marrow Transplant Group (EBMT) studies and British Society (BSBMT) studies

Strategic research priority areas

1. Patient access to new medication / treatment modalities
2. Increased commercial activity & revenue generation
3. Reduction in Directorate drug cost budget
4. Increase academic profile of department and individuals

Myeloid and lymphoid leukaemia (acute and chronic)

- Maintain a UK presence influencing clinical trials strategy with continued representation on NCRI AML, ALL, MDS, CML, myeloma and MPN groups and CLL working / trial management groups
- Significant cost savings possible e.g. CML – only centre in Wales performing studies – save c.£25K per patient enrolled
- Increase our profile as an early phase (including 1st in man) trial centre to link in with ongoing departmental translational research in AML, ALL, CML,CLL and myeloma.

Lymphoma (Non-Hodgkins and Hodgkins)

- Commonest haematological malignancy diagnosed, but C&V UHB provides limited number of trials compared to centres of similar size in England - need to widen breadth of studies available
- Increase lymphoma trials portfolio for both acute and relapsed presentation as part of clinical haematology directorates plan to increase and improve lymphoma patient care

MDS

- 20 new cases diagnosed annually
- Many novel agents being investigated – collaboration with commercial organizations to increase availability to patients

Myeloproliferative Neoplasms

- Continue to increase profile of All Wales Trials Centre for MPNs
- Will provide patient access to potentially disease-changing drugs (e.g.JAK inhibitors)

Myeloma

- 30 new cases diagnosed annually
- A number of novel agents are due to be licensed / NICE approved (Carfilzomib, Elotuzomab , Daratumumab, Ixazomib) – commercial / non-commercial trials reduce drug expenditure and provide patient access to novel agents

Bone Marrow Transplantation

- Continue to support current and future haem / onc studies
- Join BSBMT clinical trials committee and relevant EBMT working parties
- Potential for "stand alone BMT" studies potentially offering patients in S.Wales novel treatment options currently only available in England

<u>Strategic direction: non-commercial studies</u>

- Monthly R&D meeting to review all proposed non-commercial studies to evaluate feasibility of patient recruitment, trial completion, clinical trial nurse availability and potential for drug cost savings to directorate
- Funding models based on activity based funding with payment based on type of study e.g. interventional vs. observational
- Encourage PIs to act as Chief Investigators

<u>Strategic direction: commercial studies</u>

- Restructure clinical trials' nurses responsibilities into disease groups to increase capacity
- Monthly R&D meeting to review all proposed commercial studies to evaluate feasibility of patient recruitment and trial completion as well as income generation and drug cost savings to directorate
- Encourage PIs to act as Chief Investigators - this may also include phase I / II studies and linking with the CRF

<u>Constraints identified as potentially limiting haematology department from increasing R+D output</u>

1. Infrastructure – the current haematology day unit needs to be expanded / re-sited to improve overall patient care and provide dedicated clinical trials space – this is a long-term plan and under discussion
2. Staffing is perceived to be a major factor
    a. Lack of 2nd lymphoma consultant – post appointed Q3 2017

b. Clinical trials nurse(s) – business case for lymphoma trials nurse submitted Aug 2017, included in R&D spending implementation plan 2017-18 submitted to HCRW
c. Clinical trials data manager to support non-commercial investigator led / chief investigator studies
d. Additional myeloma nurse specialist nurse / trials nurse
e. Additional BMT nurse / trials nurse

Investment needed to meet objectives of haematology R&D

and potential funding sources

PRIORITY

1. Additional lymphoma consultant
   - Business case agreed for 10 sessions
   - Post appointed Q3 2017

2. 1.0 wte Band 6 lymphoma clinical trials nurses
   - 0.6 wte HCRW – included in R&D spending implementation plan 2017-18 submitted to HCRW
   - 0.4 wte from commercial trial income
   - Business case submitted

3. 1.0 wte Band 6/7 Bone Marrow Transplant Nurse specialist (0.5 wte research)
   - BMT funding

DESIRABLE

1. Additional Band 6 myeloma trials nurse
2. Clinical research fellow – funding agreed 2015 - 2017

Clinical Board Research and Development Strategy

Haemostasis and thrombosis

Background

Cardiff Haemophilia and Thrombosis Centre is a tertiary referral service for South Wales with over 40 years experience and an international reputation for conducting high quality international multicentre studies in conjunction with Cardiff University. There is close interaction with the phenotypic, research and molecular and haemostasis NHS and Cardiff University laboratories. In the past 5 years publishing > 70 peer reviewed papers, > 3000 citations

In addition to studies within haematology the directorate also leads on studies within other directorates such as Women's Health e.g. OBS2: Fibrinogen concentrate in postpartum haemorrhage (12/RPM/5572E) and the Emergency Department e.g. ANNEXA-4 – Factor Xa antidote study

Non-commercial study funding model

Portfolio studies supported by NISCHR CRC and staff in the haemophilia centre.

Studies 2014 - 2015:

- Genotyping and platelet phenotyping (The GAPP study) UKCRN ID 9858 (ongoing)
- Bleeding at the time of cardiac surgery 11/DHD/5182 (completed to time and target)
- Oxidised phospholipids in aPLS (12/DHD/5456 (completed to time and target)
- Adherence to prophylaxis: interview (13/DHD/5811) questionnaire 13/DHD/5812) (both completed to time and target)
- ITP registry (ongoing)
- TTP registry (ongoing)
- ORANGE study (closed Q2 2017)

Commercial study funding model

Studies are supported from factor concentrate savings and not the R&D budget.

Studies in 2014 - 2015:

- Calgene factor IX study
- N9GP continuation
- N8GP pivotal study
- N8GP continuation

Venous Thrombosis studies

- Only hospital in Wales participating in interventional VTE studies

Studies opened following new staff appointments

- Bax 826 Phase 1 study rFVIII
- Bax 855 Phase 3 pegylated FVIII in children
- HAVEN 1 – ACE910
- Pathfinder 2 / Pathfinder 3
- Einstein-Choice Phase 3 VTE treatment
- MARINER Phase 3 Rivaroxaban Medical thromboprophylaxis
- ANNEXA-4 Phase 2 NOAC antidote study
- CARAVAGGIO Phase 3 Apixaban Cancer associated thrombosis study

Strategic research priority areas

- Inherited and acquired disorders of bleeding
- Treatment of venous thrombosis
- Expansion into paediatric haemostasis and thrombosis studies.

Strategic direction: non-commercial studies

- Open new portfolio studies in bleeding and thrombotic disorders.

2015 – 2016 Strategic direction: commercial studies

- *To employ new staff (research nurses and clerical manager) to manage current haemophilia concentrate trials and expand into new studies.*
- *To part fund haemostasis laboratory band 6 to support both commercial and non-commercial studies*

Investment needed to meet objectives of haematology R&D and potential funding sources
2015 - 2016

1. *Band 6 nurse / Band 4 admin support - funded from haemophilia drug concentrate savings*

2. *Band 8 Haemostasis laboratory manager*
   - *Replacement for retirement of Band 8 Clinical Scientist / Lab manager retirement – banding was maintained as a result of R&D involvement*
   - *Retain band 6 haemostasis lab clinical scientist*

Planned 2016 – 2017 Strategic direction: commercial / non-commercial studies

1. *Band 8 Haemostasis lab manager – post appointed – Vince Jenkins*
2. *Band 7 Trials manager (post recruited to commence Sep)*
3. *Band 6 trials nurse 1.0 wte appointed and commenced Jan 2016*
4. *Band 6 trials nurse 1.0 wte appointed to commence Aug 2016*
5. *Band 6 paediatric 0.6 wte / trials 0.4 wte nurse – post approved June 2016*
6. *Band 4 trials administration and trial co-ordinator – post approved June 2016*
7. *Associate specialist – to support C&V UHB DVT clinical service and haemostasis & thrombosis studies*

2017 – 2018 Strategic direction: commercial / non-commercial studies

All posts approved and appointed

Band 8 Haemostasis Lab Manager	1.0 wte	Vince Jenkins
Band 7 Trials Manager	1.0 wte	Anna Guerrero
Band 6 Research Nurse	1.0 wte	Joanne Swidenbank
Band 6 Research Nurse	1.0 wte	Sylvan Njombo
Band 4 Administration	1.0 wte	Stuart Cunningham
Associate Specialist	1.0 wte	Patricia Guimaraes

7.7.6 Nephrology and Transplantation Directorate

Executive Strategic Service Priority

Long term conditions (renal disease).

Summary

Kidney disease has a detrimental impact on patient quality of life, morbidity and mortality, the management of which attracts considerable NHS costs. The integration of the clinical expertise of the Directorate of Nephrology and Transplantation within the Wales Kidney Research Unit provides a dynamic and creative environment for clinical research studies and trials.

The key aims for the directorate are:

- To develop a robust and securely funded infrastructure to support and facilitate the development of, and ongoing recruitment to, portfolio listed Clinical Trials, so patients may have the advantage of participating in studies relating to all aspects of kidney disease.
    - The staffing infrastructure comprises Principle Investigators, Research Nurses, administrative staff and laboratory support.
- To forge closer links with the Clinical Research Facility (CRF):
    - Enable early phase studies.
    - Consolidate a weekly renal research clinic for screening visits, and regular follow up of patients recruited to either investigator-led or commercial trials.
- To increase participation in relevant commercial studies.
- To liaise with other NHS and university departments, both locally and nationally, to develop novel portfolio studies.
- To use the income generated for pathway to portfolio studies that show a strong potential for development of future applications.

Background

The Cardiff Renal Unit has a catchment population of 1.5 million for renal services and 2.25 million for kidney and pancreas transplantation. As such, we are an attractive participating site for both non-commercial and commercial studies, and have been increasingly able to capitalise on this. The areas of clinical practice in which there is local investigator expertise include: Acute Kidney Injury, Chronic Kidney Disease, Vasculitis and Glomerulonephritis, haemodialysis, peritoneal dialysis, acute transplantation and long term management of transplant recipients. The directorate of Nephrology and Transplantation is closely integrated with the Wales Kidney Research Unit (WKRU), an HCRW-funded biomedical research unit (BMRU) and the first such renal-specific BMRU in the UK. Within the directorate there are close links between NHS and Academic clinicians, and several joint scientific studies with other university departments (in particular immunology) and the Welsh Transplant and Immunogenetics Laboratory. The transplant surgeons are one of eight National teams for Organ Retrieval, which provides an invaluable opportunity for participation in trials of organ perfusion and assessment of organ quality. The surgeons also supply omental biopsies, taken at the time of donor nephrectomy, to the Institute of Nephrology for isolation of peritoneal cells.

The directorate also has a keen interest in aspects of patient care at the interface between clinical research and service development, for example developing an IT driven understanding of the relationship between electronic alerts and Acute Kidney Injury (AKI), led by Professor Philips. This is an all Wales initiative that will improve understanding of regional variation and outcomes, and inform service need. Working with the UK Renal Registry, this project will help inform a better predictive model for AKI in different clinical settings.

Over the last five years, 11 nephrology and surgical trainees have completed or are undertaking research projects leading to higher degrees (MD or PhD), supported by the WCAT scheme and personal grants from Kidney Research UK and the Wellcome Trust.

From a national perspective, the renal community has invested in the establishment of the UK Kidney Research Consortium, which brings together clinicians, professional societies, the leading renal charity and industry to foster the development and promotion of multi-centre studies. The Cardiff unit is well-placed to make a significant contribution to these.

Directorate medical staff

There are 21 Consultants in the directorate:

- Ten NHS Nephrologists, four of whom have a subspecialty interest in transplantation (the total includes two acute physicians with clinical sessions in Nephrology).
- Four academic Nephrologists (two Professors, one Reader and one Senior Lecturer). Professor Aled Phillips is the Clinical Director for the Nephrology and Transplantation, and Professor Donald Fraser is the Director of the Clinical Research Facility at UHW. Dr Steve Riley is Dean of Medical Education at Cardiff University, and Dr Soma Meran is an MRC Clinician Scientist.
- Seven transplant surgeons. Mr Chavez is the R&D Lead for the Surgical Board.

There are three specialty doctors in nephrology, 5 full time SpRs, two part time SpRs and three research SpRs. Two of the research SpRs are based on the Clinical Research Facility. There are 7 surgical trainees rotating through the Cardiff Transplant Unit.

Several Consultants in the directorate are members of national and international trial management groups, and disease specific Clinical Study Groups, including those for AKI, glomerulonephritis, vasculitis, metabolic bone disease, peritoneal dialysis and renal transplantation. Professor Donald Fraser and Dr Siân Griffin are the joint NIHR Renal specialty leads for Wales.

Current Infrastructure

Directorate R&D Lead: Siân Griffin
Clinical Research Time Award 1/4/16 – 31/3/19

Research Nurses: Yvette Webley, Rachel Williams, Maria Coleman (all of whom also participate in the transplant recipient on call rota).

Administrative support: Jan Woolweaver (0.25 WTE). The directorate will be appointing a full time administrator/data entry clerk to support the increased trial activity.

Nursing support is also received from the CRF for the PIVOTAL study (initially 0.6 WTE band 5, now 0.4 WTE to July 2018).

Management of the studies in peritoneal dialysis is supported by the WKRU.

The R&D Lead's office is in the renal outpatient clinic, which facilitates outpatient recruitment. The Research Nurses' office is in the directorate administration area. Both offices have secure space for storage of trial related documents. The equipment and technical support to undertake processing and storage of biological samples are available in the Institute of Nephrology.

There are monthly open meetings attended by our R&D facilitator to monitor recruitment to active trials, review progress of trials in set up and consider those for future participation. Regular updates concerning trials in which we could participate are circulated to Consultants in the directorate.

Information on current trials forms part of the induction information for new junior doctors joining the department, and there are trial information notice boards in the out-patient clinic and on the renal and transplant wards. All junior doctors are encouraged to complete GCP training.

One commercial trial completed follow up earlier this year, and one has closed to recruitment with patients continuing in follow up. There are three open commercial trials (two run jointly with the CRF), and a further three in set-up. In addition, the directorate continues to have an agreement to supply plasma exchange effluent to a biomedical company. The revenue generated contributes to a nurses' education fund to support attendance at National meetings. Studies run by academics and scientists in the department have attracted research grants in excess of £4 million.

Investigator-led studies active in the period 1/4/16 – 31/3/17

Study acronym	Study title	PI	Start date	End date
Glomerulonephritis and vasculitis				
RaDaR	National study of Rare Kidney Disease	Griffin	1/10/09	31/12/19
MPGN	National study of Membranoproliferative Glomerulonephritis, Dense deposit Disease and C3 Glomerulonephritis	Griffin	1/2/10	30/4/17
NephroS	National study of Nephrotic Syndrome	Griffin	2/9/09	31/3/18
Haemodialysis				
PIVOTAL	UK multi-centre open label randomised controlled trial of IV iron therapy in incident haemodialysis patients	Benzimra	24/9/13	31/07/2018
DOPPS6	The Dialysis Outcomes and Practice Patterns Study	Davies		2018
PAVE	A double blind randomised controlled clinical trial to determine the efficacy of paclitaxel-assisted balloon angioplasty of venous stenoses in haemodialysis access	Szabo	June 2017	March 2018
Peritoneal dialysis				
PERIT PD	The role of T cells in peritoneal dialysis-related inflammation and infection	Fraser (CI)	1/1/08	31/12/17
LEUK PD	Time on peritoneal dialysis and peritonitis modulate the phenotype of peritoneal mononuclear cells	Donovan/Fraser (CI)	1/6/08	31/12/17
PD CRAFT	A study of clinical and genetic risk factors for Encapsulating Peritoneal Sclerosis	Donovan	Closed to recruitment 31/12/14	Annual follow up to 30/6/17
	Microcirculatory function in peritoneal dialysis	Fraser	1/6/17	31/5/19
Transplantation				
BOUnD	Understanding barriers and outcomes of unspecified kidney donation	PIC site	16/12/15	31/8/18
PoWAR	A randomised trial of antibiotics in laparoscopic donor nephrectomy	Szabo	1/11/12	31/8/16
COPE-POMP	Effect of short term oxygenated hypothermic machine perfusion after static cold storage versus cold storage alone (ECD DBD donors)	Ablorsu	1/5/14	31/10/16

EMPIRIKAL	A double blind randomised controlled investigation into the efficacy of Mirococept (APT070) for preventing ischaemia-reperfusion injury in the kidney allograft (currently suspended)	Griffin	1/5/15	31/3/17
Other				
SPEAK	Surveying people experiencing young adult kidney failure	Griffin	28/9/15	26/9/16

Investigator-led studies currently in set-up

Study acronym	Study title	PI	Start date	End date
NURTuRE	National Unified Renal Translational Research Enterprise – Chronic Kidney Disease. An investigation of determinants and risk factors for clinically important adverse outcomes in people with CKD.	Fraser		
KEPT	Knowledge, understanding and experiences of peritonitis amongst patients, and their families, undertaking peritoneal dialysis: a mixed methods study	Baillie		
SIMPLIFIED	Natural vitamin D (cholecalciferol) versus standard care in patients receiving haemoadialysis	Ghalli		
PITHIA	Pre-implantation Trial of Histopathology in Renal Transplant Allografts	Szabo		
ITOPS	Improving Transplant opportunities for Patients who are Sensitised	Griffin (CI)		

Commercial studies active in the period 1/4/16 – 31/3/17

Study acronym	Study title	PI	Start date	End date
SIGN	Syk inhibition for Glomerulonephritis (phase II)	Fraser		Open
ALXN1210	Global study of ALXN1210 for *de novo* atypical Haemolytic Uraemic Syndrome (aHUS)	Griffin		Open
CREDENCE	Effect of canagliflozin on renal and cardiovascular outcomes in subjects with T2DM and diabetic nephropathy	Fraser Roberts Bolsani		In follow up
STEADY	A phase IV trial of once daily tacrolimus in *de novo* renal transplant recipients	Griffin		Complete
Il18 blockade		Asderakis		Suspended

Commercial studies currently in set-up

Study acronym	Study title	PI	Start date	End date
ADVOCATE	A phase 3 clinical trial of CCX168 (Avacopan) in patients with ANCA-associated vasculitis	Griffin		
Dapa-CKD	A study to evaluate the effect of dapagliflozin on renal outcomes and cardiovascular mortality in patients with Chronic Kidney Disease	Fraser		
UCB	Use of a novel anti-fibrotic molecule to ameliorate interstitial fibrosis in renal transplant recipients	Griffin		

A number of pathway to portfolio studies are being undertaken, including an evaluation of patient haemodynamics during haemodialysis.

Future strategy – achieving our potential

We aim to develop a culture where all patients are routinely offered the opportunity to take part in a study for which they are eligible.

- **Staff**

  Two additional research nurses have been appointed in the last year. Pending final clarification of ABF income, their salaries are supported from the directorate endowment fund. It is anticipated that their appointments will enable significantly increased recruitment to both portfolio and commercial trials, with future salary sustainability. The benefit of these new appointments, in terms of the set-up of new trials, is already being realised. A new, larger research office has been refurbished within the directorate administration area to accommodate the expanded team.

  In addition, a number of clinical nurse specialists have undertaken GCP training to be able to support patient recruitment and follow up in a number of sub-specialty areas, specifically transplantation, vascular access and peritoneal dialysis.

- **Future expansion**

  Sustainability and security of directorate revenue will depend on ongoing enthusiasm for trial recruitment and subsequent income generation, and will be key considerations when making new appointments to dedicated research roles.

  - **Administrative assistant/data entry clerk**

  The increased complexity of data collection for both observational and clinical trials requires the support of a Band 4 Administrative assistant/data entry clerk. This will free up nursing and clinician time for trial setup, consent and recruitment (especially in satellite clinics).

  - **Laboratory technician**

  An increasing number of trials require local processing and storage of biological samples. This is supported by the WKRU using the laboratories in the Institute of Nephrology, but the

available technician time will shortly reach capacity. It is anticipated that the income generated by commercial activity will support the appointment of a second technician in the future, but in the short term we are looking to identify salary funding from either a legacy account or charity donation.

- **Wider engagement**

  - **General**

- To continue to increase awareness and visibility of trials with generic and trial specific posters in clinical areas. To include information relevant to staff, patients and relatives.
- Develop an area on the WKRU website.
- Explore the use of social media, eg twitter.
- Work with patient groups to facilitate wider participation.

  - **Medical**

- Ensure all Consultants are aware of trial opportunities, encourage uptake of the PI role, educate and assist with SSI completion etc (with R&D facilitator and nurse support).
- Enable patients seen in outreach clinics have the same opportunities to be recruited to clinical trials as those seen in UHW, by facilitating recruitment by Consultants attending those clinics or research nurse. If appropriate, these patients can be offered the opportunity to attend the renal research clinic on the CRF.
- Develop a culture amongst the junior medical staff such that research activity is viewed as integral and complimentary to their clinical work. Encourage more staff to undertake GCP training and become involved in recruitment.

  - **Nursing**

- Continue to highlight opportunities for involvement in specific trials. This is gradually increasing nursing engagement with increasing numbers completing GCP training.

  - **Others**

- Liaise with colleagues in related directorates, eg diabetes/endocrinology to identify studies for joint participation.
- Strengthen established links with the CRF with expansion of the capacity for review of renal out-patients and early phase trials.
- Wales Kidney Research Unit
  - Increase sample collection in the directorate for inclusion in the WKRU tissue bank, which is maintained in Cardiff by the WKRU research manager.
  - Encourage pan-Wales trial engagement.
- The HCRW nursing work force provided invaluable support for the SPEAK study, and enabled detailed follow up of a patient group that is traditionally hard to reach (Young Adults). This clearly demonstrated the value of the involvement of a specific researcher on recruitment rates. Unfortunately support has not been available for other projects requiring identification and recruitment of patients with a rare disease, or out of hours. However, there are now a number of larger scale studies that will be recruiting patients already known to the service, for which HCRW support will be more appropriate.

Nephrology has traditionally been a specialty with many opportunities and high expectations for research endeavours in all aspects of related basic science and patient care. The directorate looks forward to future consolidation and expansion of its portfolio of studies.

7.7.7 Neurosciences Directorate

Executive Strategic service priorities:

- **Population health, Long term conditions, Stroke, Eye Health.**

Overview

The neuroscience directorate at Cardiff and Vale UHB (CAV) encompasses neurology, neurosurgery, neurophysiology and neuropsychology. The neurology department has a long history and international reputation in research excellence in Epilepsy, Huntington's Disease (HD) and Multiple Sclerosis (MS) research. There are emerging strengths in Stroke research and Neurosurgery. Clinical epilepsy and Stroke research is based in the NHS, HD and MS research groups are based in Cardiff University, with active NHS portfolios. There have been over 100 peer review publications since 2010 authored by staff in the neuroscience department.

The clinical and academic potential CAV was recently recognized in the HCRW re- structuring and funding, with the successful bid for 3-years of funding as HCRW funded Unit – the Brain Repair and Intracranial Neurotherapeutics (BRAIN) Unit, the focus of which is to 1) support the delivery of intracranial therapeutics from drug delivery to stem cell research 2) develop collection of human biologicals for research and routine use of NHS data and prospective consenting of patients into research, 3) increase the support infrastructure for commercial and non-commercial studies, in areas of strengths, namely areas of Huntington's Disease, Epilepsy and Multiple Sclerosis .

The neuroscience department is based on the 4th floor of UHW main building with dedicated neurology, neurosurgery wards and neurosciences HDU. The neurophysiology department and clinical psychology are co-located. Close links exist with neuroradiology through multi-disciplinary meetings and clinical interactions, along with close working with neuropathology and neuropaediatrics. Neurosciences in CAV is the tertiary centre for Wales providing neurology, neurosurgery, neuropathology and neuroradiology, with unique opportunities for research and collaboration. There are close relationships with the Cardiff Brain Repair Group, which has an international reputation for the development of cell therapies in Huntington's and Parkinsons' diseases, and the School of Healthcare studies through internationally recognized research into activity based therapeutics for neurodegeneration.

Furthermore a real area of strength is the close link with Cardiff University Brain Research Imaging Centre (CUBRIC), a world leading centre, and one of Europe's top facilities for brain imaging, first opened in 2006. The new £44M CUBRIC opened on 7th March 2016 and brings together world-leading expertise in brain mapping with the very latest in brain imaging and brain stimulation. The centre plays a pivotal role in the global endeavour to better understand the causes of neurological and psychiatric conditions such as dementia, epilepsy, schizophrenia and multiple sclerosis.

CAV neuroscience has a long history of involvement in national and international multi-centre commercial trials, in particular in the areas of Epilepsy, HD, MS and Stroke these department and Principal Investigators are frequently approached by trial coordinators, the pharmaceutical industry and their agents regarding expressions of interest for new studies. These commercial studies bring significant income to the health board, both in terms of direct payments and making otherwise expensive treatments available for free.

Finally neurology has been particularly successful in successful candidates to the WCAT (Welsh Academic Trainees). There are 7 WCATs from neurology on the scheme (total funding approx. £2.3M). The MS unit currently has funding for 4 additional clinical fellows (2 international registry fellows, 1 Wellcome Trust training fellowship, and I funded by WAG). This is important as it has an effect of attracting staff, enabling clinical trials and increasing competition for all neuroscience posts around Wales, gives a substantial boost to academic research in the department as well as

contributing to the clinical service in their role as neurology trainees.

Despite historic and continuing R+D successes in the Neuroscience Directorate at Cardiff and Vale the challenges to clinical research continue to mount and are generally well recognized, from increasing regulatory processes, increasing clinical pressures and greater competition for limited funding sources. The success of neuroscience research in Cardiff and Vale UHB has been largely down to the individual efforts and enthusiasm of individual consultants, efforts through Cardiff University, and little formal infrastructure, funding or overall strategy from the UHB, though this is now being addressed. Cardiff has unique opportunities through a dedicated consultant body representing most specialist areas in neurosciences, with well-characterized clinical cohorts and activities, and research excellence in Cardiff University Neuroscience (highlighted in the recent REF). To make the most of these opportunities existing strengths and weaknesses need to be identified and challenges recognized and addressed at Health Board level.

Strengths

- Nationally and Internationally recognized clinical and academic expertise.
- Developing academic Neurosurgical department.
- HCRW Unit funding - BRAIN Unit – April 2015 to April 2018.
- Strong Track record in recruiting and contributing to multicentre non- commercial research studies. Recent highlights include:
    - Stroke Research
        - International Stroke Trial [IST3][1], Cardiff and Vale was 18th of 166 recruiting centres in participants recruited.
    - Epilepsy Research
        - SANAD. Standard and New Anti-Epileptic Drugs (MRC). 2003-2006
        - SANADII. (HTA) 2013-2016
        - NEST Non-epileptic Seizures Treatment (NEST) study April 2009-April 2011
        - Refractory Juvenile Myoclonic Epilepsy Cohort (ReJuMEC) (MRC) 2008.
        - CODES study COgnitive behavioural therapy vs standardised medical care for adults with Dissociative non- Epileptic Seizures: A multi-centre randomised controlled trial (HTA) 2014 - 2017
        - National Audit of Seizures in Hospitals (NASH) group, 2010–12 and NASH2 2013–15.
        - EMPiRE - AntiEpileptic drug Monitoring in PREgnancy (HTA) 2011 – 2014.
    - Neurosurgery
        - The British Antibiotic and Silver Impregnated Catheters for ventriculoperitoneal Shunts multi-centre randomised controlled trial (The BASICS trial) 2012 – 2017.

Huntington's research

- Established Cardiff Fetal Tissue Bank with integral GMP facility for the delivery of cells for neurological diseases
- Contibrution of donor tissue to the International study "TransEuro".
- Award of an FP7 Consortium "Repair-HD" which aims to establish the conditions for first in man studies of stem cell therapy for Huntington's disease
- Coordinating base for the English speaking sector of the European Huntington's Disease Network (EHDN) established in Cardiff
- Selected as sites for the commercial trials Pride-HD, Legato, Amaryllis (see below).
- Paper (Busse M, Quinn L, Debono K, Jones K, Collett J, Playle R, Kelly M, Simpson S, Backx K, Wasley D, Dawes H, Rosser A. A randomized feasibility study of a 12-week community-based exercise program for people with Huntington's disease. J Neurol Phys Ther. 2013 37:149-58) selected as the outstanding paper of 2013 by J

Neurol Phys Ther.

MS research

- Clinical trials: (CAMMS 223, Alemtuzumab PASS, TOPAZ, STRIVE)

Challenges

- Established UK centre of excellence for epidemiological studies of neuroinflammatory disorders
- Integrated research and clinical database with >3000 registered patients
  - Identify and track NHS R&D income and expenditure.
  - Increase visibility of NHS neuroscience research activity.
  - Improve current NHS neuroscience research environment and facilities.
  - Timely processing, adoption and set-up of new trials – 2 recent commercial MS trials lost, at the point of commencing recruitment in Cardiff, due to delays in local set-up, and international competitive recruitment.
  - Delays/challenges in the HR process in appointing new research staff.
  - Maintaining regulatory rules and requirements of GCP (Good Clinical Practice) and Regulatory duties
  - Better alignment with Cardiff University Neuroscience and Mental Health Research Institute.

Objectives and future direction

- Develop environment and infrastructure to promote NHS research.
- Ensure timely set up and initiation of studies.
- Optimize patient recruitment.
- Greater alignment and use of opportunities between Cardiff University and UHB.
- Ensure directorate HCRW ABF allocation is spent on supporting and delivering research and development activities – a separate budget line is essential for this.
- Bi-annual statement of commercial and non-commercial income and expenditure.
- Model expected commercial income streams over next 3 – 5 years.

How to Achieve the above

- Proper tracking of and appropriate allocation of Directorate R&D income.
- Appoint w.t.e. research nurse to support 4-bed research facility and existing and new trials
- Appoint research administrator to directorate office (Band 5) – to support day-to-day admin, enhance new study take up, support Ethics, R+D submissions and other regulatory submissions, and to work with the new UHB Research Liaison Manager.
- Replace research gap left by loss of epilepsy unit GP clinical assistant.
- Secure the clinical nursing support post for the South Wales Huntington's clinical service
- Develop 4 bed clinical research area on C4 neurology ward, as proposed in the BRAIN Unit bid, for phase I and II clinical trials – currently in MS and HD, and future intracranial therapies and other disease conditions.

APPENDIX 1

Non-commercial studies, Neuroscience directorate. December 2014.

Project Title	Acronym	UKCRN_ Portfolio	PI	Start	End
A UK Huntington's disease registry: collaboration with Euro-HD	Euro-HD REGISTRY	YES	AE Rosser	01/11/04	01/12/14
An epidemiological study of Multiple Sclerosis in South Wales	-	YES	NP Robertson	01/04/05	01/10/19
Neurobiological Predictors of Huntingdon's disease	PREDICT-HD	YES	A Rosser	01/12/05	01/09/14
Advanced Brain Imaging in Childhood Epilepsy	ABICE	YES	K Hamandi	01/10/10	01/01/15
REGISTRY - A Study by the European Huntington's Disease Network (EHDN)	REGISTRY	YES	AE Rosser	01/03/10	01/03/30
An Observational Study To Assess Longitudinal Changes In Clinical Abnormalities In Patients With Parkinson's Disease (TRANSEURO)	TRANSEURO	YES	AE Rosser	01/06/11	01/01/15
AntiEpileptic Drug Monitoring in PREgnancy: An Evaluation Of Effectiveness, Cost-Effectiveness And Acceptability Of Dose Monitoring Strategies (EMPiRE)	EMPiRE	YES	K Hamandi	01/02/12	01/04/15
An Open Label Study To Assess The Safety And Efficacy Of Neural All-Transplantation With Fetal Ventral Mesencephalic Tissue In Patient's With Parkinson's Disease (TransEUro)	TransEUro	YES	AE Rosser	01/06/14	01/06/17
A pragmatic randomised controlled trial comparing the effectiveness and cost effectiveness of levetiracetam and zonisamide versus standard treatments for epilepsy: a comparison of Standard And New Antiepileptic Drugs (SANAD-II)	SANAD-II	YES	P Smith	01/10/12	01/05/18
The British Antibiotic and Silver Impregnated Catheters for ventriculoperitoneal Shunts multicentre randomised controlled trial (BASICS)	BASICS	YES	P Leach	01/04/13	01/04/16
Exploring the transition from relapsing remitting to secondary progressive multiple sclerosis to inform the production of content of support programmes for patients and carers, and educational packages for clinicians	-	YES	NP Robertson	01/09/13	01/12/14
Study To Obtain Neural Stem Cells From Patients Undergoing Neurosurgery	-	YES	WP Gray	01/10/13	01/01/18
The collection of Huntington's Disease positive fetal tissue from elective termination of pregnancy	-	YES	AE Rosser	01/01/14	01/07/15
Exercise Rehabilitation Trial in Huntington's Disease (EXERT-HD)	EXERT-HD	YES	ME Busse/AE Rosser	01/01/14	01/05/15
Developing objective neuropsychological tests for the neuropsychiatric symptoms in Huntington's disease	-	YES	AE Rosser	01/06/14	01/11/16
COgnitive behavioural therapy vs standardised medical care for adults with Dissociative nonEpileptic Seizures: A multicentre randomised controlled trial (CODES)	CODES	YES	PEM Smith	01/09/14	01/03/18
Parkinson's Disease Medicines trial	PDMED	YES	TAT Hughes	1/1/07	1/1/17
Post-mortem human fetal tissue for neural transplantation in Huntington's disease	SWIFT	P2P	AE Rosser	01/01/02	01/10/17
The Characterisation Of Dementia In Huntington's Disease: A Bidirectional Translational Neuroimaging Study	-	P2P	D Jones/AE Rosser	01/08/12	01/12/14
Imaging glutamatergic neurotransmission in the human brain	-	P2P	K Hamandi	01/06/13	01/06/15
Rehabilitation in neurodegenerative disease: Effects on behavioural and MRI imaging outcome measures	-	P2P	C Metzler-Baddeley/AE Rosser	01/11/13	01/11/16
Move Wales: Welsh Movement Disorder Research Network	Move Wales	P2P	K Peall	01/05/14	01/03/17
Obtaining brain tumour tissue from patients undergoing neurosurgery	-	P2P	WP Gray	01/05/14	01/09/18
Evaluation of Learning and Memory in Temporal Lobe Epilepsy	-	In Progress	WP Gray	01/06/14	01/06/19
The Genetic Basis of Familial Epilepsy in Wales	-	P2P	MI Rees	01/10/05	01/04/15
Functional imaging of Epileptic activity	-	P2P	K Hamandi	01/03/08	01/03/16
Is the skeleton affected in Huntington's Disease?	-	P2P	AE Rosser	01/02/08	01/01/15
Supporting Activity Engagement in People with Huntington's disease: A Phase II Evaluation	Engage-HD	YES	ME Busse/AE Rosser	01/04/14	01/04/16

APPENDIX 2

Commercial studies, Neuroscience Directorate. May 2016

CT Ref.	PI	Title	Sponsor
CT-035-2014	Dr Khalid Hamandi	A Global, Postmarketing Observational Safety Study To Evaluate The Safety And Tolerability Of Fycompa (Perampanel) as Add-on Therapy In Epilepsy Patients Aged > 12 Years	Eisai
CT-043-2015	Dr Khalid Hamandi	A Nonintervential Study Of Vimpat (Lacosamide) Added To One Baseline Antiepileptic Drug Therapy In Patients With Brain Tumor-Related Epilepsy (VIBES)	UCB Pharma
CtT-020-2014	Prof Anne Rosser	A Phase 2, Dose-Finding, Randomized, Parallel-Group, Double-Blind, Placebo- Controlled Study, Evaluating the Safety and Efficacy of Pridopidine. (PRIDE-HD) Phase 2	Teva Pharmaceuticals
CT-070-2014	Prof Anne Rosser	A phase 2 randomized placebo controlled study of the efficacy and safety of PT- 02545920 in subjects with Huntington's disease (Amaryllis)	Pfizer
CT-021-2015	Prof Anne Rosser	An Open label extension study to investigate the long term safety, tolerability and efficacy of PF-02545920 in subjects with Huntington's disease who previously completed study A8241021	Pfizer
CT-002-2015	Prof Neil Robertson	A long-term follow-up study for Multiple Sclerosis patients who have completed the alemtuzumab Extension Study (CAMMS03409)	Sanofi Aventis
CT-003-2015	Prof Neil Robertson	A prospective multicenter observational post authorization study to evaluate the long term safety profile of Lemtrad ® (Alemtuzumab) treatment in patients with relapsing forms of multiple sclerosis	Sanofi Aventis
Studies in the R&D			
CT-018-2015	Prof Neil Roberston	Multicenter, randomized, double-blind, parallel-group, active-controlled, superiority study to compare the efficacy and safety of ponesimod to teriflunomide in subjects with relapsing multiple sclerosis	Acetlion Pharmaceuticals
CT-016-2016	Prof Anne Rosser	A Multi-Center, Open-Label Study Evaluating the Safety, Tolerability, and Efficacy of Pridopidine in Patients with Huntington's Disease (Open PRIDE-HD) (Open PRIdopidine Dose Evaluation in Huntington's Disease)	Teva Pharmaceuticals
CT-018-2016	Dr Khalid Hamandi	A 12-MONTH NONINTERVENTIONAL, POSTMARKETING, MULTICENTER STUDY TO EVALUATE THE EFFECTIVENESS OF BRIVIACT® (BRIVARACETAM) AS ADJUNCTIVE THERAPY IN PATIENTS WITH EPILEPSY WITH PARTIAL-ONSET SEIZURES IN DAILY CLINICAL PRACTICE'	UCB Pharma

7.8 Surgery Clinical Board

Research and Development Strategy

1. Background

Health and Care Research Wales (HCRW) implemented a new funding model starting in 2012, which was to come into effect over a 3 year period starting from 2012/13. One of the consequences of this new model is that historical R&D allocation to this Trust has fallen from approximately to £10.5 million per year to £4.5 million in 2016/17.

Also the distribution of income from commercially funded research has changed within the UHB. The new system reflects the work undertaken by the R&D office, compensates Directorates for their involvement, builds R&D capacity and incentivises Principal Investigators (PIs). The goal is that any excess income generated will be protected to support R&D and enhance the UHBs strategic plans for research.

2. Non-commercial study funding model

The new funding model from HCRW is based on activity with allocations made on the basis of a formula which takes into account the:

- Number of HCRW Clinical Research Portfolio studies
- Number of participants recruited
- Number of portfolio studies where the chief investigators belongs to the UHB
- Number of HCRW Academic Health Science Clinical Research Fellows employed by the UHB

Also complexity bands were introduced in order to differentiate between various types of studies and associated costs. Three bands were devised:

- Band 1 (Interventional studies)
- Band 2 (Observational studies)
- Band 3 (Large Sample studies) where the total sample size is of 10,000 or more participants

The funding can be used to support:

- HCRW Clinical Research Portfolio Studies, which are those studies funded through an open, peer-reviewed, nationally competitive funding stream and accepted on to the portfolio.
- Pathway to portfolio studies, which is the work undertaken to inform the development of a portfolio study or grant application for a portfolio study.

Spending plans and budget management

Each directorate R&D budget is managed by the Directorate R&D lead with the Directorate Management. Each Directorate is responsible for producing an annual spending plan and providing reports against this plan to ensure that the funding has been spend on eligible activity. The funding plan should include the costs of all posts, both clinical and non-clinical that contribute to non-commercial research, Clinical Research fellow time allocated to portfolio studies and nursing time.

Budget lines have been introduced to Directorates based on their activity and average historical R&D project costs. Future R&D Directorate will change according to activity compared with other Directorates and other NHS organisations in Wales subject to a cap of +/- 20% per year or +/- £40,000 if higher.

3. Commercial study funding model

Commercial studies are costed using a UK template per patient and additional costs based on standardised staff hourly rate.

Overhead capacity and building and location costs weighting (the All Wales Multiplier) elements are added to reach the final figure. Commercial income is then distributed according to the template which depends on whether the PI is a Cardiff University of UHB employee, ie for UHB PIs 40% of the total staff costs will return to the Directorate to cover commercial research costs to the Directorate including staff costs of individuals involved and overheads. 25% of the total UHB template staff costs are returned to specific PI UHB accounts that can be used to support research including staff training, pathway portfolio, staff salaries and equipment.

The money in the PI account is available until 18 months after the date of the last visit of the past patient, after which residual funds are transferred into the Research Legacy Fund 20% centrally and 80% to the Directorate level.

4. Strategic research priority areas

The Welsh Assembly Government policy priorities are:

- Health inequalities
- Chronic Diseases
- Cancer
- Mental health
- The Health of children and older people
- Service delivery and organisation

The strategic priority themes of the South East Wales Academic Health Science Partnership (SEWAHSP) are:

- Cancer
- Cardio-respiratory and diabetes
- Genetics and genomics
- Health services and Delivery Research
- Infection, inflammation and immunity
- Neuroscience and Mental health
- Primary care and public health
- Regenerative medicine and healthcare
- Healthcare education and healthcare education research

The Directorate R&D lead should assume responsibility in ensuring that only portfolio studies and high quality pathway to portfolio studies are supported.

5. Strategic direction: non-commercial studies

Research activity within the Surgery board will have to be focused on portfolio work and high quality pathway to portfolio studies.

a. Increase in number and proportion of HCRW registered clinical research portfolio studies.
b. Maximise recruitment and data upload for portfolio adopted studies.
c. Increase proportion of studies with Chief Investigator associated with the organisation
d. Prioritise interventional studies in the translational gaps

The Cooksey Report and SEWAHSP report identify four gaps in translation of research:

- Gap 1 related to the process of taking basic science ideas and developing them into products that can be commercialised or taken into healthcare practice.
- Gap 2 related to the evaluation and identification of those new products and interventions which are appropriate for everyday use by the NHS and the process of their implementation.
- Gap 3 concerns the failure of evidence to progress into clinical practice due to barriers created by everyday clinical situations (implementing science).
- Gap 4 relates to population based data being available to feed into the translational process

e. Meet and exceed HCRW targets covering non-commercial research

- Which includes an increase in the number of portfolio studies by 10% per annum over 5 years
- 80% of studies to receive NHS permission within 48 calendar days
- 80% of studies to recruit the first patient within 30 days of approval
- 80% of studies recruiting 80% of target
- Reduce percentage of non-recruiting studies to <10%
- Increase the number of CIs leading portfolio studies and the number of studies being sponsored by the organisation.

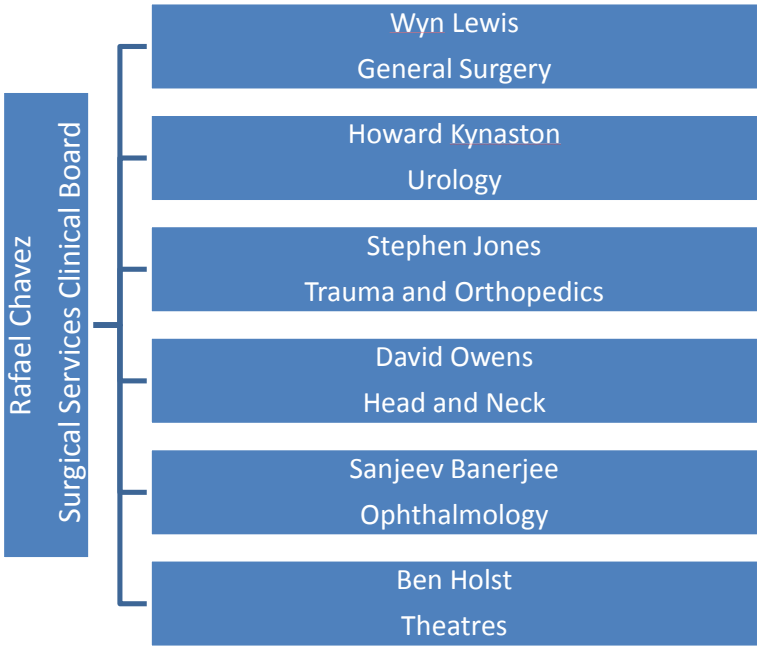
6. Strategic direction: commercial studies

It is important that the Surgery Board is proactive in commercially sponsored and funded research in order to:

- Develop more effective treatments for future use within the NHS
- Be recognised as a centre for research excellence internationally
- Save on drug costs
- Support the R&D infrastructure

7. Surgical Services Clinical Board R&D Leads

Below is a figure to show the R&D leads working within the Surgical Services Clinical Board, all who work to support the broad research strategies as outlined above.



8. Non-commercial study income, 2016/17

During the year of 2016/17, Surgical Services Clinical Board generated an ABF income of £732,081. Following top slicing to provide structural support including R&D office, pharmacy and Clinical Research Facility (CRF), the Surgical Services Clinical Board directorates received £515,352 (70% of the income generated).

	Income per directorate (after top-slicing)
General Surgery	£141,498
Head and Neck	£26,382
Ophthalmology	£48,804
Trauma and Orthopaedics	£169,266
Urology	£33,018
Theatres	£96,384
TOTAL	**£515,352**

HCRW who provide activity based funding suggest it be used for investment on NHS based infrastructure, building capacity and capability to support high quality research in a fair and transparent manner, as per Guidance for NHS Organisations 2015/16 (1.2. The Appropriate Use of NHS R&D Allocations, 1 April 2015: Version 1). To demonstrate compliance with this, each directorate are asked to create a spending plan at year start, mid year and end of year.

Non-commercial studies are able to request Excess Treatment Costs from HCRW to recoup the costs of nonstandard treatment in the experimental arm of the study. During 2016/17, £21,101 was recouped for treatment provided in research. This income is provided directly to the relevant directorate.

The total non-commercial studies income for 2016/17 was £536,453.

9. Commercial study income, 2016/17

The Clinical Board R&D lead has requested a full breakdown of the commercial income generated by the studies run in the Surgical Services Clinical Board. This information is pending but is necessary to provide full accountability of commercial work. This information will be essential to plan for the Surgical Services Portfolio and build by 5% year on year.

The funds available in PI accounts (which is 25% of the staff research costs per contract) and the Research Legacy Reserve (80% of unspent PI funds 18 months after LSLV) is available. This information, although necessary to understand funds available to the researcher, does not provide the full picture of commercial study activity within the Clinical Board. At the end of March 2017, funds were available as follows.

	PI	RLF	**TOTAL**
General Surgery	0	£8,130	**£8,130**
Head and Neck	£468	0	**£468**
Ophthalmology	£27,113	0	**£27,113**
Trauma and Orthopaedics	£9,042	£8,246	**£17,288**
Urology	£18,970	£82	**£19,052**
Theatres	£862	£20,661	**£21,523**
TOTAL	**£56,445**	**£37,119**	**£93,574**

£93,574 was available in PI accounts and RLFs at the end of March 2017. It is important to note that this is not an indication on the research activity undertaken in 2016/17.

10. Planned Surgical Services Clinical Board spend for 2017/18

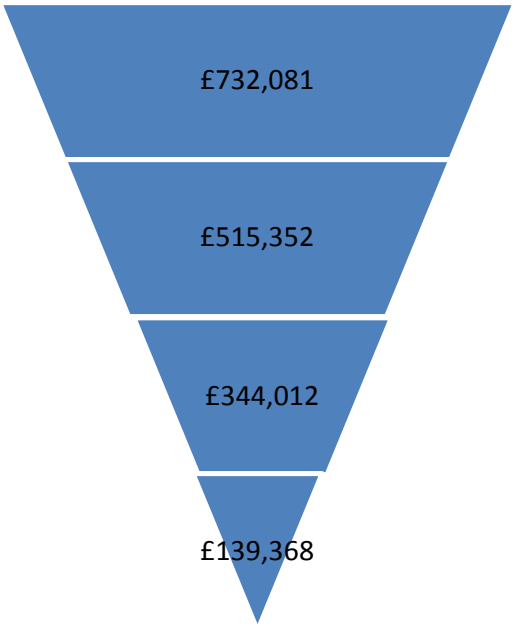
Each directorate has provided a plan for spending in 2017/18, seen in the table below. The summary below does not include vacant posts nor wages that are paid from other funding sources, only spend from the directorate allocated to the delivery or development in Surgical Services.

	Delivery	Development	**TOTAL**
General Surgery	£42,660	£13,010	**£55,670**
Head and Neck	0	£13,632	**£13,632**
Ophthalmology	0	£24,475	**£24,475**
Trauma and Orthopaedics	£84,219	£17,641	**£101,860**
Urology	£123,455	£24,920	**£148,375**
Theatres	Unknown	Unknown	Unknown
TOTAL	**£250,334**	**£93,678**	**£344,012**

All directorates show an underspend except Urology who have an overspend of £115,357. Information is not available from Theatres. Assuming there is no spending plan from Theatres because no spend is planned, there is an underspend on a Clinical Board level of £171,340.

	Income received	Spending plan	**Under**/overspend
General Surgery	£141,498	£55,670	**£85,828**
Head and Neck	£26,382	£13,632	**£12,750**
Ophthalmology	£48,804	£24,475	**£24,329**
Trauma and Orthopaedics	£169,266	£101,860	**£67,406**
Urology	£33,018	£148,375	-£115,357
Theatres	£96,384	Unknown	Unknown
	£515,352	£344,012	**£171,340**

Of the £344,012 listed in the spending plans, £175,464 (51%) is used to pay clinician wages. A further £19,230 (6%) is used to pay for directorate administrative staff. Less the half of the ABF income received by Surgical Services is used to pay for research staff wages (£139,368 or 41%). A small amount of income is planned to be spend on equipment.
The figure below shows the flow of funds from income generated to the amount used to pay research staff wages in the Surgical Services Clinical Board. Other research staff and consultants within the board are contributing to research but their wages are paid from other sources.



Income Generated

Income Received by Clinical Board
(70% of income generated)

Planned Spend by Clinical Board
(47% of income generated)
(76% of income received)

Planned Spend for **Research Staff**
by Clinical Board
(19% of income generated)
(41% of income received)

11. High Level Surgical Services Clinical Board Research Strategy

Previously:

In the last reported strategic plan (2015/16), Surgical Services Clinical Board proposed the introduction of a research manager for the Division of Surgery and/or directorate research managers to cover difference directorates of the Division, and that this concept should be subject to discussion within the Clinical Board. It was considered that this was essential to support non-commercial objectives set out in this plan and managers should fit into an overall commercial R&D structure.

The Research Legacy Fund was suggested as the funding stream for this role, but in reality ABF and commercial funds (40% of commercial study staff costs go to the directorates) would be more suitable funding streams.

Currently:

The Surgical Services Clinical Board are striving to create a Research Team that functions at a Clinical Board level to coordinate and support research across all directorates. The team would include Clinical personnel (such as the R&D lead who is already being funded) and an operational role (to be appointed) and some finance support (part time, possibly from an existing role).

The aims of the Surgical Services Clinical Board Strategy could be summarised as follows:

- Support and grow research within Surgical Services in line with R&D targets.
- Maximise income from research, specific income target to be agreed when current financial situation is understood.

- Provide support and guidance with accounting and budget management, including spending plans.
- Signposting of and coordination with other research organisations and resource.
- Provide a point of contact for Surgical Services to the R&D department.
- Work with workforce and directorates to understand resource set up and availability, ensuring income generated and workload of the trials at each directorate are considered and covered.

This concept has been suggested by the Surgical Services Clinical Board and has been accepted by many stakeholders, but further work is required to release finances to fund this. The finances presented here demonstrates that as a Clinical Board, the unaccounted for income generated from ABF (without considering other income) is sufficient to finance the research team. However, a better understanding of the research finances (both non-commercial and commercial) is required to be able to task the research team with a specific target to increase research income.

HCRW targets are set to increase number of research studies and research participants. This is not a relevant target for the Clinical Board who requires a financially based target.

21.1

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2017
Name of Meeting : Board **Date of Meeting** 28 September 2017

Executive Lead : Executive Director of Public Health
Author : Consultant in Public Health Medicine 029 2183 2125
Caring for People, Keeping People Well : This report addresses the following themes in the UHB's strategy: reducing inequalities, keeping people healthy, our priority conditions, and being a great place to work
Financial impact : Not applicable – discussion document
Quality, Safety, Patient Experience impact : A modal shift in travel would have a significant impact on the number of people developing major cardiovascular and respiratory conditions, cancer and diabetes. Staff who travel actively are more productive and experience less stress
Health and Care Standard Number 1.1
CRAF Reference Number 1.1,1.3
Equality and Health Impact Assessment Completed: Not applicable – discussion document

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The statutory requirement for an Annual Report by the Director of Public Health being met
- The recommendations for the Health Board being monitored, with a 6 month update on progress provided to the Strategy and Engagement Committee, and updates to the Well-being of Future Generations UHB working group

The Board is asked to:

- **NOTE** the Annual report, including the impacts on health and well-being of sedentary behaviour and air pollution, and the potential benefits of supporting active travel in our communities and staff

SITUATION

Each year the Director of Public Health's annual report focuses on an issue of major public health importance. This year's report, *Moving Forwards*, describes the importance of supporting and encouraging active and low emission travel among residents and staff to improve health and well-being, and reduce air pollution and carbon emissions.

Reducing and preventing illness and deaths in our communities is a key part of our ten year strategy, Shaping Our Future Well-being, and the issues discussed also have particular relevance to the Well-being of Future Generations (Wales) Act.

BACKGROUND

Declining levels of physical activity, increasing levels of obesity and diabetes, widespread air pollution, social isolation, and worsening health inequalities are all pressing public health issues in our area. Climate change is a severe threat which is already being felt in the UK and across the world.

Changing patterns in the way we travel and how we design our environments for travel have played a significant role in all these issues. Bold action is required locally if we are to reverse these trends in population and global health, and create a healthier more sustainable future for our residents.

The report sets out how our society has been shaped by the car over the last 50 years, with the percentage of journeys made by car increasing from 27% in 1952 to 83% in 2016.

This shift in travel mode has contributed to a significant decrease in physical activity, which in turn is associated with increased risks of ill health, including cardiovascular disease, cancer and diabetes. Road transport is a major contributor to harmful air pollution, and is responsible for nearly 1000 accidents causing injury or death each year in Wales. Around 5% of deaths in Cardiff and Vale are estimated to be due to particulate matter air pollution.

As our environments have been shaped around the car, interactions within and between communities have dropped. Many of the adverse impacts of road transport are felt more in more deprived communities, contributing to worsening health inequalities.

Climate change increases the risk of severe weather events including flooding which will increasingly affect our communities and our infrastructure. Flood-related displacement of communities has been found in the UK to cause significant and enduring mental health issues.

Health and well-being in our communities could be significantly improved if active travel becomes the norm for short journeys, public transport is used for longer journeys, and air quality improves.

ASSESSMENT AND ASSURANCE

A number of opportunities exist through legislation, national and local policy, and a gradually changing culture around the use of cars, which make now the time to act:

- Four recent major pieces of legislation support active travel in Wales
- Driving a car has become less popular among young people
- Examples of good practice in our area include support to residents to encourage children's street play, helping Vale Council staff travel sustainably, and the UHW Park and Ride scheme.

This report sets out a vision for Cardiff and Vale based on five key themes:

- Active travel is the default for short journeys
- There is a well used, fully integrated transport system
- We have well connected, active and social communities
- Transport emissions are significantly reduced
- Cardiff and Vale are leaders in this field

Potential benefits from realising this vision include reduced demand for health and social services through reduced rates of cardiovascular disease, cancer, obesity and diabetes; improvements in mental well-being; reduced sickness absence; reduced health inequalities; more cohesive communities and reduced social isolation; and reduced air pollution and lower carbon emissions contributing to global warming.

To make a significant and sustained improvement in our health and well-being Cardiff and Vale UHB and its partners need to take decisive action now and over the next 5-10 years, in four main areas:

- Accelerate improvements to infrastructure to support active travel and low emission transport
- Support staff to choose active travel
- Engage with the local communities and businesses on the benefits of active travel
- Discourage unhealthy and polluting travel

The publication of this report will be accompanied by a social media campaign to raise awareness of the issues described; and continued conversations with key partners, which have taken place during the research for the report, to advance action in this area.

Please note that a fully designed version of the report will be available before the Board meeting.

Moving forwards: Healthy travel for all in Cardiff and the Vale of Glamorgan

Annual Report of the Director of Public Health for Cardiff and Vale of Glamorgan 2017

Version: Final (before graphic design)

Fully designed version to follow before Board meeting

Please note: text with a light green background will be highlighted and/or be part of an infographic in the designed version

Executive summary

Declining levels of physical activity, increasing levels of obesity and diabetes, widespread air pollution, social isolation, and worsening health inequalities are all pressing public health issues in our area. Climate change is a severe threat which is already being felt in the UK and across the world.

Changing patterns in the way we travel and how we design our environments for travel have played a significant role in these issues. Bold action is required locally if we are to reverse these trends in population and global health, and create a healthier more sustainable future for our residents.

How did we get here?

While car use has sharply increased over the last 50 years, walking and cycling levels, and public transport use, have declined. Most housing and commercial developments over the last half century have been shaped by cars, not people.

- Change in travel mode in UK
  - Bus – 42% of journeys (1952), 5% (2016)
  - Cycling – 11% (1952), 1% (2016)
  - Car 27% (1952), 83% (2016)
- In 2015 total motor vehicle traffic in Great Britain reached a new record level

The effects on health and well-being

This shift in travel mode has contributed to a significant decrease in physical activity, which in turn is associated with an increased risk of ill health, including cardiovascular disease, cancer and diabetes.

Road transport is a major contributor to harmful air pollution, and is responsible for nearly 1000 accidents causing injury or death each year in Wales. As our environments have been shaped around the car, interactions within and between communities have dropped. Many of the adverse impacts of road transport are felt more in more deprived communities, contributing to worsening health inequalities.

Climate change increases the risk of severe weather events including flooding which will increasingly affect our communities and our infrastructure.

- Over half (54%) of adults in Cardiff and Vale are overweight or obese, and are classed as 'inactive' because they do less than half an hour of physical activity in an entire week
- An estimated 5% of deaths in Cardiff and Vale are due to particulate matter air pollution
- Nearly 1 in 4 vulnerable people in Cardiff and Vale report being lonely some or all of the time
- A man living in one of our most deprived communities in Cardiff can expect to live 11 years fewer than someone in the least deprived areas
- Flood-related displacement of communities has been found in the UK to cause significant and enduring mental health issues

We could do things differently

Health and well-being in our communities could be significantly improved if active travel becomes the norm for short journeys, public transport is used for longer journeys, and air quality improves.

- Daytime journeys of less than 2km should be walkable for individuals aged 5 to 74 without a disability
- For many people the trigger to take up active travel is a significant life event
- People who walk and cycle in a neighbourhood are more likely to spend money in local shops
- Public transport use is facilitated by affordable ticket prices, flexibility in stops, high quality travel information and regular services
- Clean Air Zones deliver benefits worth £29 for every £1 spent
- The NHS should set the benchmark for clean air and safe workplaces
- The London congestion charge resulted in an 80% increase in cycling

The time is right for change

A number of opportunities exist through legislation, national and local policy, and a gradually changing culture around the use of cars, which make now the time to act.

- Four recent major pieces of legislation support active travel in Wales
- Driving a car has become less popular among young people
- Examples of good practice in Cardiff and the Vale of Glamorgan include support to residents to encourage children's street play, helping Vale Council staff travel sustainably, and the UHW Park and Ride scheme.

Seizing the day: a vision for Cardiff and the Vale

This report sets out a vision based on five key themes, showing what we could achieve in Cardiff and Vale.

- Active travel is the default for short journeys
- There is a well used, fully integrated transport system
- We have well connected, active and social communities
- Transport emissions are significantly reduced
- Cardiff and Vale are leaders in this field

If we get this right, potential benefits include reduced rates of cardiovascular disease, cancer, obesity and diabetes; improvements in mental well-being; and reduced sickness absence.

- Reduced illness and deaths from cancer (20-30% lower risk of colon and breast cancer)
- Reduced illness and deaths from cardiovascular disease and stroke (20-35% fewer cases)
- Reduced type 2 diabetes (30-40% fewer cases)
- Reduced risk of depression and dementia (20-30% lower risk)
- Reduced inequality in life expectancy between most and least deprived areas
- More cohesive communities and reduced loneliness
- Reduced air pollution and lower carbon emissions contributing to global warming
- Reduce demand for health and social care services

Everyone playing their part: what we need to do together

To make a significant and sustained improvement in our health and well-being we need to take decisive action now and over the next 5-10 years, in four main areas.

- Accelerate improvements to infrastructure to support active travel and low emission transport
- Support staff to choose active travel
- Engage with the local communities and businesses on the benefits of active travel
- Discourage unhealthy and polluting travel

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My thanks to Dr Tom Porter as the chief author of the report.

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Foreword

We all want the best health and well-being we can have for our population. To achieve that the inequalities gap between our most and least deprived communities has to narrow. To achieve that we need to take every opportunity we can, working together as individuals and communities with all of our partners in public health.

Frequently, taking opportunities will mean embracing change, doing things differently, driving continuous improvement as hard as we can and telling the story about why health and well-being should be important for each and every one of us. Opportunities to improve health and well-being will always involve behavioural change at population, individual and organisational levels. This is tricky as most of us will say 'I support change but I don't want to change,' but we, each of us, have to become the change we need to see if we are to achieve sustainable improvement in our health and well-being.

Some of the opportunities we have open to us today have not been fully exploited by us as individuals, collectively as leaders or as organisations. This probably isn't surprising as change and continuous improvement are challenging and often question our current beliefs, practices and systems. Yet today across our public sector and third sector organisations we are better placed than ever before to take up those opportunities. In Cardiff and Vale excellent partnership working has led to a common understanding of the needs of the population we serve and what we need to do, to enable better health and well-being. This has been hugely strengthened by the recent Well-being of Future Generations (Wales) Act 2015,[134] the Social Services and Well-being (Wales) Act 2014[24] and the Public Health (Wales) Act 2017.[137] These put our health and well-being firmly at the top of the agenda.

Added to this we know that as a Cardiff and Vale population, people want better health and well-being and the understanding that this will involve change, including behaviour change,[168] is evident. This was evidenced in the surveys and discussions which have taken place to inform our most recent needs assessments in Cardiff and Vale.[11,48,161] Added to that we have some emerging examples of positive change in two of our biggest causes of poor health and well-being. The numbers of people smoking tobacco in Cardiff and Vale is lower than it has ever been and is continuing to decrease and the rate of obesity in our children is slowly decreasing.

This report looks at one of the opportunities that we haven't yet fully exploited, active travel. It is an issue that affects every single person in our population as well as every single organisation operating within our communities. It is an issue which demands an understanding of the past, an understanding of the disruptive technologies which our younger generations are rapidly embracing, an understanding of what the evidence is telling us, and most importantly a willingness to seriously drive rapid continuous improvement which utilises the evidence and new technologies. Inevitably it demands that we ourselves begin to adopt and adapt to active travel as part of how we live each and every day.

I hope you will enjoy reading the report and that it will stimulate you to think about your role in making active travel a part of achieving sustainable improvements in our health and well-being.

Dr Sharon Hopkins, Executive Director of Public Health

1. What is at stake?

Our health and well-being: local and global

Declining levels of physical activity, increasing levels of obesity and diabetes, widespread air pollution, social isolation, and worsening health inequalities: these are all pressing public health issues in Cardiff and the Vale of Glamorgan.

Globally, climate change is a severe threat which is already being felt in the UK and across the world in extreme weather events such as flooding and heatwaves, with impacts increasing every year as the earth warms.

These issues all have something in common: changing patterns in the way we travel over the last half century, along with how we design our environments for travel, have played a significant role.

We need to take positive action now

Bold action is required locally if we are to reverse these trends in population and global health, and create a healthier more sustainable future for our residents.

A slew of evidence available now suggests a brighter future is possible, with positive impacts on health, well-being and community cohesion, as well as reducing our reliance on fossil fuels and their impact on climate change.

The intention of this report is to stimulate thinking and discussion locally about the issues described and encourage co-ordinated and decisive action to address them.

2. How did we get here?

Changing patterns of travel

A dramatic transformation has taken place over the last century in how people in the UK travel for work and leisure.

Until the 1950s, most people got around on foot or by public transport. Since then car ownership has increased rapidly, and the last fifty years has seen a huge shift to journeys by car, with public transport use dropping precipitously. For example, in 1952, 42% of journeys in the UK were by bus, but by 2016 this figure had dropped to just 5%. Car journeys rocketed from 27% to 83% over the same period.[1]

Bus – 42% of journeys (1952), 5% (2016)

Cycling – 11% (1952), 1% (2016)

Car 27% (1952), 83% (2016)

Locally we don't have to go far back to see this stark transition. In the 1920s trams were at their peak in Cardiff, with an extensive network throughout the city and a staggering 42 million passenger journeys taken in the city each year, or around 180 journeys per resident each year.[2] The tram system closed in Cardiff in 1950, but trolleybuses – a form of electric bus – were a common sight after this, until the network closed in 1970.[3]

Figure 1. A tram running along Newport Road in Cardiff[2]

42 million journeys were taken by tram in Cardiff in 1928. The tram closed in 1950.

The railway line in the Vale between Barry and Bridgend was closed with the Beeching programme in the 1960s, and only re-opened in 2005. However, over the previous century there had been a much more extensive rail network in the Vale including a Cowbridge Railway line, which opened in 1865.

Figure 2. Cowbridge railway station[13]

Initially the car brought with it a sense of new-found freedom, and the ability for people to keep in touch more easily with friends and family, facilitating further geographic spread of these important social networks.

But this transformation in transportation came with a price: a steep decline in physical activity levels, with many adults now routinely spending their waking life sitting in the car, at the office desk, or on the sofa, with little meaningful physical activity in between. Indeed a quarter of adults in Cardiff and the Vale of Glamorgan are now classed as 'inactive' because they do less than half an hour of physical activity in an entire week.[4]

Effects on health are not limited to changes in physical activity: air pollution, social isolation, noise pollution, access to green space and health inequalities have also been impacted on by car use.

The surge in car use has reduced demand for public transport, resulting in a decline in frequency and routes. Fewer services has made public transport a less viable option for some journeys, further reducing demand. Between 2007 and 2014, bus use declined by 4% in Cardiff,[5] and yet a third of residents (35%) in Cardiff cite frequency and availability of public transport as a major issue.[5] Although 90% of residents say they are satisfied with public transport in the Vale, rates of use are much lower.[6]

Over the last five years the cost of rail fares have increased by 15%, and bus/taxi costs have increased by 14%, while the cost of running a car has decreased by 5%.[7] Over 1 in 10 (11%) journeys in the UK in the 1950s were made by bicycle, but that figure now stands at just 1%. Increasing motorised transport on the roads, both rural and urban, has also had an impact on how safe people feel cycling.

Over the last five years the cost of running a car has decreased by 5% while the cost of the bus has increased by 14%

The UK still loves its cars. In 2015, total motor vehicle traffic in Great Britain reached a new record, of 317 billion miles travelled in one year, the majority travelled by cars and taxis.[8] Growth in traffic levels over the last 10 years has been higher in Wales (5.9%) than the other home countries.[9] There are currently 206,000 licensed cars in Cardiff and Vale.[10] Population growth in the region, particularly in Cardiff, will put an increasing strain on the road network without a change in approach.[5]

In 2015 total motor vehicle traffic in Great Britain reached a new record level.

Commuting into Cardiff is a snapshot of this: each day over 80,000 people travel to Cardiff for work from neighbouring local authorities, including 20,000 from the Vale.[5] This makes up around a third of people working in Cardiff. The vast majority (about 80%) of those travelling in from neighbouring local authority areas currently do so by car.[5] There are around 59,000 working residents in the Vale, of whom around half (28,500) work in the area and

half (30,300) commute out of the area; around 14,000 people commute into the Vale. The majority commuting out work in Cardiff, with smaller numbers commuting to Bridgend and Rhondda Cynon Taf.[11]

Among staff working in the Cardiff and Vale UHB, over 1 in 6 (17%) report walking or cycling to work, 8% take public transport, and 8% share their car journey with a colleague, with the remainder travelling alone by car.[12]

One bright spot is that while overall rail use remains lower than the 1950s (10% of journeys now compared with 17% previously) this has been steadily increasing following a low of 5% in the mid-1990s.[1]

Our built environment

As our transport modes have changed over the past century, our built environment has followed. As well as a decline in the previously extensive public transport infrastructure for trams, buses and railways, our rural and urban environments have been indelibly shaped by the car. Reversing this long-standing trend will take significant effort.[14]

Unused, parked vehicles take up a significant part of our urban space - on roads and outside houses, shops and work. Despite encouraging efforts to reverse the trend in recent years, our road network is designed to facilitate the movement of cars, rather than meeting the needs of pedestrians or cyclists. Road junctions frequently prioritise cars over cyclists and pedestrians.

While there are some examples of excellent cycling infrastructure locally, there are still too many examples of cycle lanes which start and stop inconsistently, with little in the way of continuity of flow car drivers have come to expect.

Most housing and commercial developments over the last 50 years have been shaped by cars, not people

Most housing and commercial developments over the last 50 years have been shaped by cars, not people. The rise in out-of-town shopping centres and offices has necessitated car travel (and ownership) for many people.

At the same time, increasing traffic on the road has led to a progressive reduction in urban green space, and in uninterrupted peaceful green spaces in rural areas.

3. The effects on health and well-being

The profound shift in how people get around, and the built environment changes which accompanied this, are exposing us to a combination of risk factors which we now know lead directly to serious illness and reduced life expectancy.

Physical inactivity and sedentary lifestyles

Health impacts: increased risk of death from any cause; increase in risk of cardiovascular disease, cancer, and type 2 diabetes; adverse impacts on mental well-being

Over half (54%) of adults in Cardiff and Vale are overweight or obese

Over half (54%) of adults, and a fifth (21.5%) of 4-5 year olds in Cardiff and Vale are overweight or obese,[4] with the rates higher in more deprived areas. Obesity is a complex issue which has been discussed in previous annual reports, but we know that changes in physical activity levels are a key driver of the current epidemic.[15] Physical activity levels for many people are insufficient to maintain good health: two in five (41%) of adults in our area don't do sufficient physical activity, with over a quarter (27%) classed as being inactive (less than 30 minutes physical activity in a week).[4]

While physical activity levels across Wales are broadly static, this masks a recent increase in activity among the least deprived communities. This hasn't been seen among the most deprived, leading to worsening health inequalities.[16] Teenage girls have the lowest physical activity levels out of the UK countries, with only 8% of Welsh teenage girls meeting the physical activity guidelines.[16]

Fewer than 1 in 10 (8%) of teenage girls in Wales meet the physical activity guidelines.

Car ownership is linked to how much walking and cycling people do, with a perception that car journeys are invariably quicker and easier than active travel. You are much less likely to undertake active travel if you have a car (37% with a car, compared to 71% without).[17] Use of a car is associated with an increased risk of obesity, while walking and use of public transport is associated with not being overweight or obese.[18] Active travel is less common in rural compared with urban environments in the UK, and becomes less common as people age.[17]

You are much less likely to undertake active travel if you have a car

We now know that insufficient physical activity and being sedentary are dangerous to our health.[19,20] Being sedentary is associated with an increase in death from any cause of over a fifth (22%), and an increase of around one in seven in the risk of death from cardiovascular disease (15%) and cancer (13%). There is a staggering near doubling (91%) of the risk of acquiring type 2 diabetes. These effects are even more pronounced if sedentary activity is not offset by regular physical activity.[19] Over 24,000 people are currently recorded as having diabetes in Cardiff and Vale.[21]

The Academy of Medical Royal Colleges has recommended that "a change in culture is needed so that it is no longer considered 'normal' to spend a large amount of time sitting in cars."[22]

Sedentary lifestyles are associated with a 91% increase in risk of type 2 diabetes

Air pollution

Health impacts: associated with cardiovascular and respiratory disease, stroke, cancer, diabetes, low birth weight, dementia

The nature of air pollution

Great progress was made in environmental protection in the 1950s with the introduction of the Clean Air Act, which enforced smoke control areas in some cities to reduce smog and air pollution from sulphur dioxide.[23]

The main pollutants of concern today are nitrogen dioxide (NO_2), and particulate matter ($PM_{2.5}$ and PM_{10}). The primary source of both pollutants are vehicle emissions, especially those from diesel vehicles, although there are industrial, agricultural and domestic sources too. Exhaust emissions continue to be produced when diesel or petrol vehicles are stationary and the engine is on, and traffic congestion tends to worsen emissions.

Deaths from particulates increase steadily with exposure for over 65s, even at concentrations below the current WHO guidelines and EU legal levels, for both short-term and long-term exposure.[25]

Benzoapyrene (BaP) is a component of PM_{10} generated by diesels; maternal exposure to BaP has been linked to mental health problems in childhood and neurocognitive delay.[26] BaP emissions rose by 52% in the EU between 2000 and 2014, with 80% of the urban population exposed to levels above WHO limits.[26]

Roadside concentrations of NO_2, which are mainly emitted by diesel vehicles, has been above the legal limit in nearly 90% of urban areas of the UK since 2010.[27] HGVs, LGVs and buses make up just over half of the emissions, with private cars and taxis the remainder.[28] Levels of NO_2 in Cardiff and Vale residential areas are the highest in Wales.[29]

Levels of NO_2 in Cardiff and Vale residential areas are the highest in Wales.

Particulate matter ($PM_{2.5}$) pollution is also higher in Cardiff and Vale than all other LHB areas in Wales. Cardiff has the highest annual average concentration, weighted for population, among local authority areas, at 9.5 μgm^{-3}. This is slightly below the mean for England (9.9 µg m-3), but above the average concentrations in Scotland (6.8) and Northern Ireland (6.6). Due to the levels of air pollution, there are currently four statutory air quality management areas (AQMA) designated in Cardiff, and one in the Vale (see Box 1). Because of the characteristics of particulate pollution, evidence suggests there is no 'safe' threshold, so it is likely that many more people are affected by air pollution exposure beyond these localised 'hotspots'.

Box 1. Air quality management areas in Cardiff and the Vale[30]

Cardiff City Centre, Cardiff
Llandaff, Cardiff
Stephenson Court, Cardiff

Ely Bridge, Cardiff
Cogan, Penarth

Transport pollution isn't just from cars: diesel buses and trains can also be significant contributors and any plan to reduce air pollution needs to address this as well.[31,32] A recent study found air pollution levels in a large railway station in London exceeded those on a busy road outside.[31]

The general trend for air pollution from transport is a reduction over the last two decades,[8] but it remains much higher than it should be for good health.

Exposure to air pollution

The relationship between exposure to air pollution and mode of transport is complex. [27,33-35]

Exposure to air pollution is generally higher sitting inside a vehicle than outside on the road itself, because vehicle ventilation systems suck in polluted air from the vehicle in front and recirculate and concentrate it in a small area. However, because active travel increases the breathing rate, the amount of inhaled pollutant is generally higher for active travel modes. In spite of this, because of the overwhelming benefits of physical activity on cardiovascular and general health, people who travel in motorised transport still reduce their life expectancy by a year on average compared with people who actively travel.[36] When active travel routes are built away from busy roads, and less polluting vehicles become more common, the benefits of active travel increase further.

"Children sitting in the backseat of vehicles are likely to be exposed to dangerous levels of air pollution. If more drivers knew the damage they could be doing to their children, they'd think twice about getting in the car."

Prof Sir David King, former government Chief Scientific Adviser[27]

High levels of air pollution aren't confined to main roads. A recent study of estimated air pollution around health facilities in London found that over half of the NHS sites in the capital exceeded legal limits.[37] The authors recommend that organisations across the UK review air pollution levels around health facilities as a matter of urgency.

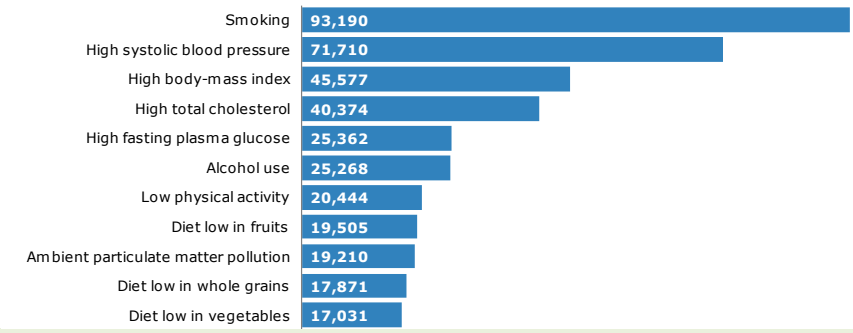
Health impacts of air pollution

Using international modelling, it has been estimated that across the UK around 40,000 deaths each year are due to air pollution ($PM_{2.5}$ and NO_2).[38] In Wales, an equivalent of around 1,600 avoidable deaths are estimated each year due to particulate matter, and 1,100 due to NO_2 exposure.[29]

It is estimated 143 deaths each year in Cardiff and 53 each year in the Vale among over 25s are due to air pollution caused by particulate matter, and 2,100 life years are lost each year.[39] Long-term exposure to particulates is

estimated to be responsible for 5.1% of all deaths in Cardiff and Vale. [29,39] Across Wales, the years of life lost due to air pollution puts it ninth out of the top 10 modifiable risk factors, but three other risk factors associated with a car-dependent environment, namely high blood pressure, high body mass index, and low physical activity are also in the top 10 (see Figure).[16]

Figure 3. Top 10 risk factors for years of life lost (YLL) in Wales (2015). Four of the top ten are impacted by car use[16]



An estimated 5% of deaths in Cardiff and Vale are due to particulate matter air pollution

Air pollution has been linked to cancer, asthma, COPD, pneumonia, stroke and heart disease, diabetes, obesity and changes linked to dementia.[38,40] Long-term exposure reduces life expectancy, principally due to increases in cardiovascular disease, respiratory disease and lung cancer.[40,41]

Children are four times more likely to have significantly reduced lung function in adulthood if they live in highly polluted areas.[40] The risk of adults developing type 2 diabetes has been found in large prospective studies to increase by up to 10% for every 10μgm^{-3} increase in exposure to pollutants.[40]

Dirty air has also been associated with premature birth, and low birth weight. It is estimated that one fifth of cases of low birth weight are due to traffic-related air pollution, with the greatest harm occurring with exposure in early pregnancy.[40] NO_2 exposure has been linked to neurodevelopmental impairment, and increased risk of attention deficit hyperactivity disorder (ADHD) in children.[40]

It is estimated that one fifth of cases of low birth weight are due to traffic-related air pollution.

Short-term exposure to air pollution can lead to negative effects on lung function, exacerbation of conditions such as asthma, and increases in hospital admissions and deaths.[41]

Health problems from air pollution in the UK have been estimated to cost society, businesses and the NHS over £20bn per year (Box 2).[40]

Box 2. The health impacts of air pollution

"Damage [caused by air pollution] occurs across a lifetime, from a baby's first weeks in the womb all the way through to the years of old age.... Harm to babies and children will have an impact that lasts far into the future. For the same reason, any air quality improvements we make now will have long-lasting benefits. Older people, and adults with long-term

conditions are also vulnerable to the effects of air pollution. Improving air quality will help them to stay independent and well, benefiting individuals and easing the pressure on our NHS and social services." Every breath we take: the lifelong impact of air pollution. Royal College of Physicians and Royal College of Paediatrics and Child Health (2016)[40]

Road traffic injuries and deaths

Health impacts: serious injuries and deaths due to physical trauma; knock-on impact on active travel levels in population; reduced outdoor play by children

Even with significant improvements in road safety over the last 30 years, with progressive advances in car safety equipment, a change in drink-driving culture, and speed limit enforcement, deaths and injuries associated with cars remain common.

There are 20 road accidents causing death or serious injury each week in Wales

In Wales there were 975 road accidents which caused death or serious injury in 2016, or nearly 20 serious accidents each week. 103 people died last year in road accidents in Wales, or two people each week. Such statistics are unfortunately so common and an accepted part of driving that they no longer cause public concern – but if there were that number of incidents or deaths on the railways in Wales each year there would be a public outcry.

Half of car drivers in 30mph zones routinely exceed the speed limit

Enforcement of speed limits is important, with half (52%) of car drivers in 30mph zones routinely exceeding the speed limit.[8] Figures for Great Britain found that a quarter (24%) of road fatalities were pedestrians.[42] The number of incidents and casualties is highly sensitive to speed. A drop of just 1mph in average speed is estimated to reduce incidents by 5-6% on urban roads.[43]

The most common cause of death for children aged 5-14 years is being hit by a vehicle.[44] Those aged over 60 are seven times more likely to die from being hit by a car at 30mph compared with other age groups;[44] over a third (35%) of all pedestrian fatalities are people aged 70 or over.

The most common cause of death for children aged 5-14 years is being hit by a vehicle.

The perception of road safety has also had a significant impact on people's willingness to cycle for work and leisure, as well as parents' willingness to let their children play outdoors in the street. This coincides with an increase in children's 'screen time', the amount of time spent by children and young people on electronic devices.[45] Play, including outdoor play, is incredibly important to children's physical development and mental well-being.[46]

Increase in loneliness and social isolation

Health impacts: Reduced mental well-being and lower life expectancy

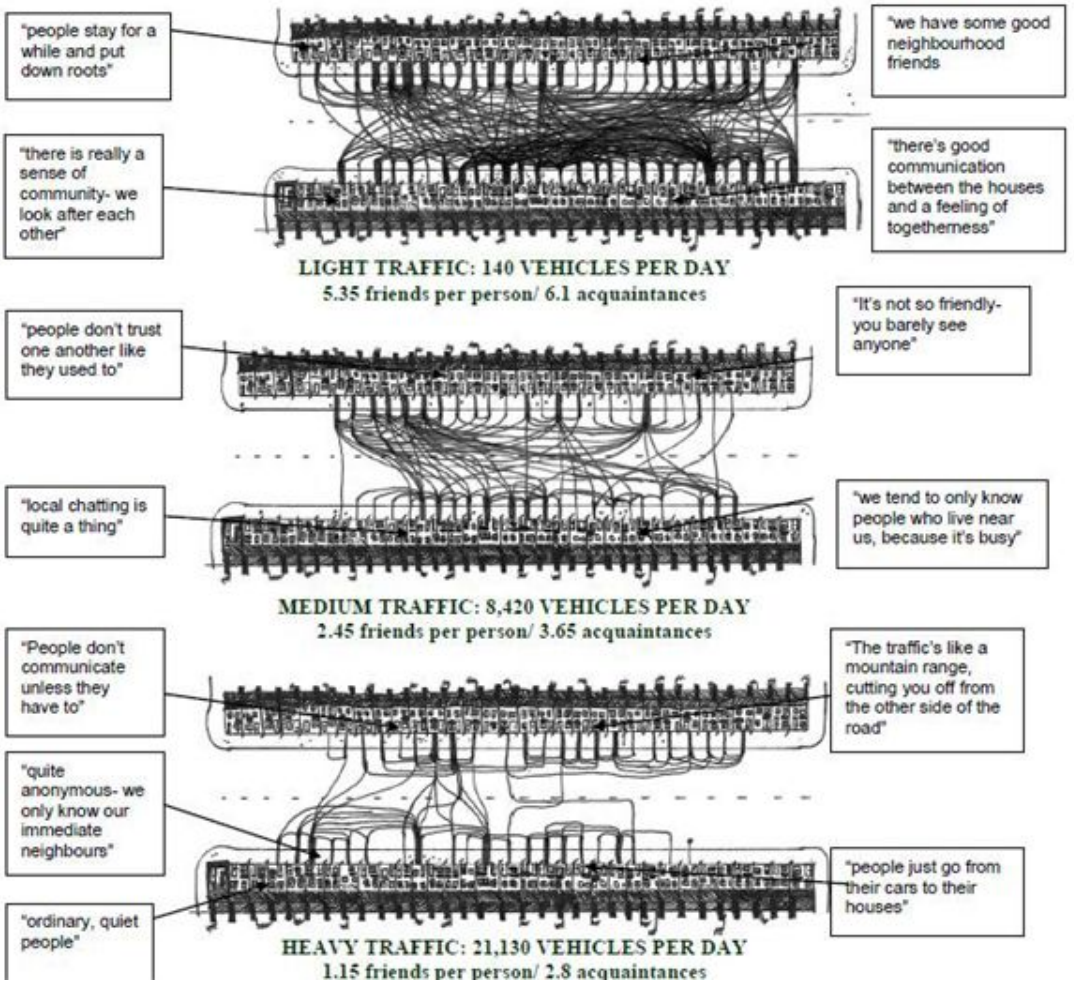
Seventeen percent of people in Wales report being lonely,[47] with results from a recent local survey in Cardiff and Vale putting the figure at nearly 1 in 4 (23.3%) among people in more vulnerable groups.[48] As car use has become more prevalent, people's social and support networks have also become more geographically dispersed.

Nearly 1 in 4 vulnerable people in Cardiff and Vale report being lonely some or all of the time

How well people are connected to their neighbours, and how many they count as friends, has been found to be directly associated in the UK and internationally with the traffic volume in their street.

Replicating a classic US study from the 1960s, a study in Bristol in 2008 found that the number of friends and acquaintances reported by residents was significantly lower on streets with higher volumes of motorised vehicles.[49] The study asked residents on quiet, medium and busy traffic streets to draw lines on a map of their street representing where their friends and acquaintances were on the street (see Figure 4). The average number of friends of each resident on the light traffic street was 5.35, compared to 2.45 on the medium traffic street and 1.15 on the heavy traffic street. Residents on the light traffic street also reported more of a sense of community and togetherness.

Figure 4. How community interactions vary by traffic volume.[49]



Residents on the light traffic street reported more of a sense of community and togetherness

The increasing reliance on the use of a car to reach shops, banks and community facilities has had a particular impact in rural communities. While a minor inconvenience for people with a car, those without become reliant on easily accessible and frequent public transport to access facilities and maintain their social networks and independence.

Increased car use has been associated with 'severance', the isolation of individuals and communities for example where a wide, busy road makes short local walks difficult.[18]

Loneliness and social isolation has a direct impact on length, as well as quality, of life. Studies have found that low levels of social integration, and isolation, significantly increase mortality. One study found social isolation increased the risk of death by a quarter (26%), partly but not wholly mediated by long-term illness and social deprivation.[50] Social participation acts as a protective factor against dementia and cognitive decline in the over 65s.[51]

Reducing car use and traffic speeds, and increasing access to public transport and active travel have been highlighted as priorities in an international report looking at healthy ageing in cities.[52]

Reducing car use and increasing access to public transport support healthy ageing in urban environments

Transport noise

Health impacts: associated with high blood pressure

There is evidence that road transport produces noise pollution resulting in noise levels in excess of WHO guidelines for over 200,000 people in Wales.[53] The majority of these are in South Wales; in our area they are focused around key trunk roads including the M4, A4232, A48 and key routes in Cardiff.[54]

Although transport noise may be seen as an inevitable consequence of living in an urban area, or near a large road, it has a long-term adverse impact on cardiovascular health, being associated with a small but significant increase in blood pressure.[55] In addition it has been associated with impaired intellectual development in children, sleep disturbance and reduced well-being.[18,56]

Traffic noise is associated with high blood pressure, impaired intellectual development in children, and sleep disturbance

Traffic noise should not be inevitable: it is possible to reduce the volume of traffic by encouraging healthier forms of travel. Reducing speeds, and moving away from petrol and diesel powered trains and motor vehicles, also have the potential to reduce noise pollution.

Reduction in green space

Health impacts: associated with reduced physical activity, reduced mental well-being, increased mortality

Across the UK there has been a historic and ongoing steady decline in green spaces, due to net deforestation and urbanisation.[57] At the same time there is a growing evidence base on the positive effect on mental health and well-being of living near and visiting green spaces.[51,58,59]

The rise in cars has led to increasing areas of our rural and urban landscape being concreted over, including the trend of paving over gardens to allow cars to be parked outside homes.[60] As well as reducing the space for nature to thrive, this impacts on the ability of urban areas to soak up rain and reduce flooding naturally.

A recent World Health Organisation (WHO) review of the health benefits of urban green spaces found multiple impacts,[61] including improved social interactions and social capital, positive effects on the immune system, enhanced physical activity and reduced obesity, reduced exposure to air pollution, noise buffering, improved cardiovascular health, reduced prevalence of type 2 diabetes, improved cognitive functioning, and reduced mortality.

Green spaces are associated with improved social interactions, increased physical activity and cardiovascular health, and reduced mortality

Exacerbating health inequalities

Health impacts: gap in life expectancy of around 11 years (Cardiff) and 8 years (Vale) between least and most deprived areas; pollution tends to be worse in more deprived areas; higher incidence and poorer outcomes across a wide range of health conditions

There are significant and persistent health inequalities in Cardiff and the Vale of Glamorgan. This is most clearly illustrated by the dramatic difference in life expectancy depending on where people live. A man living in one of our most deprived communities in Cardiff can expect to live 11 years fewer than someone in the least deprived areas. A similar gradient exists for women and for people in the Vale.

A man living in one of our most deprived communities in Cardiff can expect to live 11 years fewer than someone in the least deprived areas.

The rise in car use has exacerbated health inequalities. On the one hand, people in the least deprived communities are most likely to have a car than those in the most deprived areas. On the other, the impact of pollution (particularly NO_2)[62] is felt more in deprived areas, which tend to be located closer to main highways, have a higher proportion of 'imported' traffic (from less deprived areas), and have a higher proportion of people with chronic illness which makes them more vulnerable to air pollution exposure.[51,63]

Carbon dioxide (CO_2) emissions due to transport are significantly higher from the 10% least deprived households than the 10% most deprived, with the least deprived contributing to 17% of CO_2 emissions and the most deprived 2%.[64]

Road traffic injuries and deaths are also higher in more deprived areas. Children in more deprived wards are four times more likely to be hit by a car compared with the least deprived wards.[51] Fatal accidents on the road are also particularly high among children of unemployed parents.[51]

Children in more deprived wards are four times more likely to be hit by a car compared with the least deprived wards

Car-dependent environments isolate people without a car, making it difficult for them to access employment and education opportunities, further exacerbating and embedding inequalities.[65,66] This is a particular issue in rural areas which are more reliant on good public transport networks. Young people, and older people who can't drive, are particularly affected.

UK public spending to support transportation is nearly four times higher for the richest 10% (who primarily use a car or the train) than for the most deprived 10% (who primarily use the bus).[44]

Access and visits to green space, often curtailed by highway expansion and an important contributor to physical activity, obesity and well-being levels, are also lower in more deprived areas.[51]

Thus there is a double-whammy on health inequalities: cars are owned and used more by the least deprived, but the negative consequences from car use impact most on the most deprived.

Cars are owned and used more by the least deprived, but adverse impacts are felt most by the most deprived

4. How the planet is responding

Climate change

Health impacts: mental health impacts of severe weather events; food insecurity; impact on community cohesion from mass migration

There is incontrovertible evidence from the international scientific community that climate change is taking place due to man-made emissions of greenhouse gases. Burning fossil fuels is a major contributor to these emissions, and nine in ten adults in Wales identify man-made emissions as contributing to global warming.[47]

If existing commitments made by countries around the world are all implemented, global warming of 2.7°C is currently predicted, but there is a real danger of warming exceeding this.[67] The 'business as usual' modelling scenario, which assumes emissions continue unabated, projects increases of more than 4°C above the pre-industrial temperature by 2100.[68,69] Regional variation across the globe means some parts of the northern hemisphere will experience temperature increases of over 10°C.

Global temperatures are expected to increase by 4°C by 2100 if current trends continue, with some areas experiencing 10°C increases

Global warming is not something we should welcome. Projections suggest there will be real impacts on people, communities and infrastructure around the globe within the next generation.

A rise in global temperatures will bring with it more frequent extreme weather events (such as heatwaves and flooding), food insecurity (as the traditional areas of the world which produce food suffer from drought and less fertile land), and the likelihood of mass migration over many years, from areas of the world which are no longer habitable. Rising sea levels will increase the likelihood of coastal flooding – particularly relevant in our area.[68] There are also less predictable impacts, such as the potential for infectious diseases to spread more easily.[67] The most recent UK Climate Change risk assessment also highlights substantial risks to UK wildlife and natural ecosystems.

Increased flood events will affect our communities and core infrastructure such as hospitals, health centres and transportation networks

Each of these impacts will be felt in the UK, ranging from increased flood events affecting our communities and our core infrastructure such as hospitals, health centres and transportation networks;[53,67] pressure on water availability during the summer; through to increased food prices, likely to have the largest impact on the most deprived groups in society; and increased migratory flows which, if large or unmanaged, may impact adversely on community cohesion. In Wales, rainfall during the summer is predicted to fall by 20% by the 2080s, and rise by a similar amount in the already wet winter months.[70] Effects on transport networks, energy and digital infrastructure

are also predicted.[71] Climate change also poses a threat to coastlines and tourism reliant on the natural environment.

Flood-related displacement of communities has been found in the UK to cause significant and enduring mental health issues.[72] Across Western Europe, there will also be an estimated increase in heat-related deaths of around 14,000 per year if there is no adaptation and climate change continues at the current rate.[73] The threat of climate change to human health is increasingly being recognised within the UK public health arena.[68,74,75]

Flood-related displacement of communities has been found in the UK to cause significant and enduring mental health issues.

The impacts of climate change will be felt most heavily in the southern hemisphere and poorer countries. Globally, between 2030 and 2050, climate change is projected to cause approximately 250,000 additional deaths per year, from malnutrition, malaria, diarrhoea and heat stress.[76]

Two thirds (67%) of adults in Wales are concerned about climate change,[47] and in a recent 'national conversation' involving 70,000 people across Wales for the Well-being of Future Generations Act, climate change was rated as the single most important issue for people in Wales.[77]

One quarter of domestic greenhouse gas emissions are due to car transport

One quarter (23%) of UK domestic greenhouse gas emissions were from car transport in 2014,[64] up from 15% in 1990.[8] In contrast, just 3% of household emissions are due to public transport. Car CO_2 emissions are highest in the 45-55 age band, and lowest among under 25s and over 65s. In our area, it is estimated that 5 tonnes of CO_2 are emitted per person in Cardiff, and 4.9 tonnes per person in the Vale.[78] These have both shown a progressive decline over the last 10 years.

The issue of greenhouse gas emissions from transport is far from solved: for each of the last two years in the UK, emissions from road transport have actually increased.[79,80] Reducing the burning of fossil fuels for transport would not only have a beneficial impact on the climate, but would have geopolitical and sustainability benefits too, reducing the UK's reliance on gas and oil imports.

Yet reducing car use is low in the public's mind when it comes to addressing climate change. In the National Survey for Wales, a large annual survey of households, almost everyone reported recycling waste as a means to protect the environment (97%), with a much smaller proportion, 1 in 4 (25%), reporting they have reduced the amount they travel by car.[47]

5. We could do things differently

What we need to do

A growing body of evidence describes the positive impacts on health and well-being across society which are possible if we increase our active travel rates, reduce air pollution, and prioritise designing well-connected and attractive urban and rural communities. Recent technological advances may also help with this.

Support active travel and public transport

Reduce car use

In order to increase physical activity it is necessary to reduce use of the car.[66] Many of the journeys which are currently made by car in Cardiff and the Vale could be made by walking, cycling or public transport. Daytime journeys of less than 2km, which do not involve carrying bulky loads, should generally be walkable for individuals aged 5 to 74 without a disability.[81] When combined with public transport as part of an integrated transport system, active travel can also be a sustainable and healthy alternative to car-based travel for longer journeys.[65]

Daytime journeys of less than 2km should be walkable for individuals aged 5 to 74 without a disability

Over half of residents in Toronto (54%) and Copenhagen (63%) cycle regularly.[5] A similar proportion in Cardiff (56%) say they would like to ride a bike more, and three quarters (74%) think it would be better if there was more cycling.[5] Furthermore, over half of Cardiff residents (57%) travel less than 5km to work.[5] 84% of residents in the Vale use a car once a week or more, compared to 7% who cycle weekly.[6]

Because lifestyles have developed around near-universal car use, alternatives to the car must provide a level of accessibility similar to the car to be widely adopted.[66] In Cardiff, use of the car for commuting is only one quarter of journeys, with a similar proportion due to each of leisure, shopping, and other purposes.[5]

NICE recommends the use of car-free days to raise awareness and interest in active travel,[41] and has published evidence-based guidance on increasing walking and cycling levels.[82]

'Designed to move: Active Cities' cites an extensive evidence base on the economic, well-being and environmental benefits of cities becoming more active.[83] Examples include significant increases in employment and visitors and community involvement; and falls in crime (74%), pollution and stress.

Improve infrastructure to support active travel

Well-designed infrastructure to support active travel, as well as frequent, reliable public transport which covers all major local destinations, are essential elements in increasing take up of these travel modes.[51] Eight in ten Cardiff residents think that safety for cycling needs to improve.[5]

Historically, investment in infrastructure for cars has dwarfed that of walking and cycling routes. The UK Faculty of Public Health has called for 10% of transport budgets to be committed to walking and cycling.[84] NICE found that off-road cycle routes were good value for money, with every £1 investment in off-road routes returning around

£14 in benefits.[41] They advise that cycle routes should ideally be on quiet streets or segregated, in order to minimise exposure to air pollution. Investments in walking infrastructure return £37 for every £1 invested.[85]

NICE found that off-road cycle routes were good value for money, with every £1 investment in off-road routes returning around £14 in benefits

Road space should be progressively reallocated to active travel modes as their share of journeys increases;[22,66] this prevents car use from increasing again as congestion starts to fall, and is also highly efficient, especially for a growing population: 12 bicycles can be stored in a single car parking space.[86] Road crossings should be modelled around pedestrians and follow their 'desire' lines.[51]

12 bicycles can be stored in a single car parking space

In designing environments to encourage active travel, evaluation of success may include the use of data from smartphone apps, for example cycle app data which can reveal changing patterns of local travel.[87]

Box 2. Road design in Europe

The Netherlands adopted five principles of sustainable safety in 1992, to prevent severe crashes and reduce the severity of injuries when crashes do occur.[88] The principles include clearly defined road categorisations which separate road users according to speed and purpose, and segregating traffic where speed differences cannot be eliminated. Motorized vehicles are considered as 'guests' in residential areas, with pedestrians and cyclists prioritised.[89] Predictable road layout is encouraged, with a 'forgiving' environment should errors occur (e.g. 45° rather than 90° pavement edges to reduce the likelihood of a cyclist falling if they hit the kerb edge). Sustainable safety has been found to contribute to a significant reduction in fatalities.[90] Filtered permeability is another concept common in European transport planning, with pedestrians and cyclists given an advantage, in terms of speed and convenience, compared to motor traffic – for example, a two-way cycle route but one-way car traffic.[84]

Support people to take up active travel at trigger points in their life

Suitable active travel infrastructure is necessary to enable a modal shift, although not sufficient in itself.[91] In addition to investing in infrastructure, for many people the trigger to take up active travel is a significant life event.[92] For example, starting a new job or moving to a new workplace location, becoming a parent, people recovering from ill health, and people retiring, have all been found to be triggers which make people more likely to review their travel options and switch to active travel. Raising the topic of active travel at these critical points is something which could be done systematically throughout the public sector locally, which will be involved in these events for many people.

For many people the trigger to take up active travel is a significant life event

Provide high quality, flexible public transport

Public transport use is facilitated by affordable ticket prices, flexibility in stops, high quality travel information and regular services.[22,93]

Modelling in Australia found that there was significant potential to increase the number of adults physically active by encouraging people to take public transport.[94] The study reviewed international evidence and found that on average around 15 minutes' walking time was associated with public transport use each day.

Mixed mode travel, especially important in rural areas where combined active travel and public transport is the most pragmatic approach for many journeys, can be enabled by allowing easy transport of bicycles on buses and trains.[93] In Germany a controlled study which gave free public transport tickets and a personal schedule to people who had recently moved house resulted in a doubling of public transport use (18% to 36%) and a decline in car use (53% to 39%).[66]

Public transport use is facilitated by affordable ticket prices, flexibility in stops, high quality travel information and regular services

Reduce air pollution and carbon emissions

National Institute for Health and Care Excellence (NICE) recently issued detailed guidance on improving air quality and health. Recommendations include supporting active travel, providing infrastructure for electric vehicle charging, introducing clean air zones, and bringing in 'no idling' bylaws outside schools (see Box).[41]

NICE recommends the introduction of Clean Air Zones which support low-emission travel

NICE found that clean air zones cost around £2 per head annually (based on Amsterdam costs), but deliver benefits which far exceed this, of around £29 benefit for every £1 spent.[41] Low emissions zones should ideally cover all motor traffic, including cars and vans, to be effective at improving air quality.[26]

No idling zones outside schools were estimated to have a return on investment of up to £44 for every £1 spent.[41]

Clean Air Zones deliver benefits worth £29 for every £1 spent

Box 3. Selected recommendations from NICE guidelines on improving air quality.[41]

Support active travel. There should be a choice of cycle routes, including routes avoiding highly polluted roads
Support car sharing schemes and car clubs
Provide electric vehicle (EV) charging points in workplaces, commercial developments and residential areas
Consider introducing a clean air zone that introduces restrictions or charges on certain classes of vehicle, and supports zero- and low-emission travel (including active travel)
Where traffic congestion is contributing to poor air quality, consider incorporating a congestion charging zone within the clean air zone
Introduce bylaws to support 'no idling' areas where vulnerable groups congregate such as outside schools, hospitals and care homes
Specify emission standards for private hire and other licensed vehicles
Address emissions from public sector transport
Introduce 20mph zones without physical measures, to avoid unnecessary accelerations and decelerations which contribute to air pollution

Many of the NICE guidelines are echoed by a major joint Royal College report into air pollution,[95] which also recommends promoting safer 'school runs' which avoid using the car, encouraging employers to support alternatives to commuting by car, promoting leisure cycling, and monitoring and displaying air pollution around schools. They also recommend local authorities should publish serious incident alerts when levels exceed WHO and EU limits.[40] The report calls on the NHS to lead by example and set the benchmark for clean air and safe workplaces. Guidance on reducing outdoor air pollution is due to be issued shortly to NHS Wales.

The NHS should set the benchmark for clean air and safe workplaces

While electric vehicles are preferable to petrol and diesel-fuelled vehicles in terms of air pollution, it is important to note that EVs still produce particulate matter, albeit at lower levels than diesel vehicles especially. Therefore strategies to improve air quality and health should still focus primarily on active travel and low emission public transport. Where vehicles are still required, EVs (and other ultra low emission technologies) should be prioritised over ICE vehicles.

Shifting the model of car ownership to a shared or rental model would change the cost profile of driving; instead of a large up-front investment (buying a car) with individual journeys relatively cheap to make after that (thus encouraging them), the costs would be more evenly distributed. This would not only lower the barrier to use of car when required (e.g. carrying bulky goods) but also discourage use of the car when public transport or active travel may be as easy. This would also potentially be cost-saving for more deprived households, reducing inequalities.[66]

Case studies demonstrating systematic approaches to improving air quality are available on Defra's website,[96] and guidance to local areas in Wales from Welsh Government and Public Health Wales is due shortly.

Design well-connected and attractive communities

Street layout and proximity to other routes has been found to relate to active travel behaviour, with more active travel and less car use in more 'integrated' streets (those linking better to other streets).[97,98] Streets with lower traffic volumes have also been found to have stronger social networks between neighbours,[49] reducing social isolation.

Walking is encouraged by safe, traffic free walking routes and large public open spaces.[51] A UK survey on walkability in large cities found Cardiff had a lower score for accessing green spaces (50%) compared with the UK mean (54%), but did score well for safety of walking.[99] The Faculty of Public Health suggests transport and land use proposals with a negative impact on walking and cycling should routinely be rejected, and towns and cities should be 'people friendly' rather than car-friendly.[84] Higher density development should be encouraged near public transport hubs,[22] and commercial developments should have zero car parking except for blue-badge users.[22]

Reducing traffic speed with 20mph limits make streets more inviting for walking, socialising and cycling. Published modelling for Wales has estimated that if all 30mph roads were reduced to 20mph in Wales, between 1,200-2,000 casualties would be avoided each year, along with a net reduction in deaths and years of life lost due to air pollution.[100] The Faculty of Public Health has called for 20mph limits to be the norm for residential streets, with higher limits only on strategic traffic routes.[84]

Reducing traffic speed with 20mph limits make streets more inviting for walking, socialising and cycling

People who walk and cycle in a neighbourhood are more likely to spend money in local shops than people in cars who are more likely to drive through.[51,65] Retail sales have been found to increase by around 30% where walking and cycling projects have been undertaken.[101] It is therefore important to engage with local business communities to raise awareness of the financial benefits associated with prioritising walkability, active travel and public transport access.[93]

People who walk and cycle in a neighbourhood are more likely to spend money in local shops

Tools to help people moving to an area identify neighbourhoods which are more walkable are becoming available, such as Walk Score in the US.[102] A newly devised walkability score for London was tested against walking behaviour in a large cohort study, and found that people in more walkable areas were – unsurprisingly – more likely to walk.[103] Understanding the key characteristics of walkable neighbourhoods and incorporating these into future developments and works is therefore important in improving physical activity.

In some areas of the UK residents are working with local authorities to allow children to safely play in the streets outside their houses, by temporarily closing the street.[104] Many examples are in England, but there have also been recent examples in Cardiff (see Good practice locally, below) which have been well received and demonstrate this approach can work in a local context.

Protect and enhance our green space

Ensuring everyone has access to good quality open and green spaces is a key recommendation of the Marmot report on spatial planning and health inequalities.[51] Green space encourages physical activity and play, and should be accessible for those walking, cycling and using public transport, and have sufficient cycle parking.[51] In a rural context, outdoor recreation and activities are a key driver of the economy.[53]

Trees naturally absorb air pollution and improve air quality,[60] reducing particulate matter by up to a quarter (24%) in their vicinity.[105] Furthermore, trees sequester carbon (mitigating climate change), reduce summer air temperatures by 0.5 to 2.0°C (for example during heatwaves), and reduce noise pollution.[105]

Provide leadership

Senior, visible leadership and role-modelling on these issues is essential, in order to raise awareness and knowledge and build a broad consensus on action required. Engagement with local residents and organisations is a key part of this.[65] Active travel should be prioritised in urban planning and infrastructure development.[65]

A passionate call has been made in the British Medical Journal (BMJ) for healthcare professionals to lead by example on this, reducing their own car use and providing leadership to help others do so.[106]

Moves such as the introduction of the London congestion charge, which resulted in an 80% increase in cycling in central London since its inception in 2000,[84] and the UK government's timetable for phasing out fossil-fuelled cars by 2040,[28] have both reset expectations of what is possible, and the terms of public debate around travel and transport.

This is important: we are currently working from a 'norm' of routine petrol and diesel car use and this will only shift if leadership continues to be shown in this area.

The London congestion charge resulted in an 80% increase in cycling

Recent technological progress

The evidence of how we could make positive changes is supported by, and in some cases being overtaken by, significant progress in a number of different technologies over the last decade.

Being able to understand and respond to disruptive technologies will be an essential part of future strategy.

Bicycles

Dockless bike hire

Bike hire schemes have been around for a long time, and have increased in popularity and visibility in the last decade with schemes such as 'Boris bikes' in London. However, the cost to set up such schemes are high, and they rely on people finding docks near the start and end of their journey.

More recently 'dockless' bike schemes have started to appear, firstly in South East Asia and now in Europe.[107,108] These schemes do not require docks, with users finding the nearest available bicycle through a smartphone app, and leaving the bike at any convenient location near their destination. The schemes are run directly by the bicycle hire company, with no investment required by the host city. While promising increased convenience for residents with no startup cost for the city, there have been concerns voiced by city authorities, principally where large numbers of bicycles have been discarded or left in inappropriate locations. Working with scheme operators to agree an approach which benefits local residents and addresses concerns would be a win-win for local authorities and the private firms.

Bicycle sharing schemes including bike hire and pooled bicycles increase the availability of bicycles

More broadly, other bicycle schemes such as pooled bicycles at workplaces, peer-to-peer sharing of bicycles, and workplace bicycle purchase schemes also offer ways to increase the availability of bicycles.[109]

E-bikes

One of the barriers for people taking up cycling, especially in more rural areas where journeys may be longer and hilly, is the physical effort required to cycle. E-bikes offer power assisted cycling with power provided by a rechargeable battery integrated into the bike. Pedalling is still required to move the bicycle, but the motor assists when there is significant resistance such as a hill.

E-bike technology is improving and coming down in price rapidly, and is a price-competitive option for personal ownership, bicycle hire or shared bike schemes.

Car pooling and sharing

Car pooling, where individuals use a shared car (e.g. operated at their workplace, or with other residents in a local area), aims to reduce the number of journeys made by car while maintaining access when required. For example, if

staff in an office need to make house visits or journeys for meetings during the day by car, a car pool would enable them to commute to work by public transport, then use a pooled car when required during the day.

Pool car systems can be locally organised, or large providers including some car hire firms offer this service. Prioritising parking for pooled cars encourages their use. Smartphones have enabled car pool systems to be used in residential areas, with residents locating the nearest pool car through an app when they make a journey for which they need a car.

Car sharing schemes aim to put co-workers in touch who live near each other, to help them save fuel and reduce emissions by sharing journeys on the same route.[22]

Real-time pollution monitoring

Technology to monitor pollution is becoming cheaper and more portable. A personal monitoring device is already available which costs less than £50, CleanSpace.[110] An accompanying app tracks your exposure to carbon monoxide during your daily journeys (a measure of vehicle exhaust exposure), presenting you with a summary of your journey on a map. This allows people travelling by foot or bicycle to avoid particularly polluted areas for future journeys.

Although delayed in its development and implementation, a system is due to start imminently in Swansea (Nowcaster) which will monitor air quality and divert drivers via electronic signs when pollution is above a certain level.[111]

Ultra low emissions vehicles

Cars

Reducing emissions from vehicles is important to improve air quality and reduce harmful greenhouse gas production.

The most developed ultra low emission technology currently available is the battery electric vehicle (EV), with charging infrastructure and vehicle ranges improving rapidly. The car industry is undergoing rapid change, with the number of manufacturers launching pure EVs rapidly increasing, and Volvo recently committing to all new models being hybrid or pure electric from 2019.[112]

The car industry is undergoing rapid change, with the number of manufacturers launching pure EVs rapidly increasing

To further stimulate a transition to EVs, the rollout of charging facilities needs to continue, and particularly address charging where off-road parking isn't available. For example, there are now trials in London and elsewhere in the UK of EV charging from streetlamps.[113] For transitional uses where current driving range and charging infrastructure is insufficient, plug-in hybrid models offer significantly lower emissions and fuel consumption than pure ICE vehicles.

Did you know…? Electric vehicles aren't new. The first production electric vehicle was built in 1884, over 20 years before the Ford Model T started production in 1908

A number of cities across the UK are now incentivising or mandating taxis to be plug-in hybrids or pure electric vehicles, including London where all new taxis presented for licensing from 1 January 2018 will need to be able to travel at least 30 miles with zero emissions.[114] A UK Government plug-in taxi grant has also been introduced to incentivise electric taxis, and taxi charging infrastructure is being subsidised in 10 cities.[115] Fleet-owned vehicles are another opportunity for introducing ultra low emission vehicles. A number of NHS organisations in the UK including acute trusts and ambulance services have already started introducing electric vehicles to their fleets,[116,117] and Royal Mail has started trialling electric delivery vans.[118]

A number of cities across the UK are now incentivising or mandating new taxis to be electric

While EVs certainly help in reducing local air pollution, they do not eliminate it altogether (due to particulates produced from tyre wear), and do nothing to improve physical activity rates, so measures to move people to active travel and public transport are still essential.[119]

Box 4. Moving to cleaner energy sources

Switching to zero emissions vehicles is an important contribution to reducing local air pollution. Electric vehicles are inherently 3-5 times more efficient in their use of energy than internal combustion engine (ICE) vehicles.[120] However, to reduce wider air pollution and carbon emissions, it is important that the transition to EVs is accompanied by the continuing decarbonisation of the UK electricity grid, through increasing use of renewable energy sources.[53,95]

There is an opportunity to marry some new demands for energy with generation at the point of use, such as through solar car parks,[121] or e-bike charging stations. Wales is currently generating around 9,000 gigawatt hours of energy from renewable resources, with this figure rising.[60]

Buses

Buses are a major source of pollution, particularly older diesel vehicles. Newer technology (such as Euro VI diesels) have much lower NO_x emissions than previous generations of engines. Cardiff Bus has recently purchased ten Euro VI models.[122] Bus fleets elsewhere in the UK have also introduced hybrid, plug-in hybrid and full electric buses into their fleets.[32] While converting an entire fleet may be expensive, this could be done over time, with the busiest routes converted first; and with costs of conversion being directly subsidised by levies on polluting vehicles.

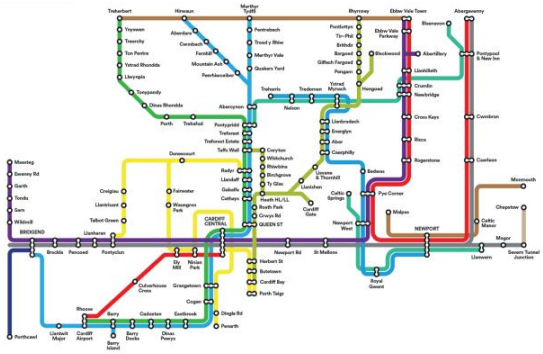
Retrofit technology for buses has been taken up extensively across the UK, with around 3,000 older diesel buses retrofitted with selective catalytic reduction (SCR) to reduce NO_x emissions by over 90%, reductions which have been confirmed in real-life testing by Transport for London (TfL).[32] TfL alone have retrofitted over 2,100 buses with SCR.

Retrofitting buses can reduce NOx emissions by 90%

Another option in some cases would be to replace bus routes served by polluting buses with electrified light rail services.

Box 5. Cardiff Capital Region Metro proposals

A £1.2bn City Deal was agreed in March 2016 covering ten South East Wales local authorities, including a substantial investment in a Cardiff Capital Region Metro integrated publi transport system. The details of the Metro are still being worked through, but the proposal includes electrified rail; integrated transport hubs; park and ride facilities; light rail and/or bus rapid transit routes; better integration across modes and operators; and active travel interventions.[123] The City Deal also included a commitment to electrification of the Valley Lines rail network by 2023.[5]



Trains

Diesel trains are also responsible for high levels of pollutants. Electrification of lines will reduce the use of diesel locomotives, but can be very expensive to roll out. This is planned already for the main line to Cardiff,[124] although a previous policy to extend electrification further west has recently been cancelled. Trials have suggested that battery-operated locomotives may be able to provide a solution for areas where electrification is too costly.[31]

Home working and remote meeting technology

A further alternative to car-based travel to work or during work time is avoiding travel altogether by making use of remote technologies. This includes home working but also a reduction in travelling during work hours by substituting face-to-face meetings with teleconferences or videoconferences.

While homeworking and remote meetings are only suitable for some roles, some of the time, they are nonetheless important options as part of an overall solution. Homeworking one day a week, for example, is likely to reduce transported-related air pollution and carbon emissions for an employee by one fifth.

Using data to analyse gaps in public transport

There is now a huge amount of anonymised data collected at a population level on people's movements, using information from smartphones. This data can be used to improve public transport. The makers of a popular transport app, CityMapper, used data in London to identify gaps in existing routes and have now set up a night bus route to meet this need. [125]

Technology on the horizon

Improvements in electric vehicle technology

The range and affordability of electric vehicles is increasing rapidly, with most major manufacturers now planning to release EVs within the next 1-2 years. Prices of EVs are expected to fall progressively.

Increases in EV uptake rates will require the introduction of smart charging technology to avoid overloading the electricity grid, for example by scheduling charging at various points overnight to even out demand.

Technology to allow on-the-go charging of vehicles ('dynamic charging') through the road surface, is already being trialled in South Korea and the US.[126] This has the potential to allow public transport vehicles to stay in service while charging.

Autonomous and connected vehicles

While some vehicles already available connect to the internet, the scope and nature of this connectivity has the potential to evolve further over the coming years, with cars communicating with traffic lights or other cars, to better understand local traffic conditions, pollution levels, and to avoid collisions.[127]

Self-driving cars are on the verge of becoming a reality due to improvements in sensors and advances in artificial intelligence. Cars are already on the market which can brake by themselves to avoid collisions, park themselves, and drive autonomously on motorways. Major manufacturers plan to have almost fully autonomous cars on the road within the next 4 years.[128] Autonomous freight vehicles are also planned.

Major manufacturers plan to have high automation cars on the road in the next 4 years

The potential impact of autonomous or driverless vehicles within the next 10-15 years is noted in the Welsh Government Future Trends report.[71]

Within the context of an integrated transport system, perhaps the biggest potential for autonomous vehicles is a role in 'mobility as a service'. This would see autonomous vehicles running a fixed route, or being summoned on demand (essentially a driverless taxi), and could help plug holes in public transport coverage. Driverless pods have been used at London Heathrow airport for over 5 years now, and are now being trialled in Greenwich.[129] Car-sharing technology firms such as Uber, which are already having a disruptive impact on the transport sector, are also trialling autonomous technology.[130]

As the technology matures, autonomous vehicles have the potential to have a broad range of impacts, from improvements in road safety, to reducing personal car ownership, and impacts on jobs in the transport industry.

How health and well-being could improve

Encouraging walking and cycling, and reducing air pollution, should result in significant improvements in cardiovascular health, rates of diabetes, overweight and obesity, falls, cancer and mental health, as well as overall increases in life expectancy.

For example, increases in physical activity result in a reduction in the overall death rate by up to 30%, a 20% to 35% lower risk of cardiovascular disease and stroke, a 30% to 40% reduction in type 2 diabetes, a 30% lower risk of falling among older adults, a 30% lower risk of colon cancer and 20% lower risk of breast cancer, and a 20-30% lower risk of depression and dementia among adults.[93,131-133]

Other benefits include reductions in low birth weight babies, reduced staff sickness absence and improved productivity, and increased time children spend playing outdoors.

6. The time is right for change

A number of opportunities exist through legislation, national and local policy, and a gradually changing culture around the use of cars, which make now the time to act. This chapter describes the main opportunities we need to seize.

Bringing about cultural change in our communities and large organisations will not take place overnight. Using existing tried and tested approaches to change such as continuous improvement methodology, and making the most of the opportunities posed by disruptive technologies, will need to be fundamental to our approach.

Legislation

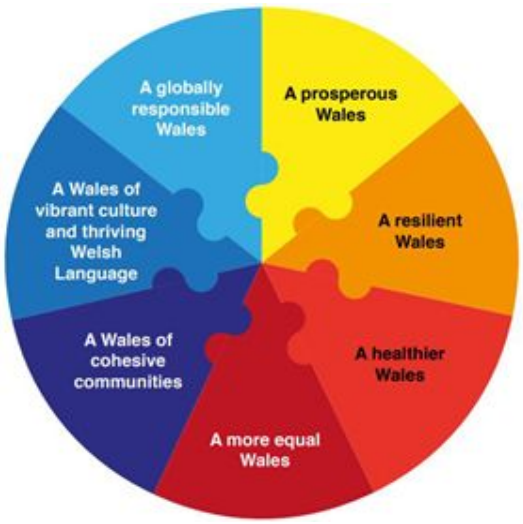
National

Four key pieces of legislation have recently been passed in Wales which pertain to improving health, well-being and environmental sustainability (see Box 6).

Box 6. Recent Welsh legislation relevant to sustainable travel, health and well-being

Well-being of Future Generations (WFG) (Wales) Act 2015[134]	Introduces duties on public sector organisations in Wales to take into account future generations when planning services and making decisions
Active Travel (Wales) Act 2013[135]	Makes it a legal requirement for local authorities in Wales to map and plan for suitable routes for active travel, and to build and improve their infrastructure for walking and cycling every year.
Environment (Wales) Act 2016[136]	Places a duty on Welsh Ministers to ensure that the net Welsh emissions account in 2050 is at least 80% lower than the baseline.[a55]
Public Health (Wales) Act 2017[137]	Introduces a duty to carry out Health Impact Assessments

Figure 5. Well-being goals established under the Well-being of Future Generations Act



The WFG Act set up public services boards (PSBs) in each local authority area with a duty for members to act together and individually to meet challenges in the area identified through a well-being assessment. The WFG Act, and its implementation presents a significant opportunity in addressing the issues highlighted in this report.

The Future Generations Commissioner (FGC) role is to act as an advocate for future generations and guide implementation of the WFG Act. Of the top seven priorities listed by the Commissioner in office, five are directly related to the issues discussed here: City Region Deals, integrated transport systems including South Wales Metro, prevention, early years, and climate change.[138] Separately, the FGC has reiterated the requirement for urgent action on climate change.[139,140]

International

Internationally, the UK is a signatory to the 2015 Paris Agreement on climate change. This legally binding agreement commits the UK to take significant steps to reduce greenhouse gas emissions to restrict global warming to less than 2°C, with an aim of 1.5°C maximum warming.[141] For the UK to meet its obligations under the Paris Agreement a significant reduction in emissions from road transport will be required.

Strategy and policy

There are a number of strategies and policies relevant to the issues described here. International and national strategies are listed in Box 7, and local strategies in Box 8. A description and reference for each is given in the Appendix.

In addition to the local strategies shown, each public sector organisation has an active travel strategy; and an air quality strategy is currently being developed for Cardiff.

Box 7. Key international and national strategy and policy

UK plan for tackling roadside nitrogen dioxide concentrations
Real Driving Emissions (RDE) regulations
Office for Low Emission Vehicles (OLEV) grants
Town & Country Planning Association (TCPA) guidance: Planning for better health and well-being in Wales
Royal Town Planning Institute (RTPI) policy
Local air quality management (LAQM) Wales guidance 2017
Manual for Streets
UN Convention on the Rights of the Child (UNCRC) and Rights of Children and Young Persons (Wales) Measure 2011
Public Health Wales (PHW) Well-being Objectives
Future Generations Commissioner for Wales – Draft strategic plan 2017-23

Box 8. Key local and regional strategy

Public Services Boards – Well-being objectives and plans
Regional Partnership Board – Area plan (in development)
Local Development Plans (LDPs)
Local Transport Plans (LTPs)
Shaping our Future Well-being
Cardiff Transport Strategy
Cardiff Cycling Strategy

City Region Deal

Culture change

The green shoots of a shift away from cars are starting to be seen. Residents in our area are keen to cycle more, take more physical activity, and want to see improvements in public transport.

Driving a car has become less popular among young people over the last few years, partly as a result of large increases in insurance costs, as well as the availability of ride-sharing apps such as Uber.[8] There has also been an increase in shoppers visiting high streets rather than out of town sites in Wales.[142]

Driving a car has become less popular among young people

While the car used to be an essential means to keep in touch with friends and relatives, the recent explosion in the use of social media, video calls and instant messaging, has made many of these journeys unnecessary.

Public transport accessibility for people with mobility difficulties has increased significantly over the last 10 years, with nearly all (94%) of buses now accessible in England, up 65% since 2005.[8] (comparative figures for Wales are not available).

Although petrol and diesel cars still dominate sales, ultra low emission vehicle sales are rising rapidly in our area, from below 20 vehicles sold in Cardiff and Vale each quarter three years ago, to over 300 now.[143]

Good practice locally

There are already some fantastic examples of projects which are paving the way for a brighter future in our area.

Cardiff and Vale University Health Board

There are a number of examples of good practice across the Health Board, including a new Park and Ride scheme for the Heath site (see Box 9); development of the Orchard at University Hospital Llandough, to encourage physical activity in a nearby green space; a bicycle purchase scheme; the establishment of a 'Park and Stride' scheme at Severn Road Primary School in North Cardiff, to reduce car emissions and hazards outside school gates; plans for an integrated bus hub at the UHW site, working with the local authorities; including ease of access by public transport and active travel in decisions around developing new health and well-being centres across the area; and the establishment of a group to review air quality data for schools to help promote active travel.

Box 9. Park and ride service for University Hospital of Wales

A new Park and Ride bus service has been introduced for the University Hospital of Wales, in conjunction with Cardiff Bus and the City of Cardiff Council. The regular bus service reduces traffic-related congestion and emissions on-site, helping to make the environment more conducive over time for active travel and pedestrians. Using the Park and Ride is cheaper for staff and visitors than parking on site.

Vale of Glamorgan Council

Vale of Glamorgan Council are keen to see their staff travel sustainably (see Box 10). The Greenlinks scheme in the Vale is a form of on-demand transport, enabling people without regular access to a car to make ad hoc journeys which are not served by the public transport network.[144]

Box 10. Helping staff travel sustainably

Vale of Glamorgan Council are taking the lead in encouraging their staff to travel sustainably. Their approach includes provision of pool bikes to get between nearby offices; pool cars; and a travel expenses policy which encourages short journeys to be made actively.

City of Cardiff Council

In addition to the ambitious Cardiff Transport Strategy,[5] there are a number of projects encouraging people to ditch their cars in Cardiff. These include street play (see Box 11); a programme to encourage active travel among staff who work at County Hall; Cardiff shared car scheme; and the ongoing development of a local air quality strategy.

Box 11. Encouraging street play

Ely and Whitchurch in Cardiff saw streets closed on 2 August 2017 to allow safe play for children in a residential area. The events, organised by Play Wales and following the 'Playing Out' model, with the support of the City of Cardiff Council, are hoped to be the first of many such examples, allowing children to get outdoors and get active, reducing screen time and increasing physical activity. Children were encouraged to come together to play on the street along with their families and bring their scooters, footballs, chalk and skipping ropes.

Cardiff resident and mother of two, Toni Morgan said 'I wanted to kick start the project in my street as I was aware of the many families living in the street, however I had never actually encountered any children at any time playing outside in the three years of living here.'

Other examples

Public Health Wales Environmental Health is working closely with public health teams and councils across Wales to foster closer collaboration between local specialists to improve local air quality, and has played a key role in raising the profile and awareness of air pollution as a health issue in Wales.

Information on air pollution for primary and secondary schools in Wales is being developed,[145] based on experiences in Scotland and Northern Ireland.

7. Seizing the day: a vision for Cardiff and the Vale

What future do we want for ourselves and our communities? A vision is presented here around five key themes, showing what we could achieve in Cardiff and Vale.

Active travel is the default for short journeys	Built infrastructure consistently enables and promotes walking and cycling as the default for short journeys
	Residents including schoolchildren routinely travel by active means for short journeys
	Active travel is routinely raised and promoted at key life points for residents and staff in Cardiff and Vale
	Employers positively encourage active travel, recognising benefits in staff well-being, sickness absence, and productivity
	Infrastructure developments for active and sustainable travel are funded through ring-fenced charges on polluting transport
	Local businesses support active travel by customers
	There are one or more annual car-free days co-ordinated across Cardiff city centre and Vale towns
	Some journeys for work are avoided by using remote technologies
There is a well used, fully integrated transport system	There is a comprehensive public transport system with timetables and ticketing integrated across travel modes
	Residents routinely travel by public transport (and/or active travel) for journeys over 2km within the region
	There is a steady decline in private car use for commuting and leisure
Well connected, active and social communities	20mph town and city-wide speed limits are introduced throughout the region
	The planning system and people moving into the area recognise the importance of walkability of residential and mixed use areas
	Children regularly play safely in residential streets
	Green space (including trees) is protected and enhanced, with good access to areas by active travel and public transport
	Communities are more cohesive, with increased social networks on streets
	Improvements in active travel and air pollution are seen first in our most deprived communities
	There is an ongoing re-vitalisation of local high streets for shopping and leisure, with these locations chosen by local shops and national chains in preference to 'out of town' areas
Transport emissions are significantly reduced	Low emission buses, trains, taxis and public sector fleets
	There are one or more low emission zone(s) in Cardiff
	There is a comprehensive charging infrastructure for electric vehicles
	Public awareness of local air pollution is high
	'No idling' zones are introduced around all schools and health facilities in Cardiff and Vale
	Local planning principles include expectations around reducing private vehicle use and ownership, and promoting ultra low emission vehicles
	Decarbonising transport is accompanied by an increase in locally generated renewable energy
Cardiff and Vale are leaders in this field	Cardiff and Vale is recognised as an exemplar for active travel and reducing car use within the UK and internationally

This is a summary of a more detailed vision which has been prepared for this report.

The potential impact...

The impact of achieving our vision	What this could mean for us...
Reduced illness and deaths from cancer	30% lower risk of colon cancer & 20% lower risk of breast cancer
Reduced illness and deaths from cardiovascular disease and stroke	20-35% fewer cases
Reduced rates of overweight and obesity	Decrease in BMI of 0.3-0.45kg/m^2
Reduced type 2 diabetes	30-40% fewer cases
Improved mental well-being	20-30% lower risk of depression and dementia
Reduced rates of falls among older adults	30% less risk
Reduced sickness absence	46% reduction if people cycle to work
Improved employee productivity	15% increase in concentration, reductions in stress
Increased retail sales	30% increase in retail sales
Other benefits...	Reduced inequality in life expectancy between most and least deprived areas
	More cohesive communities and reduced loneliness
	Reduced air pollution and lower carbon emissions contributing to global warming
	Reduce demand for health and social care services

References: 50,51,53,58,59,93,98,100,132,133,146-148

8. Everyone playing their part: what we need to do together

We have set out a bold vision of the future locally. This vision is entirely achievable; indeed many aspects of it are already a reality in cities such as Amsterdam; and other European cities including Hamburg and Madrid have set out plans to drastically reduce the number of cars in them in the next 20 years.[149]

To make a significant and sustained improvement in our health and well-being we need to take decisive action now and over the next 5-10 years. Doing so will mark out Cardiff and the Vale of Glamorgan as leaders in this field in Wales and across the UK. The public sector has a vital role to play in leading and modelling behaviours.

Throughout the chapters we have suggested many actions which will make a lasting difference in improving health, by making active and healthy travel the norm in our communities. The most important and achievable actions are highlighted below.

Who	What should be done
City of Cardiff Council and Vale of Glamorgan Council	(a) Accelerate improvements to infrastructure to support active travel and low emission transport • continue improvements and ongoing development of dedicated walking and cycling infrastructure, prioritising deprived areas first • provide access to local green spaces by active travel • maximise opportunities presented by Metro programme, including in rural areas • introduce bike hire schemes (including e-bikes) • consider widespread introduction of 20mph zones • increase electric vehicle charging infrastructure, particularly for areas without off-street parking • reject planning proposals which have an adverse impact on walking or cycling • support local renewable energy generation (b) Support staff to choose active travel • encourage all staff to travel actively, to reduce sickness absence and increase productivity • visible senior leadership and role-modelling • assess opportunities at times of workplace moves • support employees preparing for retirement (c) Engage with the local community and businesses on the benefits of active travel • agree consistent communication across local public sector • emphasise increased customer spend in walkable areas • organise and promote co-ordinated car free days across the region (d) Discourage unhealthy and polluting travel • introduce 'no idling' zones outside all schools • consider gradual increases in public car parking charges to fund and accelerate improvements in active travel facilities and public transport

	• scope the introduction of a low emission zone in Cardiff, with any charges levied used to fund active travel and public transport improvements • introduce low emission pool cars for major sites where they are not already in place
Cardiff and Vale UHB	(a) Accelerate improvements to infrastructure to support active travel and low emission transport • work closely with local authorities to maximise opportunities for active travel to current and future sites, including links with new strategic cycle routes • introduce electric vehicle charging infrastructure • introduce pool bikes on UHW campus, and further improve off-road cycle routes through UHW site (b) Support staff and students to choose active travel • visible senior leadership and role-modelling • encourage all staff to travel actively, to reduce sickness absence and increase productivity • assess opportunities at times of workplace moves • encourage healthcare students to travel sustainably, as future health leaders • support employees preparing for retirement (c) Engage with our local communities on the benefits of active travel • increase communications encouraging visitors to sites to use active travel and public transport • agree consistent communication across local public sector • promote and participate in co-ordinated car free days across the region • additional messages at key transitions, including new parents (d) Discourage unhealthy and polluting travel • introduce low emission pool cars for major sites • scope introduction of ultra low emission vehicles to fleet • review prices of staff car parking at congested sites. Changes in charging could directly fund improvements in active travel facilities and public transport
Cardiff and Vale Local Public Health team	(a) Prioritise promoting healthy travel in the public health work plan • identify promotion of active travel and addressing air pollution as cross-cutting themes in workplan • include active travel and air pollution references and actions in Making Every Contact Count • agree suitable performance indicators to measure progress and impact (b) Work with partners to promote healthy travel • work with PHW Environmental Health to produce local geographic maps of air pollution exposure, including exposure at schools and health sites • take action in response to forthcoming guidance from Welsh Government and PHW on addressing local air quality • work with Cardiff and Vale Healthy Schools Schemes to review air pollution levels around schools, to engage in

	conversations with staff and parents around active travel and impact of bringing cars to school gates • consolidate and strengthen links between Local Public Health team and local authority planning and transport departments, including in developing LDPs and the Health Board IMTP,[a161] to support action on active travel and air pollution (c) Engage with our local communities and businesses on the benefits of active travel • engage with Employers' Network • support the development and promotion of co-ordinated car-free days across our region
Public Services Boards	Identify actions relating to active travel and air pollution which would benefit from a co-ordinated approach across the partnership, e.g. active travel support for staff, car-free days, joint procurement of low emission vehicles Agree key public messaging across the public sector in Cardiff and the Vale on the rationale and health benefits associated with increased active travel, reducing car use, and low emission transport Provide visible senior leadership and role modelling at a PSB and organisational level to promote active travel
Current and future bus and train operators in Cardiff and the Vale	Provide clean, frequent and reliable services across the network Transition to low emission buses / electric trains Provide routine space for carrying bicycles on buses/trains, including key routes at busy times and in rural areas Support the introduction of integrated ticketing across travel modes Make data available to support real-time travel information
Public Health Wales (national)	Support local campaigns to increase active travel and reduce air pollution through • standard promotion materials • support to produce local air pollution profiles with map of area highlighting schools and health facilities • continuing national leadership on active travel and air pollution as health issues
Welsh Government	(a) Consider policy changes to support healthy travel • make it easier for residents and local authorities to make temporary street closures to encourage children's outdoor play • prohibit secondary schools from offering car parking places for pupils who live within 2km of the school, except if they are disabled • consider allowing Local Health Boards to introduce proportionate parking fees for staff where alternative modes of transport are available, in order to incentivise appropriate active travel and public transport use • review NHS travel expenses policies to ensure they promote active travel where appropriate, for example by not routinely

	reimbursing for distances <2km (b) Consider further legislative changes to support healthy travel • introduce legal requirements for public transport operators to participate in region-wide integrated ticket programmes • introduce legal requirements for large public sector organisations to have sufficient cycle parking spaces (e.g. a minimum specified ratio of spaces per employee) (c) Engage with citizens across Wales to encourage healthy travel • undertake a national communications campaign to improve the image of active travel

Appendix

Summary of relevant strategies and policies

International and national strategies and policies

UK plan for tackling roadside nitrogen dioxide concentrations[28]	Defra and DfT plan to reduce NO_2 emissions. Includes proposal for a Clean Air Zone framework for Wales, suggesting Cardiff may be one of the first areas to implement, by 2021; also guidance to be issued to Directors of Public Health and Local Authorities to support delivery of LAQM plans; and schemes to encourage bus retrofitting and electric taxis. Also commits that UK Government will 'end the sale of all new conventional petrol and diesel cars and vans by 2040'
Real Driving Emissions (RDE) regulations	Requirement for vehicle manufacturers to ensure real world NO_x emissions are controlled across a range of driving conditions, from September 2017.[28]
Office for Low Emission Vehicles (OLEV) grants	Grants available from UK Government for local authorities to support on-street charging,[150] and for employers, including the public sector, to support workplace charging[151] for staff and fleet vehicles
Town & Country Planning Association (TCPA) guidance: Planning for better health and well-being in Wales[98]	This guidance was developed in conjunction with Public Health Wales and the Wales Health Impact Assessment Support Unit. It sets out opportunities for public health to work with planning, for each to positively influence the others' work programme using their area of expertise.[98] It also recommends using the Director of Public Health Annual report to tackle unhealthy environments.
Royal Town Planning Institute (RTPI) policy[152,153]	Policy paper on transport infrastructure investment, including challenge to integrate schemes to encourage inter-modal transport
Local air quality management (LAQM) Wales guidance 2017[154]	Guidance for LAQM in Wales in light of the WFG Act. Specifically, LAQM should not be carried out to seek short-term solutions; and should be carried out in an integrated way to find solutions to related outcomes including reduced carbon emissions and healthier lifestyles. Also recommends LA and public health should work together to reduce health risks and inequalities; and special consideration should be given to long-term risks of exposure by babies and children, including in homes, schools and nurseries, and travel between these locations
Manual for Streets[155]	UK Department for Transport guidance on designing streets. Recognises a user hierarchy which places pedestrians and cyclists above cars, explained more in Making Space for Cycling.[156]
UN Convention on the Rights of the Child (UNCRC)[157] **and Rights of Children and Young Persons (Wales) Measure 2011**[158]	Rights of children applicable under international law and domestic law in Wales. Article 31: Children have the right to relax and play, and to join in a wide range of cultural, artistic and other recreational activities. Article 24 includes the right to a safe environment
Public Health Wales (PHW) Well-being	Objectives required under the WFG Act. One of the 7 well-

Objectives[159]	being objectives is to 'maximise the potential of our natural and cultural resources to promote physical and mental health and well-being and contribute to a low carbon, environmentally resilient Wales'. Giving children opportunities to play and learn in a healthy and safe environment is another objective.
Future Generations Commissioner for Wales – Draft strategic plan 2017-23[140]	Sets out four key purposes for the plan period. Includes highlighting the big issues facing future generations – the first of four being climate change, for which the focus should be reducing emissions and tackling impacts.

Local and regional strategies

Public Services Boards – Well-being objectives and plans	Well-being assessments and plans are required for each local authority area under the WFG Act, overseen by the local PSB. In the Vale, the objectives in the draft well-being plan focuses on four priority areas, including giving children the best start in life, and protecting, enhancing and valuing the environment, and tackling inequalities.[160] In Cardiff, the draft objectives include resilient growth, giving children the best start in life, tackling poverty, and caring for older people (including tackling social isolation).[161]
Regional Partnership Board – Area plan	An assessment identified needs including social isolation and loneliness; insufficient physical activity; and accessibility to green space. An Area Plan is being developed to respond to the assessment.
Local Development Plans (LDPs)	Cardiff's LDP was adopted in 2016 and includes a commitment to over 40,000 new homes and a similar number of new jobs;[162] specific aims include to reduce reliance on the car, by improving travel choices for communities, integrated travel, orbital rather than radial bus networks, and improved traveller safety. Achieving a 50/50 modal split is described as a necessity for the transport network to cope with growth. It also sets out plans to retain and protect trees and green infrastructure in the city. The Vale LDP was adopted in June 2017 and includes improvements to walking, cycling and public transport infrastructure (including a proposed coastal cycle route, NCN 88, running east/west through the Vale), modernising the Valley rail line as part of the Cardiff Metro, and identifying areas for potential renewable energy regeneration.[163]
Local Transport Plans (LTPs)	The Vale LTP promotes a shift from car use to sustainable travel, including increasing the number of cycle routes and encouraging integrated transport as the Vale of Glamorgan railway line is electrified. Where active travel is difficult due to the rural nature of the Vale, public transport accessibility will be enhanced.[164] The Cardiff LTP promotes a shift away from hub and spoke bus lines to a grid system, which links communities better and prevents all traffic having to go through the centre of the City.[165] The supporting masterplanning principles laid out by Cardiff Council recommend high density residential and mixed-use development along public transport corridors; and providing

	strategic walking and cycling corridors.[166] Streets will give priority to pedestrians and cyclists, and infrastructure should enable easy interchange between and active travel and public transport. All residents will be within easy access of off road paths. Varied green space open corridors will be provided.
Shaping our Future Well-being	Cardiff and Vale UHB's 10 year strategy prioritises prevention as a key theme, keeping people well for longer.[81] It also aims to support people to choose healthy behaviours and reduce health inequalities; and also be an excellent employer to work for. Air pollution, obesity and physical activity are recognised as key issues in the population profile in the Health Board's integrated medium term plan.[167]
Cardiff Transport Strategy	The Cardiff Transport Strategy sets out an ambitious aim to create a modal shift to a 60/40 split of sustainable travel compared with car use by 2026, preceded by a 50/50 split in 2021.[5] The strategy includes commitments to a city-wide cycling network, central cycle parking hub, transport interchanges at strategic points throughout the city, green bus technologies, integrated ticketing, and support for car clubs. This follows on from a laudable decline in city centre traffic of one quarter (26%) between 2004 and 2014
Cardiff Cycling Strategy[a110]	The draft strategy sets out a vision of a city where cycling is normal, practical and safe for short trips, for people of all cycling abilities, and to double the number of cycle trips by 2026. Sets out plans for two primary route corridors in Cardiff – North/South and East/West; and promoting cycling in schools, workplaces, for shopping.
City Region Deal	A £1.2bn City Deal was agreed in March 2016 for 10 South East Wales local authorities, including a substantial investment in a Cardiff Capital Region Metro integrated public transport system. The City Deal also included a commitment to electrification of the Valley Lines rail network by 2023.[5] The details of the Metro are still being worked through, but the proposal includes electrified rail; integrated transport hubs; park and ride facilities; light rail and/or bus rapid transit routes; better integration across modes and operators; and active travel interventions.[123]

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21.2

HEALTH AND SAFETY ANNUAL REPORT 2016/17
Name of Meeting : Board Meeting **Date of Meeting** 29/09/2017

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety 029 2074 3751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact : Not applicable
Quality, Safety, Patient Experience impact: The Annual Report covers staff and patient health and safety risks with specific reference to the 8 strategic areas.
Health and Care Standard Number 2.1
CRAF Reference Numbers: 8.1.4, 6.4.4, 6.4.5, 6.47
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Health and safety aspects being monitored and progressed as appropriate

The Board is asked to:

- **NOTE** the content of this report

SITUATION

This report has been prepared to provide assurance to the Board that the Health Board's health and safety risks have been appropriately managed during 2016/17.

The main driver of health and safety actions has been based on dealing with "real risks and practical solutions. The Health and Safety Executive refers to this as material breaches i.e. non compliances which are likely to result in injury and implementing practical solutions which then makes a meaningful difference.

The prioritised approach identified eight strategic areas for action, these being:-

1. Health and Safety Management Structure (including incident reporting)
2. Violence and Aggression Management
3. Manual Handling
4. Health Issues
5. Environment Safety and Health and Safety Patient Issues
6. Fire Safety Management
7. Health and Safety Estates Management.
8. Sharps Safety

21.2

The report covers the period the 1st April 2016 to the 31st March 2017, however it also refers to progress made since this date.

BACKGROUND

Cardiff and Vale University Health Board (UHB) is committed to ensuring that all of its health and safety statutory and mandatory obligations are met. In order to meet these requirements, it is necessary to monitor health and safety performance.

The Health and Safety Policy requires that an Annual Report is prepared for submission to the Board on progress and standards being achieved.

The Health and Safety Executive identifies that measuring performance is a key element of successful health and safety management.

NHS standards mandate the preparation of an annual report. It is therefore utilised as a significant document in demonstrating compliance within both the internal and external audit processes.

In July 2017 the Director General Health and Social Services/ NHS Wales Chief Executive wrote to all Health Boards and Trusts requiring that they satisfy themselves and their Boards that the management of health and safety is sufficiently robust and that improvement plans are in hand, when needed.

He also expected health and safety be allocated to a Director and that Health and Safety features within our performance and objectives.

The Annual report 2016/17 was considered at the July 2017 Health and Safety Committee.

ASSESSMENT

The attached report (appendix 1) identifies a number of key aspects.

The Report outlines performance and management arrangements together with existing performance and future affairs.

The Annual Report considers trends in incidents, training and management processes. It concluded that the trends of incidents and management processes continue to show progress in improving staff and health and safety risks.

Key issues highlighted included:

- Incident data collated from the Datix system is showing a high level of close out and management involvement (94% of the staff health and safety incidents were closed out and only 6 of nearly 3600 remain as awaiting review) .
- Whilst the number of RIDDOR events have remained constant there has been a continued increase in the number of patient behavioural incidents

up 28% on the previous period. These events include self harm and refusal of treatment

- The Health Board received its second HSE enforcement action since 2001 relating to compliance to Legionella requirements. An action plan was put in place and the Enforcement Action revoked by the Inspectors.
- The HSE were also active in visiting the Health Board and applying “Fees for Intervention”. They have also continued to pursue the investigation into the Contractor Fall with no decision if legal action is warranted.
- A change to the way fines are applied highlighted the significant potential risk of a fine being in the order of £1-2 million.
- The number of Prosecution and other Police inventions were significantly lower than previous years; however the Health Board is working closely with the Police, Crown Prosecution Service and Shared Services Legal to improve the Memorandum of Understanding between all parties.
- Training compliance for both manual handling and violence and aggression has improved, although this mostly relates to e-learning module A and not tutor led training. Progress in improving the percentage of their staff trained. This is being pursued by the Mandatory Training Steering Group.
- Tutor led training continues to show a very high level of failure to attend on the day and this is being considered by the Health and Safety Operational Group.
- With the appointment of a new Staff Safety Representative Chair and Deputy the workplace inspection regime has been reviewed and enhanced local representatives involvement.
- Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period.
- It also reports on the improvement in the management of health and safety aspects through the priority action plan and the control of policy schedule, keys areas of progress include:

  (1) Acquiring approval from Welsh Government for renewal of £420k of patient hoists for implementation in early 2017/18.
  (2) Implemented improved re-usable glide sheets reducing injury risks whilst resulting in a saving.
  (3) Introduced new lone worker devices and improved usage from 20% - 74%.
  (4) Revised all health and safety policies within their required reviewed period.
  (5) Needle stick and sharp incidents were again lower than the previous period justifying the safer sharps devices introduced.
- Finally, performance has been summarised into a benchmarking type format, which allows for comparison by area and Clinical Board. This was considered helpful in progressing assurance when Clinical Board’s Health and Safety performance is considered as part of the Committee’s work programme.

APPENDIX 1

21.2

2016-2017 HEALTH & SAFETY ANNUAL REPORT

INTRODUCTION

The main driver of health and safety actions has been based on dealing with "real risks and practical solutions. The Health and Safety Executive refers to this as material breaches i.e. non compliances which are likely to result in injury and implementing practical solutions which then makes a meaningful difference.

The reports covers the period the 1st April 2016 to the 31st March 2017, however it also refers to planned advancements and progress since this date.

The report takes the structure of the 5 key areas of responsibility of the Committee **SCRAP** - **Strategy, Compliance, Risk, Assurance and Policy.**

Cardiff and Vale University Health Board (UHB) is committed to ensuring that all of its health and safety statutory and mandatory obligations are achieved. In order to meet these requirements, it is necessary to monitor health and safety performance.

The Health and Safety Policy requires that an Annual Report is prepared for submission to the Board on progress and standards being achieved. NHS standards mandate the preparation of an annual report.

The Health and Safety Executive identifies that measuring performance is a key element of successful health and safety management.

The Annual Report is therefore utilised as a significant document in demonstrating compliance within both the internal and external audit processes.

The previous 2015/16 report was considered at the July 2016 Health and Safety Committee. The continued implementation of E Datix (Electronic Incident reporting) has allowed the report to be brought again to the Committee's attention at its July meeting.

1.0 STRATEGY

1.1 HEALTH AND SAFETY MANAGEMENT STRUCTURE

The Health and Safety Committee is a full Committee of the Board, this ensures robust governance and effective communication within the Health Board. The Committee's membership includes Board Members, Management, Safety Specialists and Trade Union/staff representatives.

The Committee is chaired by an Independent Member and meets on a quarterly basis with a clear responsibility to provide assurance to the Board through a defined reporting structure. Quorum requirement is 2 Independent Members. It also has a significant role in complying with The Safety Representatives and Safety Committee Regulations 1977.

ATTENDANCE **Table 1**

	April 16	July 16	October 16	January 17
IM - Legal (Chair)	1	1	1	1
IM - Trade Union	1	1	1	1
IM - Local Authority	0	0	0	0
Director H&S Lead	0	1	1	1
Other Executive Directors (or Deputies)	2	1	2	3
Staff Safety Representative	2	1	1	2

Table 1demonstrates the Health and Safety Committee has met its terms of reference in both of frequency of meetings and quorum. It has also met the organisation's responsibilities to The Safety Representatives and Safety Committee Regulations 1977.

The Board Lead for Health and Safety and Personal Safety was transferred in December from the Director of Planning to the Director of Corporate Governance, however the Director of Planning still retains the lead for Fire Safety.

The Committee has three formal sub groups; these are the Operational Health and Safety Group which is chaired by the Director of Corporate Governance, the Fire Safety Group which is chaired by the Director of Capital, Estates and Facilities and the Personal Safety and Security Strategy Group which is chaired by Head of Health and Safety in the delivery of health and safety responsibilities.

Health and Safety Committee Reporting Structure

Chart 1

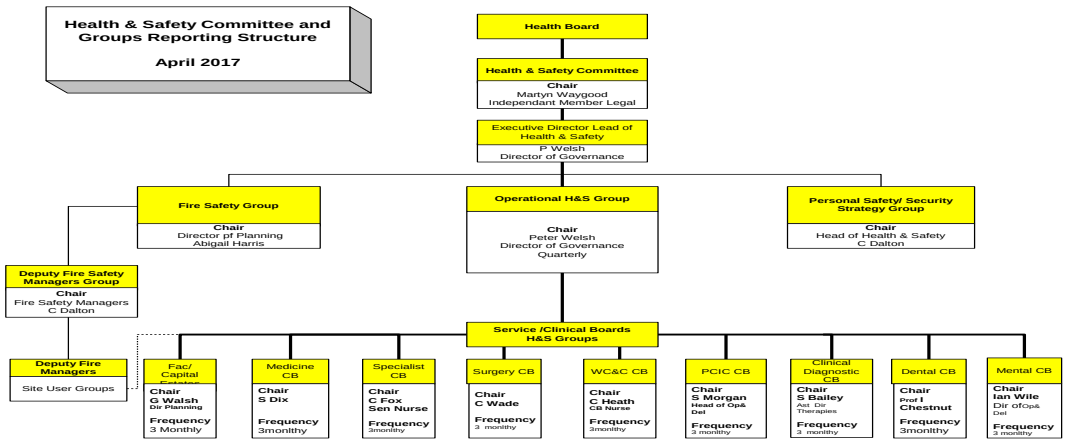


Chart 1 shows those groups reporting through the Board Director to the Health and Safety Committee.

Table 2 shows the number of meetings and deficiencies during the period.

Table 2

Health and Safety Strategic Groups	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Operational	P Welsh	3 monthly	4	5	+1

Fire Safety	G Walsh	3 monthly	4	4	0
Personal Safety	C Dalton	3 monthly	4	4	0

Table 3

Health & Safety Group	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Estates/Facilities	G Walsh	3 monthly	4	9	+5
Medicine	S Dix	3 monthly	4	1	-3
Specialists	C Fox	3 monthly	4	4	+1
Surgery	C Wade	3 monthly	4	6	+2
C&W	C Heath	3 monthly	4	4	1
PCIC	S Morgan	3 monthly	4	4	0
CD&T	S Bailey	3 monthly	4	6	+2
Dental	I Chestnut	3 monthly	4	4	0
Mental Health	I Wile	3 monthly	4	3	-1

Information based off Health and Safety Advisory invitation

Table 3 shows each Clinical Board has a designated Health and Safety Group Chair with an agreed frequency of meeting. In some cases these are incorporated into the Quality and Safety meeting but with an emphasis on health and safety.

Advisory Team
Establishment during 2016/17 **Table 4**

Position	2016/17 WTE
Head of Health and Safety	1
Health & Safety Advisers (inc of Specialist Environmental Adviser (0.7wte)	2.4
Manual Handling Advisers	1.4
Personal Safety/Case Management	2
Manual Handling/Violence and Aggression Trainers	5
Health & Safety Support /Admin	3.71

In addition to the corporate team, the Capital, Estates and Facilities Service Board manage 1 WTE Health, Safety and Asbestos Manager and 1WTE Health, Safety and Asbestos Officer.

The Health and Safety Advisers are all Chartered Members of the Institute of Occupational Safety and Health and Registered Safety Practitioners; these are assisted by 0.4wte of an Assistant and supported by part time Administrators who also maintain assessment data bases and support the Datix System.

Staff Health and Safety Representatives

Staff re-organised it's Safety Representative structure during the period, it subsequently appointed a new Lead Health and Safety Staff Representative - Stuart Egan (Unison) and Catherine Salter (RCN) as deputy lead, both of which were existing Committee members. All unions have come together within the last 12 months to raise the profile of Health and Safety within the Health Board.

To ensure Health and Safety Representatives participate at every level, the Lead and Deputy Lead Health and Safety Staff Side Representatives will sit on the

Health and Safety Committee, Operational Health and Safety Group, Personal Safety/Security Strategy Group and the Fire Safety Group.

Other meetings now attended by Health and Safety Staff Side Representatives include the Quality and Safety Committee, Local Partnership Forums, Health and Wellbeing Steering Group, Maximising Attendance and the Mandatory Training Steering Group.

Monthly Staff Side Health and Safety meetings have been re-established. All active Health and Safety Representatives have been identified and their names have been supplied to the Head of Health and Safety. Staff Side plan on holding Health and Wellbeing events across the Health Board throughout the year.

The Lead and Deputy Lead Representatives meet with the Head of Health and Safety on a monthly basis to raise members concerns, influence the health and safety agenda and transfer health and safety information. Health and Safety Staff Side are now informed of any HSE involvement within the Health Board. Health and Safety Staff Side have now been granted access to all health and safety incidents on e-datix.

A working group has been set up between unions and health and safety staff to update the Workplace Inspection Form and formalise the process. The change in working practice has resulted in a more efficient way of working and communicating.

Staff Side have acknowledged the positive steps taken during this year by the Health and Safety team to engage with Staff Side and work in partnership to improve the health and safety of our staff. We look forward to continuing this positive work and supporting all staff within the Health Board.

1.2 STRATEGY - HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN

In 2011, the Health Board was required to submit to the Health and Safety Executive (HSE) along with all other Health Boards and Trusts, details of their health and safety priorities. These priorities have been updated each year to reflect both new areas of strategic risk and the progress made.

The Health and Safety Committee has received an update report on progress made at each of its meetings during the period. Equally progress on each of the identified requirements is actively monitored by the Operational Health and Safety Group and within local Health and Safety Groups.

The Health Board has continued to pursue a prioritised approach in eight indentified strategic areas for action, these being:-

9. Health and Safety Management Structure (including incident reporting)
10. Violence and Aggression Management
11. Manual Handling
12. Health Issues
13. Environment Safety and Health and Safety Patient Issues

14. Fire Safety Management
15. Health and Safety Estates Management.
16. Sharps Safety

Below summarises the status of the plan by the strategic area as at April 2017

Table 5

	Total no of require ments	Green	Amber	Red
Health and Safety Policy Management and Organisational Arrangement	4	0	2	2
Violence and Aggression (inc Lone worker)	6	2	4	0
Manual Handling	4	1	3	0
Health Issues	4	0	4	0
Patient and Environment Health and Safety	8	1	6	1
Fire Safety Management	3	1	1	1
Estate Health and Safety Management	5	0	3	2
Sharp Safety	1	0	1	0
Total	35	5	24	6

Table 5 demonstrates of the total of 35 requirements, 5 have been resolved and 6 remain as high priority and non compliant. A further 24 are identified as amber, thus meaning that the risk has been reduced as a result of action taken but further control measures are required. The plan is a live document and during the period a total of 12 key items have been added and progressed. Below outlines those areas progressed during the period.

Key Areas Progressed During the Period

AREAS OF PROGRESS DURING PERIOD

Table 6

Area	Requirement	Action	Status
2 V&A	Ensure effective implementation of Lone Worker system.	Report submitted to the Operational Health and Safety Group and Health and Safety Committee. Monthly named reports sent to local managers. Current compliance improved from 20 % to 72%	**Amber to Green**
2 V&A	Staff at risk has access to suitable lone worker system	Monitoring each Clinical Board and effective distribution of current budgeted devices	**Amber to Green**
2 V&A	Establish forum for violence associated with caring for Mental Health patients in an acute or non acute setting (non mental health environment).	Forum established on an all Wales basis with findings being progressed through the All Wales case management group and V&A advisory group.	**Amber to Green**
3 Man Hand	The lack of flat glide sheets which are essential Manual Handling equipment	Glide sheets have been delivered and are being dispatched to areas, with a mechanism for laundering and replacement.	**Amber to Green**
3 Man Hand	The Health Board has a contract to maintain hoist.	A procurement led group including H&S and estates has been established to improve mechanisms and simplify maintenance of hoists. The pro act audit findings has been adopted as the	**Red to Amber**

		definitive database	
3 Man Hand	Restricted finance has resulted in aged hoisting stock.	UHB has purchased 60 new hoists on a legacy scheme, these will replace the oldest and poorest condition hoists within the UHB., delivery anticipated start of next financial year	**Amber to Green**
3 Man Hand	A procurement review of maintenance contract has resulted in delays in repairs to key items which compromises patient care.	Meetings held with procurement to discuss a change to the servicing contract, to speed up repairs existing level of service maintained, servicing only. The replacement of 60 old hoists within the UHB it is anticipated the breakdowns will be less, but not diminished.	**Amber to Green**
4 Health	Hydro therapy pools Evidence shows variance of agreed standards – lack of monitoring at the required frequency and outstanding maintenance issues.	Implementation Group has met and established and action plan; this is being progressed with extensive improvement and consistency across the Health Board pools. This is being progressed through the Water Safety Group.	**Red to Amber**
5 Pat Environ	Lack of control of Legionella Assessment & Flushing at local level HSE Improvement Notice	Legionella Policy approved and Water Safety Group established Enhance monitoring established	**Red to Amber**
5 Pat Environ	Hoover Jacks have been procured for UHW& UHL to safely move fallen patients with risk of spinal injuries	2 Devices purchased from CB budget.	**Amber to Green**
6 Fire	Fire Risk Assessments shows no direct progress. Revision of Deputy Fire Safety Manager responsibility and local area ownership.	Deputy Fire Safety Managers meetings and agreement via HOD's of DFSM areas. Progress reports on actions to be submitted to the Health and Safety Committee.	**Amber to Green**
7 Estates	Passengers lifts HSE wrote requiring confirmation of suitable plans to coordinate the findings of the inspection with the maintenance company.	Maintenance Contract reviewed and improvement noted. Contractor changed enhanced maintenance no further HSE reports.	**Amber to Green**
7 Estates	Policy and AMP requires only controlled breach of asbestos	Enhanced contractor control introduced.	**Amber**
8.5 Sharps	Enhanced protection for staff against needle stick injuries and implement requirements of the EU Directive	Review of other safety devices. Audits received from clinical areas to be reviewed to identify further use of safety sharps devices.	**Red to Amber**

Table 6 shows progress in each of our strategic priority areas during the period.

1.3 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

Table 7 below shows policies that have been submitted and approved at each meeting and that all health and safety policies under the remit of the Health and Safety Committee have been reviewed within the appropriate timescale.

Below is a list of those policies reviewed during the year 2016/17.

Table 7

POLICY	REF NO	SUBMISSION TO H&S COMMITTEE	REVIEW DATE
Contractor Control	UHB 163	July 2016	July 2019
Health and Safety	UHB 021	October 2016	October 2018
Safe Working with Electricity Policy	UHB	January 2017	January 2020

Table 8 is a list of those Policies which were not submitted during the year as they remain within their review period.

Table 8

POLICY	REF NO	SUBMISSION TO HEALTH & SAFETY COMMITTEE	REVIEW DATE
Management of Violence and Aggression	UHB 035	January 2014 (2nd review)	April 2017
Lone Worker	UHB 034	January 2014 (2nd review)	April 2017
Minimal Manual Handling	UHB 036	January 2014 (2nd review)	April 2017
Waste Management	UHB 038	January 2014 (2nd review)	April 2017
Control of Legionella (now Water Safety)	UHB 091	April 2017 (previously Quality and Safety December 2014 review)	April 2017
Management of Stress and Mental Health Wellbeing in the Workplace	UHB 071	July 2014 (2nd review)	July 2017
Management of Asbestos	UHB 072	July 2014 (2nd review)	July 2017
First Aid at Work	UHB 093	July 2014 (2nd review)	July 2017
Fire Safety	UHB 022	July 2015 (2nd review)	July 2017
Closed Circuit Television (CCTV)	UHB 303	October 2015	October 2018

Table 9 shows policies which are health and safety related but approved through other Committees of the Board, these have also been added to the committee policy schedule to facilitate the timely progress of these documents.

Table 9

POLICY	REF NO	APPROVING COMMITTEE	REVIEW DATE
Safe Use of Ionising Radiation	UHB 031	Quality and Safety	December 2019
Safety Notices and Important Documents	UHB 069	Quality and Safety	August 2014
No Smoking and Smoke Free Environment	UHB 073	UHB Board	July 2019
Occupational Health	UHB 103	Workforce and OD	March 2015
Incident, Hazard and Near Miss Reporting	UHB 138	Quality & Safety	August 2015
Mandatory Training	UHB 080	Workforce and OD	June 2016
Risk Management	UHB 023	Audit	July 2016
Working Time	UHB 168	People, Performance and Delivery	July 2017
Domestic Abuse, Violence against Women & Sexual Violence	UHB 167	People, Performance and Delivery	March 2018

1.4 HEALTH AND SAFETY EXECUTIVE/ENVIRONMENTAL HEALTH ENFORCEMENT ACTION

A presentation made to the Health and Safety Committee meeting in October by Legal and Risk Services, highlighted key changes to the sentencing charges that courts now apply for offences under the Health and Safety at Work Act 1974.

They advised fines would now be related to the size of the companies turn over and as such a fine applied against the Health Board would generally fall in a high range of up to £3million with a starting point of the higher category of degree of accountability up to 1.2million. The briefing warned that such a fine would have significant financial consequences to any Health Board and that recent prosecutions had demonstrated public service bodies would not be treated any differently to private companies.

21.2

During the period the HSE were involved in 6 issues with regards to incidents within the Health Board. These being:-

- Passenger lifts
- Patient fall from bed on Ward B5, UHW
- Needle stick risk associated with the needle exchange service
- Monitoring arrangements of the hydrotherapy pool
- Legionella incident on Ward C4, UHW
- Contractor fall from height.

Subsequently one Improvement Notice was issued in regards to the management of Legionella flushing for which an action plan was implemented and the Inspector confirmed compliance**.**

In addition to the above “Fees for intervention” were made in relation to:

- the Passenger lifts for LOLER compliance,
- hydrotherapy pool monitoring COSHH and
- the Contractor fall from height.

The Contractor fall from height is subject to an ongoing investigation by the HSE with no determined outcome as yet. With the exception of this the HSE have completed their involvement and satisfied with the remedial actions implemented. There remains however continued working groups progressing ongoing requirements of these issues.

During the period there were no Enforcements issued by Environmental Health, there were however a number of satisfactory food hygiene audits, which are detailed later in the report.

1.5 INCIDENT STATISTICS

In January 2015 the Health Board commenced its introduction of the E-datix Electronic Incident Reporting System. This report details incident data statistics in relation to staff and patient health and safety. All incidents are investigated in the first instance by the local manager and subject to an assessment by the relevant Adviser a more detailed investigation may be undertaken. Incident data allows the Health Board to identify opportunities to learn lessons and minimise reoccurrences.

All incidents are reported via the e-datix electronic incident reporting system. Information detailed below is taken from this system. The Health and Safety Department continue to send letters to all incidents reporting staff injuries to the employee to ensure we collate all RIDDOR events.

Table 10

All Incidents	2013/14	2014/15	2015/16	2016/17
Injuries affecting visitors, or the public	104	71	122	136
Incidents affecting the staff/contractors (exc rejected)	**4147**	**3891**	**3337**	**3537**
Patient *	16181*	14686*	13582	15157
Organisation	N/a *	436*	1251	1139

Totals:	**20432**	**19084**	**18292**	**19969**

Table 10 shows that the total number of incidents reported increased by 9.2% during the period with staff incidents increasing by 6%.

Number of Incidents relating to no action or not closed off

Chart 2

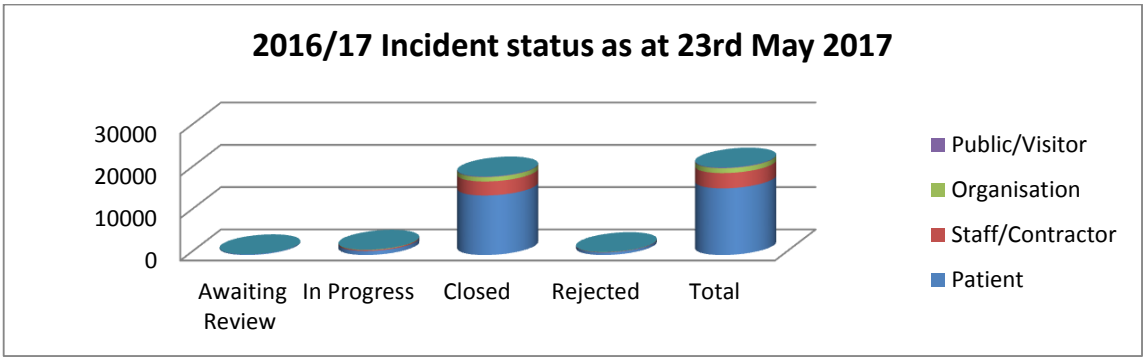


Table 11

	Awaiting review	Being Reviewed	Final Approval	Rejected	Total
Total 2015/16 (as at 3/7/16)	192	955	16565	610	18322
Total 2016/17 (as at 23/5/17)	**175**	**1242**	**18553**	**686**	**20656**
Staff/Contractor	6	223	3308	62	3599

Chart 2 shows as at 23rd May 2017 94% of reported events have been closed. Only 6 of the 3599 staff incidents remain awaiting review, this may be related to manager's absence.

1.5.1 REPORTING OF DISEASES AND DANGEROUS OCCURANCES (RIDDOR)

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations requires the reporting of over seven days' incapacitation and some specified injuries such as broken bones. It also relates to reporting dangerous occurrences and certain occupational health events.

RIDDORS 2015/16 & 2016/17 **Table 12**

Staff RIDDORs	Total 2015/16	Total 2016/17
Contact with Sharps	**4**	**4**
Contact/Collision with Object/Animal	**16**	**22**
Entrapment	**2**	**1**
Lifting/Manual Handling	**34**	**32**
Slip/Trip or Falls	**27**	**27**
Inappropriate/Aggressive Behavior	**31**	**28**
Exposure to unhygienic Environmental Conditions	1	0
Exposure to unsafe Environmental Conditions	1	1
Other	0	1
Workplace Stressors/Demands	1	0
Total	**117**	**116**

These must be reported within 10 -15 days of the date of knowledge.

21.2

Table 12 and Chart 3 shows there were 116 total RIDDOR events during the year; this is a small decrease of 1 over the 117 reported in 2015/16. Lost time events relating to violence have reduced but contact injuries have increased. The trend since 2008/9 shows a sustained reduction in the number of manual handling reportable events.

Chart 3

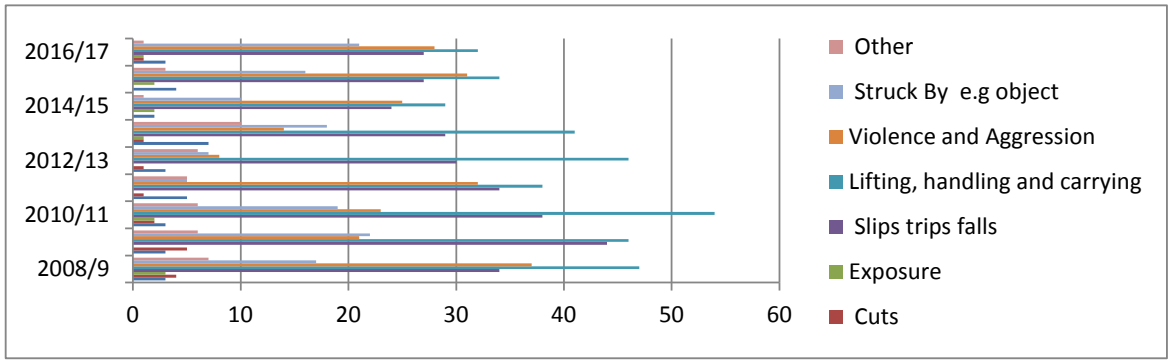


Table 13

	Sharps	Cuts	Exposure	Slips trips falls	Lifting, handling and carrying	Violence and Aggression	Struck By e.g object	Other	Total
08/09	3	4	3	34	47	37	17	7	152
09/10	3	5	0	44	46	21	22	6	147
10/11	3	2	2	38	54	23	19	6	147
11/12	5	1	0	34	38	32	5	5	120
12/13	3	1	0	30	46	8	7	6	101
13/14	7	1	1	29	41	14	18	10	121
14/15	2	0	2	24	29	25	10	1	93
15/16	4	0	2	27	34	31	16	3	117
16/17	3	1	1	27	32	28	23	1	116
Totals	33	15	11	287	367	219	135	45	1114

RIDDOR EVENTS by Clinical Board 2015/16 & 2016/17

Table 14

	Accidents/Falls		Violence and Aggression		Total	
	15/16	**16/17**	**15/16**	**16/17**	**15/16**	**16/17**
Mental Health	11	**6**	16	**15**	27	**21**
Surgical Services	12	**12**	4	**2**	16	**14**
Capital, Estates & Facilities	27	**25**	2	**1**	29	**26**
Specialist Services	10	**15**	4	**1**	14	**16**
Medicine Services	9	**15**	4	**7**	13	**22**
Children and Women's	4	**5**	1	**1**	5	**6**
Clinical Diag and Therapies	5	**2**	0	**0**	5	**2**
PCIC	3	**5**	0	**0**	3	**5**
Executive and Corporate Services	4	**2**	0	**1**	4	**3**
Dental Services	1	**1**	0	**0**	1	**1**

21.2

Total	82	**88**	30	**28**	117	**116**

Table 14 relates to RIDDOR events by Clinical Board and category. Medicine Clinical Board shows a notable increase over the period, both in relation to accidents and violence and aggression, whilst Mental Health Clinical Board has seen a significant reduction in the number of non violence RIDDOR events.

1.5.2 ALL STAFF INCIDENTS
Staff Incidents by Clinical Board

Incidents by Incident date and Category **Table 15**

	Staff injury inc needle stick	Cuts	Exposure to Unsafe Environ/Unhygienic/ Substances	Slips, trips and falls	Lifting, handling	Contact/entrapment /Struck By eg object	Contact with potential infectious material	Other	Work related ill health	Workplace stressor demands	VA - Assault	VA - Verbal V and A	Behavioural other /property	Total
10/11	398	41	153	300	469	281	5	64	17	0	1066	1480		4297
11/12	324	62	152	251	341	219	10	67	53	0	878	1558		3929
12/13	445	63	135	261	351	197	7	99	18	0	864	1454		3907
13/14	413	52	116	212	361	207	11	115	15	0	881	1729		4137
14/15	311	44	102	197	266	185	11	101	13	0	1062	1581		3891
15/16	298	NA	255	198	211	246	0	85	0	196	951	839		3279
16/17	258	NA	293	216	229	226	61	54	0	241	935	903	121	3537

Chart 4

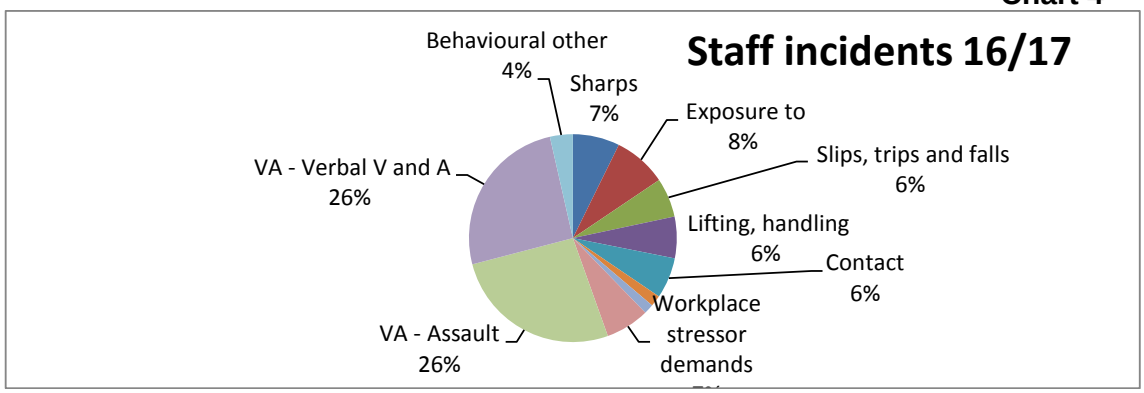


Chart 4 identifies that 56% of all reported staff incidents are violence and aggression/behavioral, 7% are sharps injuries and 7% are workplace stressor. Staff Incidents are catagorised into 4 classes as shown in Table 16.

Table 16

Staff Incident by Tier 1 Category	
Accidents/Falls	1031
Behaviour (Including Violence and Aggression)	1900
Exposure to Environmental Hazards	534
Property	72

21.2

Total	3537

ACCIDENTS/FALL BY CLINICAL BOARD AND CATEGORY TABLE 17

Staff accident by clinical board	&Facilities Capital, Estates	Children & Women's	CD&T	Dental Services	Executive	Medicine	Mental Health	PCIC	Specialist	Surgical	No value	Total
Contact with Sharps	11	21	42	48	2	30	12	9	30	46	7	258
Lifting/Manual handling	28	18	15	3	6	31	32	14	42	33	7	229
Slip/Trip or Fall	36	26	20	10	12	28	19	13	21	24	7	216
Contact/Collision with Objects	66	16	20	5	7	21	13	5	28	24	7	212
Contact with Infectious Materials	1	6	7	0	0	9	0	0	18	13	7	61
Other	8	2	2	5	0	5	1	7	5	4	2	41
Entrapment	6	2	0	0	0	1	0	0	2	3	0	14
Total	156	91	106	71	27	125	77	48	146	147	37	1031

Behaviour (Including Violence and Aggression) Table 18

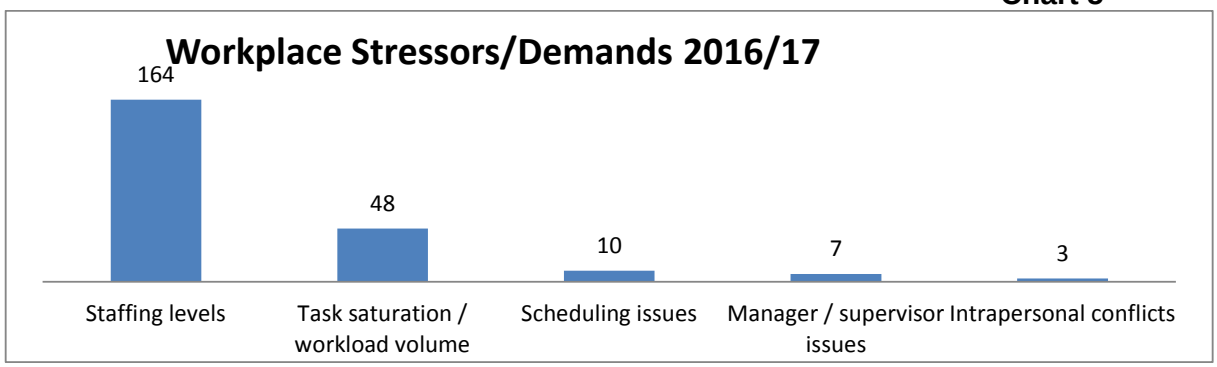
Staff accident by clinical board	&Facilities Capital, Estates	Children & Women's	CD&T	Dental Services	Executive	Medicine	Mental Health	PCIC	Specialist	Surgical	No value	Total
Inapp/Aggressive Behaviour towards Staff by a Patient	45	45	48	16	94	344	701	48	112	72	37	1562
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	4	37	11	0	6	44	25	18	16	14	4	179
Inappropriate/Aggressive Behaviour towards Staff by Staff	5	10	5	2	1	22	5	4	6	26	11	97
Other	1	0	6	1	3	8	9	9	3	11	3	54
Persons Performing Unauthorised Acts	0	0	1	0	0	1	1	2	0	1	1	7
Use/Possession of Prohibited/Stolen Goods	0	0	0	0	0	0	1	0	0	0	0	1
Grand Total	**55**	**92**	**71**	**19**	**104**	**419**	**742**	**81**	**137**	**124**	**56**	**1900**
From Above Staff V&A												
Physical contact (actual assault)	28	13	15	3	60	212	447	12	79	45	21	935
Verbal Abuse	10	57	35	10	28	118	97	41	33	46	11	487
Physical threat (no contact)	10	6	2	0	6	39	131	8	6	8	8	224
Psychological abuse (bullying and harassment)	2	15	8	4	2	16	33	5	9	10	7	111
Sexual (including harassment and indecent exposure)	2	0	2	0	2	12	12	3	3	1	0	37
Verbal abuse with racial content	2	1	0	0	1	10	6	0	3	1	1	25
Verbal abuse with gender content	0	0	1	0	1	2	4	0	1	1	3	13
Verbal abuse with disability	0	0	1	1	1	1	1	1	0	0	0	6

content												
Total Staff V&A	**54**	**92**	**64**	**18**	**101**	**401**	**731**	**70**	**134**	**112**	**51**	**1838**

Exposure to Environmental Hazards **Table 19**

Tier 3	Exposure to Hazardous Substances	Exposure to Unhygienic Environmental Conditions	Exposure to Unsafe Environmental Conditions	Workplace Stressors/Demands	Total
Staffing levels	0	0	0	164	164
Task saturation / workload volume	0	0	0	48	48
Chemical agent	37	0	0	0	37
Incorrectly disposed medical sharps (non needle)	0	0	30	0	30
Incorrectly disposed needle	0	0	25	0	25
Blood or body fluids	19	0	0	0	19
Heat	0	0	17	0	17
Floors/walls	0	16	0	0	16
Machinery/equipment	0	0	16	0	16
Infectious agent	0	0	15	0	15
Unhygienic furnishings	0	14	0	0	14
Buildings infrastructure (walls, floors)	0	0	12	0	12
Materials (e.g. asbestos)	11	0	0	0	11
Biological agent	10	0	0	0	10
Scheduling issues	0	0	0	10	10
Others	3	13	55	19	90
Total	80	43	170	241	534

Chart 5



The total number of incidents reported during the fiscal year was 3537. This is 258 more incidents than the previous year however includes 126 behaviour or property incidents reported. Most notable increase relates to workplace stressors/demands and increase of 23% to 241which as shown chart 5 mainly relate to staffing levels or workload, in addition to this there was a further 517 insufficient professional or support staff events reported as organisational incidents.

1.5.3 PATIENT HEALTH AND SAFETY INCIDENTS

Patient Slips, Trips and Falls

The Patient Falls Strategy is led by the Director of Therapies and Health Sciences. Health and safety and particularly manual handling work in close liaison and sit on a number of joint working groups including the Safe Guarding Adults Group and support falls reduction approaches.

Detailed below are those events classified as patient health and safety incidents. A total of 5341 events were reported during the year, 66% of these events related to witnessed or un-witnessed slips, trips or falls, including faints.

Chart 6

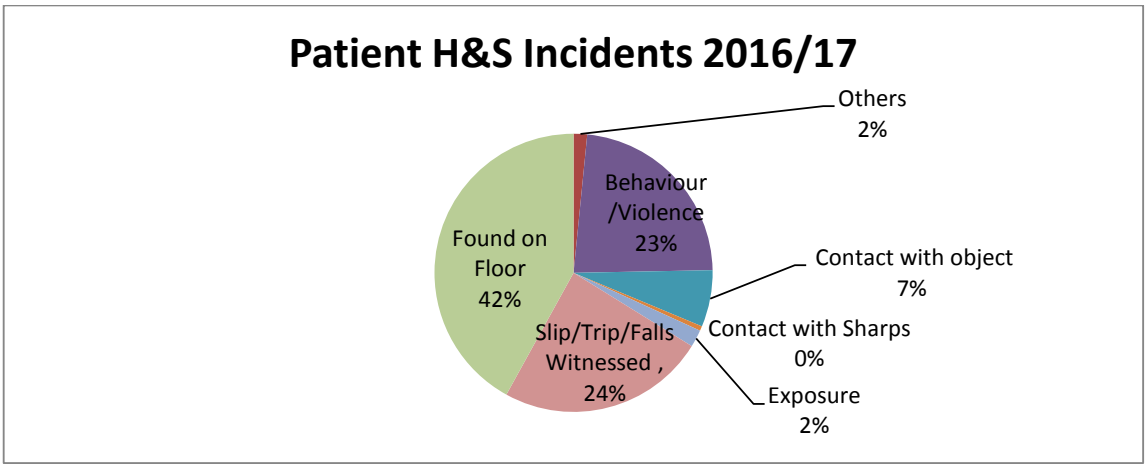


Table 20 demonstrates a 4.5% increase in the total number of events which were previously classified as patient health and safety events, however the new e-datix incident reporting system has revised categories and these classifications are chosen by the reporting member of staff.

Most significant is a continued increased in behavior reports of 28.4% to 1235 which is notable given that there was no decrease in the number of staff violence events which therefore cannot be considered as staff generalizing on its violence incidents.

Table 20

	2012- 13	2013/14	2014/15	2015/16	2016/17
Patient Incidents by Category	**Category**				
Others (inc injury form unknown origin)		**78**	**74**	**109**	**84**
Infrastructure Problems		**14**	**21**	**111**	
Behaviour/Violence	**510**	**461**	**588**	**962**	**1235**
Collision/ Entrapment/ Contact with object	**402**	**312**	**337**	**290**	**352**
Contact with Sharps	**37**	**17**	**18**	**31**	**29**
Exposure	**49**	**33**	**27**	**84**	**107**
Slip/Trip/Falls Witnessed , (inc Faints)	**2128**	**1899**	**1723**	**1276**	**1292**
Found on Floor (Unwitnessed inc Faints)	**2566**	**1921**	**1565**	**2248**	**2242**
Totals:	**5692**	**4735**	**4353**	**5111**	**5341**

Chart 7

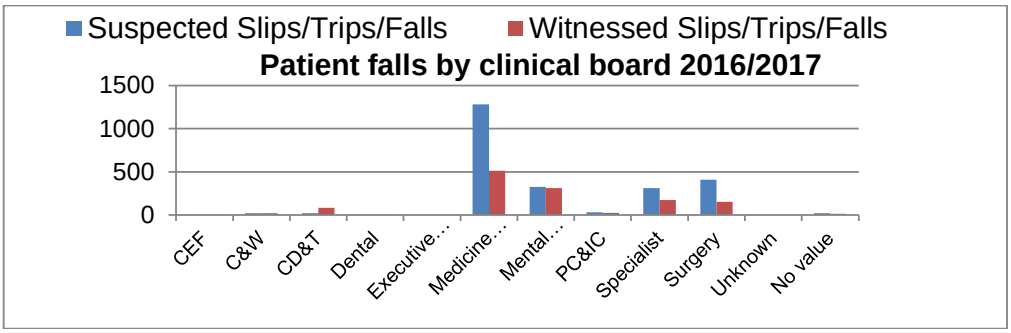
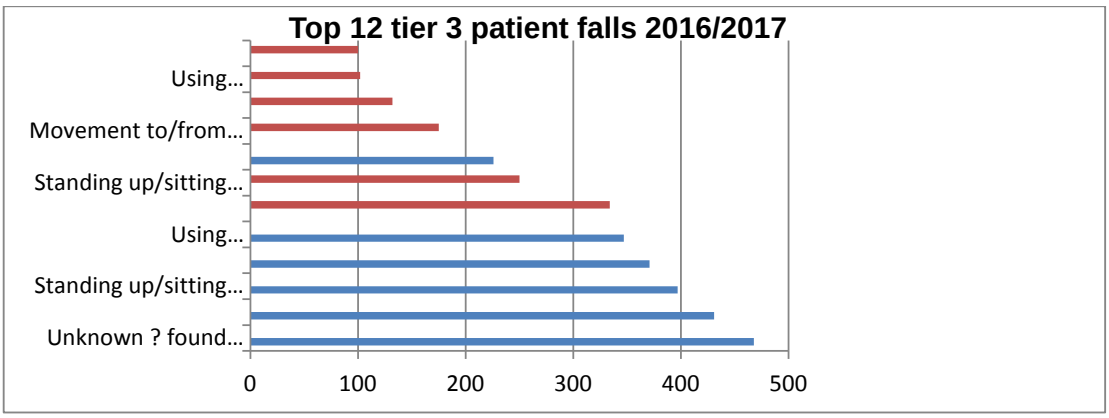


Chart 8



1.6 HEALTH AND SAFETY TRAINING

The Health Board aims to achieve 85% training compliance, this is considered an achievable target when reflecting on long-term sickness, staff turnover and maternity leave.

Is 85% training compliance achievable?
All stats have been rounded up and do not include Strategies and Interventions for Managing Aggression (SIMA) training delivered by the Mental Health team.

Manual handling training – 5 part time Trainers = 105 hours per week x 52 weeks per year = 5460 hours. 5460-A/L & BH (90 hours x 5 Trainers = 450) = 5010 training hours per year (668 days).

The Training Needs Analysis (TNA) identifies that 3809 staff require patient handling per annum. With an 11% staff turnover rate we can estimate that 419 staff would require the 2 day foundation and 3390 staff would require the 1 day update, therefore 4228 training days are required.

The TNA also identifies that 2165 staff require inanimate training per annum. As both the foundation and update are ½ day in duration this equates to 1083 days per annum required.

To summarise – 668 training days x 8 spaces per Trainer = 5344 are available each year with a demand of 5311 training spaces required. Therefore we would be able to meet 100% compliance (101%) if all spaces offered were effectively utilised. With training currently not utilised at full capacity, this allows us to provide income generation training. Module A is completed as e-learning.

S.I.M.A. (Violence & Aggression) training – 3 part time Trainers = 60 hours per week x 52 weeks per year = 3120 hours. 3120 A/L & BH (90 hours x 3 Trainers = 270) = 2850 training hours per year (380 days).

The TNA identifies that 203 EU/Security staff require a 2 day course annually. 688 staff requires Care Control level training per annum and with an 11% staff turnover rate we can estimate that 76 staff would require the 2 day course and 612 staff would require the 1 day update therefore 967 training days are required.

The TNA also identifies that 2824 staff require Module B&C training per annum. With an 11% staff turnover rate we can estimate that 311 staff would require the 1 day B&C and 2513 staff would require the 1/2 day Module C update therefore 1568 training days are required.

To summarise – 380 training days x 8 spaces per Trainer = 3040 are available each year with a demand of 2535 training spaces required. Therefore we would be able to meet 100% compliance (120%) if all spaces offered were effectively utilised. With training currently not utilised at full capacity, this allows us to provide income generation training and to supplement the violence and aggression training. Please note that the above calculations do not include temporary staff (Nurse Bank), volunteers or candidates from the Work Ready Programme. Modules A&B are completed as e-learning.

The Health and Safety training department has updated the TNA in 2017 to reflect the new Clinical Board layout.

The S.I.M.A. course for staff working in paediatric areas has been running since July 2014 and even though feedback on the content has been positive, attendance levels remain low. The Senior Trainer has met with the Quality and Safety Group within Paediatrics to promote this training. Modules A&B are now completed via e-learning (instead of the separate ½ day course).

Modules A&B are now completed via e-learning and are being discussed for all staff in the Health Board (in line with other UHB's in Wales). This would mean all staff at risk of physical assault or those required to use safe holding (restraint) techniques would continue to attend their classroom based training, however those staff only at risk of verbal abuse would not need to attend any classroom training and e-learning would be sufficient. This has resulted in additional practical courses being offered instead.

Refresher courses continue to be popular as now staff only need to attend a refresher course which is half the duration of the foundation course rather than

repeating the whole course every year e.g. 1 day refresher course for the 2 day Care Control/Older Peoples course and a ½ day refresher course for module C for the 1 day B&C course. All manual handling foundation courses continue to be accredited with Agored Cymru.

The Health and Safety Trainers have been training alongside the Mental Health S.I.M.A. Trainers to deliver the EU/Security Module D courses. These commenced in January 2016 (with 1 course of 15 places offered every month) and the feedback on training has been very positive however several courses have been cancelled due to Trainers and staff attending not being available (due to sickness, department demands and so on).

Specialist courses for manual handling continue and this offers areas such as Dental or Theatres to focus on specific equipment and techniques commonly used. The ½ day Out-patients update courses are not only shorter in duration, but allow staff to only practice techniques relevant to their areas. We have delivered several of these courses in various departments and feedback from these are all positive, however attendance on the courses planned for individuals to book on in the training unit have been poor and several have been cancelled.

As well as delivering training to staff working within the Health Board, the Training Department has increased its training arrangement with local Universities and has continued to train a local NHS Trust. This is beneficial because many students then going on to seek employment within NHS organisations and the additional income ensures that the training team are in post and are able to offer the number of spaces for Health Board staff to meet the TNA.

The new Health and Safety Training Unit in Llandough Hospital has proved a success with the venue being fit for purpose and increasing our presence on the Llandough site.

As of October 2016, the management of the Trainers has transferred to a different member of staff within the Department as the Senior Trainer's Union facility time has increased. Senior staff within the department are working together to try and address this loss within the team.

The health and safety department have been looking into ways of increasing training compliance and during this year, presented a paper to the Operational Health and Safety Group to approve charging Clinical Boards for staff who do not attend training (with no notice). It was suggested by the group that higher penalties should be considered as well as other avenues to explore. This work is ongoing and another paper will be taken to the group.

The health and safety department are in the process of devising a health and safety training course for managers. The need for this has been acknowledged and it is anticipated to have this in place by July 2017.

1.6.1 FIRST AID AT WORK COURSE

Table 21

Month	Places	Places	Attended	FTA	Pass

	Offered	Booked			
3 Day FAW Totals	48	48	45	3	100%
2 Day Requalification	38	20	17	3	100%
Total	86	68	62	3	100%

Table 21 demonstrates a 79% up take of booked places with 6 failures to attend, this is considered to be related to imposing a cost for non attendance without justification.

1.6.2 RISK ASSESSMENT/WORKING SAFELY IN THE NHS

These courses are offered to all managers and staff who undertake risk assessments. The course is carried out by the health and safety team and covers topics such as the general health and safety risk assessment process, manual handling, COSHH, violence and aggression and personal safety which includes lone worker.

Table 22

No of Course	Places Offered	Places Booked	Number of Attendees	FTA	Withdrawn
Total 6 delivered	160	143	120	23	22

1.6.3 MANUAL HANDLING TRAINING STATISTICS

Manual Handling Training Trend Statistics April 2014 – March 2017 **Table 23**

Annual Total	Spaces Offered	Spaces Booked	Spaces attended	% of spaces booked that attended
2014/15	4600	3796	2385	63%
2015/16	4293	3857	2591	67%
2016/17	**4059**	**3670**	**2315**	**63%**

Table 23 shows that the number of spaces offered were 234 lower than previous years, this was mainly as a result of the relocation of training rooms to Llandough Hospital and reduced availability of training staff due to 1 employee taking up safety representative duties and a member of staff on long term sickness . It also shows that 37% of staff that booked onto the courses failed to attend.

Table 24

			Overall			**2015/16**	Patient Handling		Object Handling		E learning	
By Clinical Board	Staff in Post	TNA	Annual Comp Need	No Trnd	% Compliance	% Comp Variance 15/16	Nos trnd	% traind	No's traind	% trg	No's trg	% Trg
Capital, Estates &	1310	1466	987.	297	**30%**	-13%	13	**63%**	53	**11%**	231	**47%**

21.2

Facilities												
Children & Women	2029	1905	1534	612	**40%**	14%	133	**26%**	80	**24%**	387	**61%**
CD&T	2277	2049	1448	1145	**79%**	21%	259	**77%**	206	**54%**	647	**95%**
Dental	557	621	443	275	**62%**	13%	43	**32%**	14	**14%**	216	**104%**
Corp/Executive Services	224	174	101	149	**100%**	94%	33	**213%**	21	**131%**	95	**169%**
Finance	103	85	30	18	**59%**	N/a	0	**100%**	0	**0%**	18	**64%**
Medical	107	79	53	31	**58%**	N/a	6	**38%**	4	**36%**	21	**80%**
Medicine	1832	1751	1302	640	**49%**	1%	315	**52%**	10	**9%**	315	**54%**
Mental Health	1383	1335	1025	386	**38%**	15%	135	**39%**	27	**16%**	209	**47%**
Nursing	104	101	60	18	**30%**	N/a	0	**0%**	2	**9%**	16	**48%**
Primary, Com Int Care	852	1268	952	279	**29%**	-20%	106	**24%**	8	**12%**	160	**38%**
Public Health	78	66	46	19	**41%**	N/a	0	**100%**	5	**21%**	12	**55%**
Specialist Services	1769	1719	1305	724	**55%**	1%	310	**59%**	34	**24%**	344	**60%**
Surgical Services	2017	1887	1465	641	**44%**	3%	283	**46%**	48	**28%**	285	**45%**
Workforce & OD	144	134	99	23	**23%**	N/a	0	**0%**	2	**5%**	21	**47%**
Grand Total	**14776**	**14640**	**10853**	**5257**	**48%**	**5%**	**1636**	**46%**	**514**	**25%**	**2977**	**61%**

Table 24 demonstrates that overall compliance has improved by 5% over the previous year, this however is mainly related to higher numbers undertaking the module A e-learning course for those who have no significant manual handling role**.**

It also shows some very low compliance within a number of the Clinical Boards both in terms of patient and object handling.

1.6.4 VIOLENCE AND AGGRESSION TRAINING STATISTICS

Violence and Aggression Training Trend Statistics April 2015 – March 2016

Table 25

Annual Total	Spaces Offered	Spaces Booked	Spaces attended	% of spaces booked that attended
2013/14	1920	1517	891	59%
2014/15	2615	1806	1120	62%
2015/16	2216	1527	948	62%
2016/17	**1787**	**1483**	**701**	**47%**

Table 26

		Overall		**+/- 15/16**	**Module D &C+**		**Module B & C**		**Module A**	
By Division	Staff in Post	TNA	Annual Comp Need	No Trnd	% Comp liance	% Comp Vary 15/16	Nos trnd	% traind	No's traind	% trg	No's trg	% Trg

21.2

Capital, Estates & Facilities	1310	1466	673	318	**47%**	-26%	4	**7%**	63	**49%**	251	**51%**
Children & Women	2029	1905	1428	762	**53%**	35%	32	**78%**	349	**74%**	379	**60%**
Clinical Diagnostics & Ther	2277	2049	1173	1323	**113%**	43%	19	**53%**	596	**131%**	708	**104%**
Dental	557	621	385	391	**100%**	0%	0	**100%**	171	**103%**	215	**104%**
Medicine	1832	1751	1302	694	**53%**	2%	102	**52%**	272	**93%**	320	**55%**
Mental Health	1383	1335	1361	778	**57%**	12%	351	**54%**	228	**88%**	209	**47%**
Primary, Com Int Care	852	1268	983	373	**38%**	16%	0	**100%**	189	**33%**	178	**42%**
Specialist Services	1769	1719	1203	848	**70%**	46%	59	**24%**	367	**96%**	422	**74%**
Surgical Services	2017	1887	1174	568	**48%**	39%	10	**13%**	246	**53%**	312	**50%**
Overall Grand Total	**14776**	**14640**	**10023**	**6438**	**64%**	**24%**	**657**	**42%**	**2600**	**73%**	**3181**	**65%**

The percentage compliance for violence and aggression training significantly improved to 65% overall, although Level D training for Mental Health dropped, this mainly relates to the transfer of staff and patients to its new location. This meant a halt to training of a 2 - 3 month period.

2.0 VIOLENCE AND AGGRESSION MANAGEMENT

Violence and aggression continues to be one of the most significant risks to staff within Cardiff and Vale. The Health and Safety Committee receives regular reports on progress made in tackling violence and aggression within the Health Board.

The Department has approached this progress from 5 key elements:

- Review of Incident Data
- Personal Safety
- Violence and Aggression Training
- Case Management (Victim Support)
- Lone Worker

2.1 VIOLENCE AND AGGRESSION INCIDENT STATISTICAL DATA

Chart 9

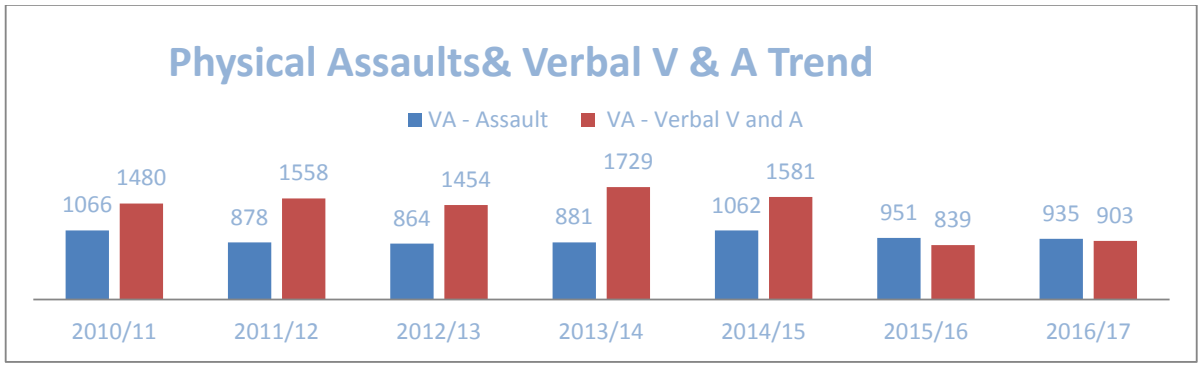


Table 27

	2012- 13	2013/14	2014/15	2015/16	2016/17
Patient Behavior/Violence Incident	**510**	**461**	**588**	**962**	**1235**

Overall the statistical data illustrated in Chart 9 identifies that there has been no significant trend change over the period. However patient incidents reported by

staff of behavior and violence has increased significantly over the period by over 28% from 962 to 1235 and since 2014/15 has more than doubled from the then 588.

2.2 VIOLENT WARNING MARKERS

In 2013/14 the Violent Warning Marker Procedure was developed and implemented within Cardiff and Vale on both the Paris and PMS electronic patient records.

A patient warning marker may be applied in instances of intentional and non intentional violence. It is important to state that the marker is not a mechanism for attributing blame but is a process for alerting staff to the possibility of violence.

A marker does not just apply to circumstances where the individual abusing the staff member is a patient, but may equally apply where the person is the patient's associate – for example their guardian, friend, or relative.

Table 28 details the alerts that have been received by the Case Management Team and actions taken.

Table 28

	Alerts Received	No action	Alerts	Violent markers	Safe Haven Markers	Violent Markers Removed
2014/15	527	136	193	63	32	15
2015/16	465	147	228	74	16	16
2016 -17	220	0	220	107	19	146

Alerts Received – this includes alerts received via PARIS and incident forms.

No action – where attempts to contact staff have been made but no response received.

Alerts –where staff have indicated the only risk is to working in the community.

2.3 CASE MANAGEMENT SERVICE

The function of the Health Board's Case Management Team has been fundamental to the success of reducing violence and aggression within the Health Board. It uses structured case management and support for the victim achieved through early and effective actions.

The service operates in addition to existing support arrangements within the Health Board. Case management is not a clinical or counseling service and must not impede the support relationship offered by local management or formal support services. The team adopts a sympathetic approach to the victim, and operates as a 'listening friend', albeit one who can provide practical advice to both the victim and their manager. Strong emphasis is placed upon the advantages of formal support mechanisms for staff that are experiencing ongoing difficulties.

Case management service continues to support victims following violence either through the criminal system or by internal sanctions and support. During the period the number of Police inventions has reduced. However a review of the Memorandum of Understanding between the NHS, Police and Crown Prosecution Service is being progressed which is considered will enhance the interventions in the coming year.

2.4 COMMUNICATION

Numerous means of communication have been utilized to promote the service and personal safety awareness including, seminars, meeting attendance, promotional stands, posters, press releases and also social media.

Communication links with Primary Care have strengthened during the period and processes devised to enable information sharing between the Health Board and Primary Care services. Information on violent warning markers placed by the Health Board is shared with GP Surgeries, Health Centres and the Out of Hours Service.

Communication/information sharing with South Wales Police has been problematic during 2016/2017 due to the police not being able to pass police occurrence numbers or weekly reports to the Case Management Team. This has led to a decrease in reported incidents and convictions as shown in table 29. The Case Management Team has requested changes i.e. disclosure to the police to the DATIX form to make information sharing more readily available to the police.

2.4.1 Direct Victim Support

The Team has directly met with numerous victims and continues to provide the essential post incident support. Where necessary this will include accompanying witnesses to court. Many staff incidents reviewed by the team are followed up by both face to face meetings and telephone conversations. The support offered will continue until the victim is satisfied that the team have done all they can to ensure that the most appropriate sanctions have been applied.

2.5 CRIMINAL SANCTIONS

Table 29

Year	No referred to Police	Number of Convictions	Other Sanction ASBO, Internal etc
2009/10	27	17	2
2010/11	118	55	130
2011/12	176	58	121
2012-13	110	48	47
2013 -14	97	49	55
2014-15	132	57	86
2015- 16	171	57	195
2016- 17	93	27	24
Totals	924	368	660

21.2

Table 30 further demonstrates prosecutions and other criminal sanctions applied.

Health Board Successful Outcomes April 2009 to March 2016

Table 30

Year	Cautions	ASBO Referrals	PNC	Convictions	Restraining Orders/Crasbos	Police actions
2009 – 2010	2	0	2	17	0	21
2010 – 2011	5	23	2	55	1	86
2011 – 2012	8	136	6	85	1	306
2012 – 2013	10	29	8	43	2	90
2013 – 2014	15	29	11	49	0	104
2014- 2015	4	68	2	57	1	132
2015- 2016	11	80	7	57	1	171
2016 – 2017	**6**	**9**	**1**	**24**	**0**	**84**
Totals	61	374	39	387	6	994

2.6 LONE WORKING

The lone worker alert system is a discreet communication device. When a 'red alert' is activated a channel is opened to the Alarm Receiving Centre (ARC). Trained operatives listen to the call and determine the appropriate action to take, including the deployment of emergency services if needed. In addition to this, audio evidence can be secured and used in cases that are progressed through the criminal justice system.

It is necessary for the Health Board to have suitable control measures in place to manage these low frequency high risk events as it is to protect against the frequent violent events experienced by our staff.

At the commencement of the fiscal period the Health Board decided to replace the Reliance Lone Worker devices with an updated contract as the existing contract was 5 years old and the devices were obsolete and required upgrading.

Concern was also raised in relation to the poor usage for these devices which was shown to be at around 25% and was considered partly related to the dislike of the current device.

A new lone worker contract was implemented in June 2106 replacing the previous system, the new system has a much improved device and greater flexibility of system.

The devices are issued to those staff in the community that are at risk, unless management has confirmed that suitable alternative mechanisms have been introduced to support staff.

Number of Contracted Devices **Table 31**

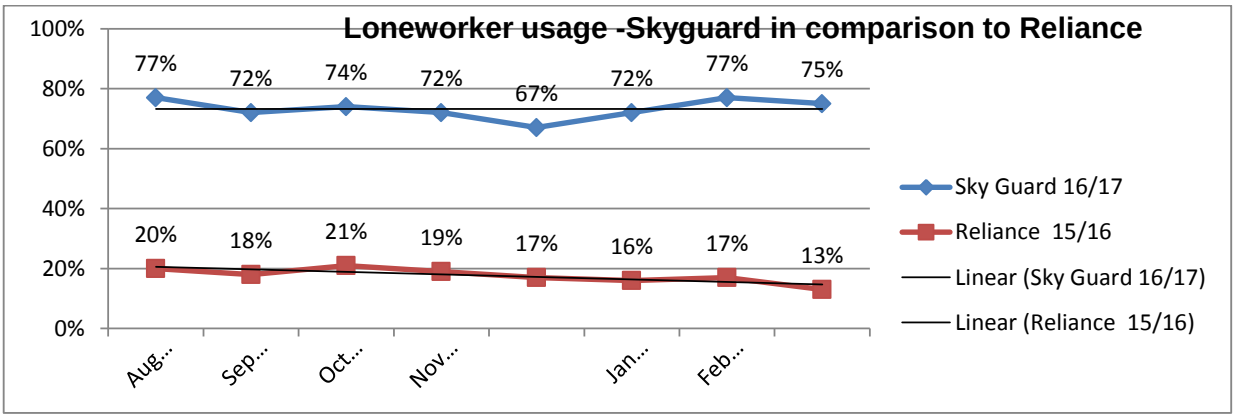
	Nov	Dec	Jan	Feb	Mar
Reliance 15/16	626	604	600	600	600
Skyguard 16/17	457	480	487	576	613

The Clinical Boards currently have 613 Skyguard devices in use, this compares to the 600 devices which were in use prior of the Reliance System (excluding the termination period).

The Health and Safety Committee has asked for reconfirmation that those staff at risk have either a device or suitable alternative arrangements in place.

Percentage Utilisation

Chart 10



The above overall data shows that average utilisation was 73.25% for the 8 month period from 1st August 2016 to the 31st March 2017.

This demonstrates a significant improvement over the previous system and relates to an extremely high level of compliance given the likelihood of non usage due to holidays and term time working and sickness absence.

The system administrator passes details on to each Clinical Board of non usage by name, for local review and remedial action.

The success of the system is resulting in a greater demand from areas to return to using the devices. This cannot be achieved within the current budget. Clinical Boards have been advised that further devices are available if local funding can be found.

The Operational Health and Safety Group continues to monitor usage by Clinical Board and Sub Group.

3.0 MANUAL HANDLING

Chart 11

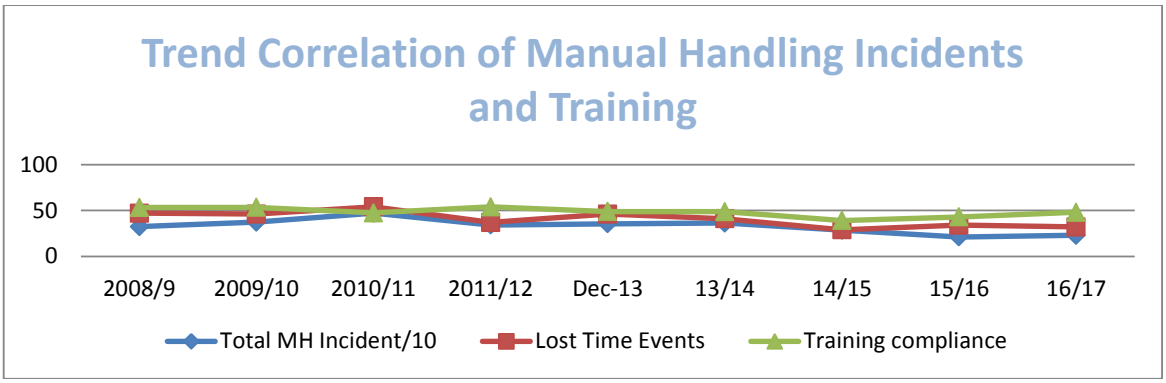


Table 32

	2008/9	2009/10	2010/11	2011/12	12/13	13/14	14/15	15/16	16/17
Total MH Incident/10	32.3	37.3	47.1	34.2	35.4	36.2	28.5	21.1	22.9
Lost Time Events	47	46	54	37	46	41	29	34	32
Training compliance	53.21	53.41	47.37	53.82	48.91	48.68	39	43	48

Chart 11 shows the Health Board's training compliance has improved to 48% over previous years and the total number of manual handling lost time incidents have subsequently reduced, although the total number of related incidents has slightly increased.

3.1 PROVISION OF SUITABLE GLIDE SHEETS

An investment of £24K secured purchase of reusable flat slide sheets following risks identified when using the "paper" style version. The Health Board was able to purchase approximantly*1200* new glide sheets that are a uniquely identifiable colour (bright yellow) within Wales, with the aim to reduce loss especially from Greenvale laundry. These were labeled and distributed to all Cardiff and Vale Health Board sites in June 2016 according to the needs identified in the Pro-Act Audit.

The new sheets have proved to be a far superior product compared to the "paper" style sheets although these may continue to be used in areas of high patient turnover e.g. theatres. The Manual Handling Department has received very positive feedback from staff using the new yellow sheets and no in-patient Datix incidents concerning slide sheets have been reported in this period.

There has been considerable cost saving by purchasing the fabric slide sheets.

3. 2 PROACT AUDIT

A comprehensive audit of patient manual handling equipment was carried out in September 2015 which indicated urgent replacement of patient hoisting equipment

to ensure the Health Board fulfilled its requirement under the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Results from the audit identified 150 passive and 103 active hoists with 117 of these over 10 years old and obsolete making them difficult to repair.

Funding was secured from Welsh Government end of year monies for replacement of 60 hoists (39 passive and 21 active hoists) under a legacy scheme where the old hoist is taken away in “part exchange” and a discount applied. This also saves the Health Board scrappage and battery recycling costs.

Funding was also provided for 10 high specification mechanical shower chairs suitable for wet room areas which reduce the risks for patients and staff when showering.

Distribution of the hoists and a follow up audit are planned for June 2017 to include an update of the current stock of fabric/reusable hoist slings, batteries and chargers.

3. 3 POLICY AND PROCEDURE UPDATE & APPROVAL

The Minimal Manual Handling Policy and Procedure were approved at the Health and Safety Committee in April 2017

The Patient Hoist Sling Inspection Procedure is due for renew but this has been postponed until after the next ProAct audit has been carried out and the range of fabric slings within the organisation can be rationalised. The training for inspecting slings is included as part of the Manual Handling Link Worker Course.

3. 4 CONTINUING PROJECTS

- Hoverjack Training – the Manual Handling Advisers continue to provide ad hoc training to staff in the use of the Hoverjack to ensure the organisation can fulfil the requirements of the National Patient Safety Alert. The product has proved to be most useful in enabling the retrieval of fallen patients in a dignified, comfortable and timely manner that other Hospital sites are considering/have purchased Hoverjacks.
- Specialist Training - the Health Board and Local Authority Manual Handling Advisers provide specialist joint update training for District Nurses and Occupational Therapists in the more appropriate environment of the Local Authority training rooms. The integration of training and approach to manual handling has benefitted the skill levels of those involved and ensured a more joined up approach between the organisations.
- Specialist Advice – the Manual Handling Advisers offer specialist assessment, advice and risk control measures to all areas of the Health Board. Following the results of the health and safety audit they have concentrated on assisting managers on the formal manual handling risk assessment process for areas especially those identified as deficient.
- Joint Working – the Manual Handling Advisers have developed and strengthened links with their colleagues by

- Chairing the All Wales NHS Manual Handling Group.
- Developing assessment tools with Senior OT Managers in Health Board and Local Government.
- Carrying out joint assessments for complex patients.
- Working closely with Medstrom, the organisation's bed management company in training, assessment and feedback in use of their products within the Health Board, identifying suitable products.
- Developing links with Cardiff University looking at training.

- Bariatrics - the Manual Handling Advisers continue to offer a weighing service to ensure patients are within the safe working load of equipment used within the organisation.
- Link Worker – 62 Link Workers have been trained in the period of April 2016/17 by the Manual Handling Advisers and a list of active link workers is being updated. The Link Workers continue to support manual handling in their area by local induction of new staff, assessing fabric slings, audit of manual handling equipment and training frequency assessment of their colleagues. They help fulfil the organisation's duties under Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), Provision and Use of Work Equipment Regulations (PUWER) and Management of Health and Safety at Work Regulations.
- New Practice/Equipment – the Manual Handling Advisers aim to keep themselves updated in new developments in clinical practice, health and safety law/regulations, social care and equipment innovations by attending local and national meetings and exhibitions and close working with fellow NHS and Social Service colleagues.

3.5 ONGOING WORK/FUTURE DEVELOPMENT

- Establish a process for controlled procurement.
- Re undertake the Proact audit to verify progress since 2015
- Implement the revised requirements of the All Wales Passport Scheme

4.0 SHARPS/NEEDLESTICK EVENTS

4.1 INCIDENT STATISTICS

Table 33

Staff Sharps 2016/2017	2015/16	2016/17
Dirty needlestick	185	154
Dirty medical sharps (not needle)	59	54
Dirty non-medical sharps	14	20
Clean medical sharps (not needle)	13	10
Clean needlestick	13	10
Clean non-medical sharps	10	10
Total	294	258

Table 33 above shows that dirty needle stick injuries were 17% lower in the current period from the previous year.

Table 34

Staff Injuries	12/13	13/14	14/15	15/16	16/17

Dirty Sharps	271	270	234	177	169

Chart 12

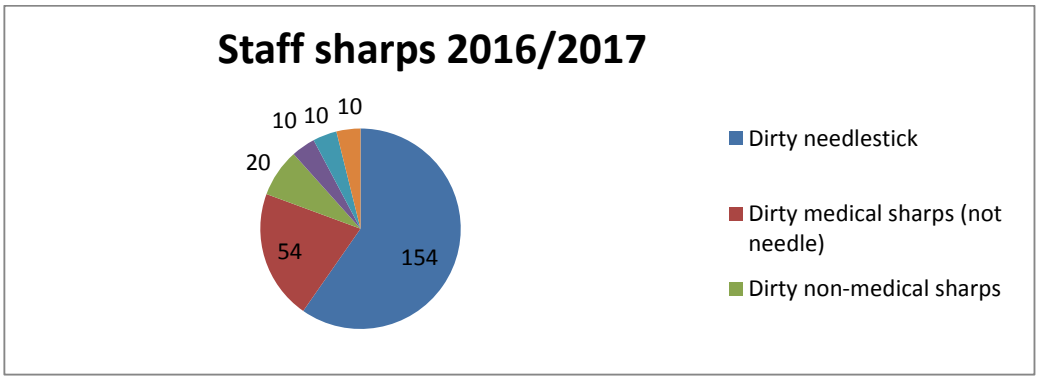


Chart 13

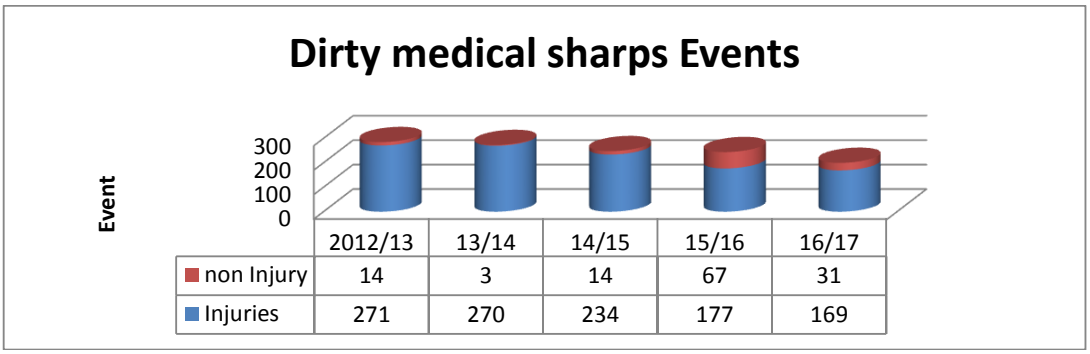


Chart 13 demonstrates that since the introduction of our safer sharps programme in 2012/13, the number of dirty medical sharps injuries has significantly dropped by 37%.

5.0 CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH)

The Health Board is required to complete risk assessments for all hazardous substances in use. This is to ensure sensible steps are taken to prevent ill health. The Health Board uses local COSHH co-ordinators to identify hazardous substances in use. The Alcumus COSHH management database is then used to generate appropriate COSHH assessments for substances. Progress has been made in meeting this requirement, there are currently 3182 identified hazardous substances with 8513 COSHH assessments on the database.

There are approximately 246 COSHH co-ordinators in place across all Clinical Boards, covering 263 areas.

The overall compliance rate has remained fairly stagnant over the past few years and it is therefore recommended that the COSHH compliance rates are taken to each Clinical Board quarterly health and safety meeting where performance is monitored and improved.

Table 35

Clinical Board	No. COSHH Co-ordinators	Approx No. Identified Areas	No. of Areas Compliant/ in date	% Compliance 15/16	% Compliance 16/17	Change since last year
Children and Women	32	32	27	88%	84%	↓
Clinical Diagnostics & Therapies	47	47	32	74%	66%	↓
Dental	2	2	2	100%	100%	↔
Medicine	32	42	24	51%	57%	↑
Mental Health	51	52	40	62%	77%	↑
PCIC	6	6	3	67%	50%	↓
Specialist Services	33	33	20	76%	61%	↓
Surgery	33	39	11	46%	28%	↓
Other (Exec, CEF)	10	10	5	50%	50%	↔
Total	246	263	164	66%	62%	↓

6.0 ENVIRONMENTAL MONITORING APRIL 2016 – MARCH 2017

6.1 MONITORING AND OCCUPATIONAL HYGIENE

The Department has undertaken environmental monitoring surveys and reports to ensure compliance with legislation in areas of high risk or responding to areas of concern raised by Clinical Boards. This includes hazardous substances monitoring, thermal comfort (temperature and humidity), noise surveys, light surveys, room space assessments and flooring slip assessments.

The following formal monitoring reports have been completed for areas of higher risk during the period, a substantial number of informal visits/responses to queries have also been undertaken.

Table 36

Higher Risk Survey Type	Total
Hazardous Substances	16
Temperature /Humidity	8
Noise	2
Lighting	1
Office Environment/Space	2
Total	29

The Environmental Adviser has additionally:

- Co-ordinated Capital/Estates Contractor Control Group and action plan following HSE intervention regarding serious contractor incident.
- Facilitated meetings and action plan with physiotherapy and estates teams regarding HSE intervention on hydrotherapy pools.

- Coordinated responses to HSE following continued intervention with previous lift contractor.

- During this period of intensive intervention by the HSE, environmental monitoring was prioritised based on risk and some items postponed until 2107/18. This item was added to the Health & Safety Priority Action Plan and communicated in the Health and Safety Committee.
- Supported the strategic approach for health and safety by completing Dental Hospital health and safety inspections and assisting with prioritising actions and following up occupational hygiene/environmental related issues.
- Continued to provide general health and safety advisory support for the Dental Clinical Board, Executive Team and Capital, Estates and Facilities Service Board.

6.2 FOOD HYGIENE

During the period there have been a total of 8 Environmental Health Inspections of kitchens or cafés within the Health Board, as can be seen from Table 37 the inspections score attained either the highest level of 5 or 4.

Table 37

Kitchen	Aroma Cafe	SPAR SHOP, UHL	Teddy Bear Nursery	UHW Central FPU	UHL	Llanfair Unit	Rookwood	Y Gegin	Whitchurch	I Jones	West Wing	St Davids	Barry	Average
Score 13/14		N/A	5	N/a	4		4	5	4	4	4	5	5	4.25
14/15		N/A	5	N/a	4	5	4			4		5	4	4.5
15/16	5	N/A	4	(2)(3) 5	5		4	5	5	4		5	5	4.66
16/17	5	5	4	(5) 5	4		5	5	N/A		N/A	5		4.75

6.3 WASTE MANAGEMENT

Overall compliance with the Hazardous Waste Regulations 2005 (Amended 2009) and other waste legislation remained consistently high at 99%. Compliance has improved by 0.68% compared to the previous report presented to the Health and Safety Committee in April 2016.

Of the 5,470 samples taken 45 non conformities (0.8%) were identified against the Environmental Protection (Duty of Care) Regulations (1991) and Hazardous Waste Regulations 2005 (Amended 2009).

March –September compliance per waste stream, **Table 38**

2016 Mar-Aug	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
Total	**100**	**99.9**	**100**	**100**	**99.3**	**99.7**	**97.1**	**97.95**	**98.17**

Compliance Audits relating to September to March is planned to be submitted to the Committee early in the new fiscal year.

7.0 FIRE

A detailed Annual Fire Report will be submitted to Health and Safety Committee in July 2017 as a separate agenda item.

8.0 HEALTH AND SAFETY ESTATES

Progress continues to be made within Capital Planning and Estates with regular reports on compliance and progress in the key areas of:

- Asbestos
- Legionella
- Control of Contractors
- Health and Safety at Work Act
- Electricity at Work

Other statutory/mandatory legislative issues include: medical gases, ventilation, pressure system regulations, COSHH, autoclaves, lifts, energy/environmental management and the current status of compliance for these areas are being assessed and progressed.

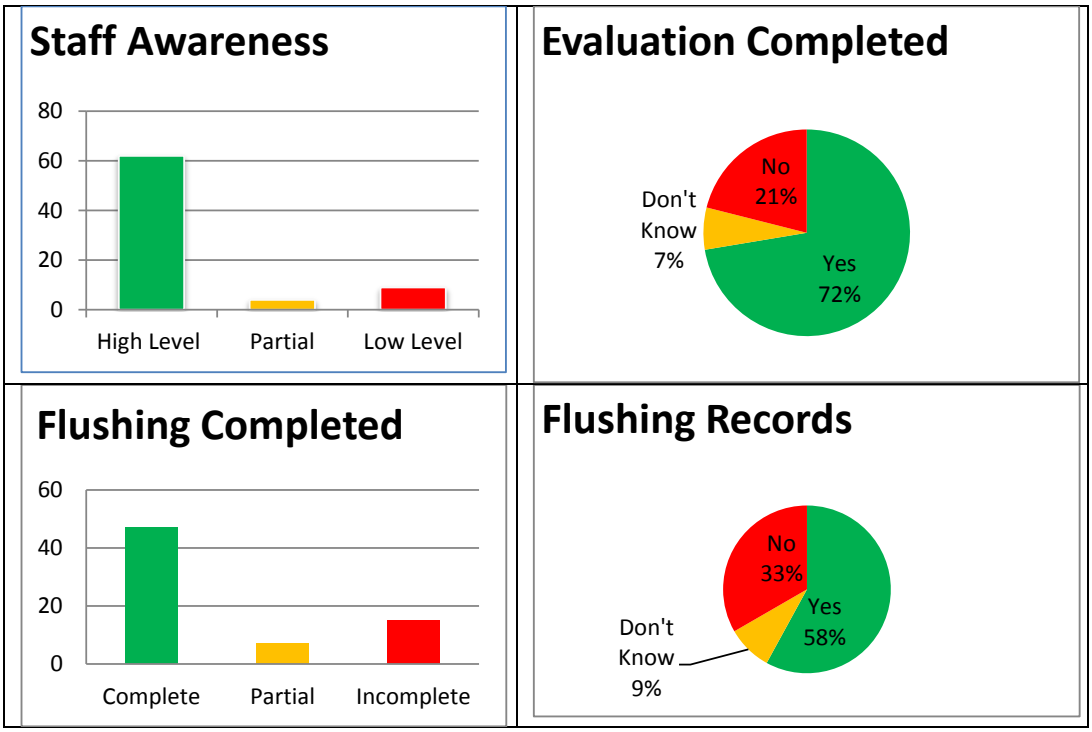
8.1 ESTATES HEALTH AND SAFETY COMPLIANCE

A Compliance and Performance Section is based in the Capital Planning and Estates Management Department. A monthly compliance and performance/safety group is supported by task and finish teams formulated to undertake the strategic elements of statutory compliance.

A Head of Statutory Compliance and Programme Delivery and an Estates Health, Safety and Asbestos Manager have since the Contractor Fall event significantly progressed enhanced contractor control including the introduction of a red & yellow card system of banning/warning contractors.

8.2 WATER SAFETY

Estates play a pivotal role in monitoring the status of Legionella. Intervention during the year by the HSE identified that whilst the Estates Department had undertaken the relevant central role, Clinical Boards were deficient in undertaking the required flushing regime as referenced earlier in the report. The Compliance and Performance Section therefore maintain a database and reports to the Water Safety Group.



Analysis of the Audit completed by the Estates Department shows that whilst staff awareness of the requirements are high, evaluations of which water outlets require flushing and undertaking the flushing is lower. Equally those maintaining records are even lower.

During the 2016/17 period 54 areas were audited with a further 21 undertaken in April 2017, below are the findings.

Please note N/A refers to no Audit undertaken in these Clinical Board areas.

Table 39

	Cap & Fac	C&W	CD&T	Dental	Exe	Med	MH	PCIC	Spec	Surg	Overall
Legionella Awareness	91%	100%	100%	N/A	N/A	100%	68%	70%	100%	100%	83%
Legionella evaluation	91%	100%	100%	N/A	N/A	100%	68%	50%	50%	100%	72%
Water flushing	82%	100%	100%	N/A	N/A	100%	33%	43%	25%	100%	68%
Water flushing records	91%	100%	100%	N/A	N/A	100%	22%	20%	25%	100%	58%

SUMMARY BENCHMARKING

Although no benchmarks have been agreed with the exception to those within the Priority Action Plan, the following table is a summary of some of the key measurable health and safety report findings.

These could be considered as the format for the assurance reports to be submitted to the Health and Safety Committee as Service/Clinical Boards attend the meeting as part of its work plan.

It is recognised that the summary contains no data relating to fire; however this could be adopted from information within the Annual Fire Report such as Fire Training Compliance and status of Fire Risk Assessment Actions.

Table 40

Strategic Priority Area		Capital, Estates and Facilities	Children and Women	Clinical Diagnostics Therapeutic	Dental	Executive Corporate	Medicine	Mental Health	Community Intermediate care	Specialist	Surgical	Overall
1 Management	Frequency of CB Health and Safety Meeting	4	4	4	4	N/a	1	3	4	4	4	3.55
1 Management	Frequency of CB Rep at Op Health and Safety Group (4)	3	3	1	2	4	0	3	1	2	4	2.3
1 Management	RIDDOR Variance	1	1	-3	0	0	9	-5	2	2	-2	-1
1 Management	Staff Incident Variance	-20	18	27	25	44	59	9	-9	58	58	+200
1 Management	Healthcare Standard Status	3	3	3	3	n/a	3	3	3	3	3	3
2 V&A	V&A Training Compliance	47%	53%	100%	100%	100%	20%	53%	38%	70%	48%	64%
2 V&A	V&A Training Improvement 16/17	-26%	35%	43%	0%	55%	2%	12 %	16 %	46 %	39 %	24%
2 V&A	Lone Worker Utilisation	N/A	75%	66%	N/A	100%	92%	57%	76%	77%	N/A	73%
3 Man H	MH Training Compliance	30%	40%	79%	62%	100%	49%	38%	29%	55%	44%	48%
3 Man H	MH Training Improvement	-13%	14%	21%	13%	94%	1%	15%	-20%	1%	3%	5%
3 Man H	MH Incident Variance	-5	2	1	3	0	-9	20	-2	10	-1	19
4 Health	Legionella Awareness	91%	100%	100%	100%	100%	100%	68%	70%	100%	100%	83%
4 Health	Legionella evaluation	91%	100%	100%	100%	100%	100%	68%	50%	50%	100%	72%
4 Health	Water Flushing	82%	100%	100%	100%	100%	100%	33%	43%	25%	100%	68%
4 Health	Water Flushing Records	91%	100%	100%	100%	100%	100%	22%	20%	25%	100%	58%
4 Health	COSHH Compliance	50%	85%	66%	100%	50%	57%	77%	50%	61%	28%	62%
5 Patient Enviro	Patient Accident (inc falls) improvement	4	-9	24	8	-1	101	-45	9	88	54	273
6 Fire Safety												
8 Sharps	Sharp Injury Variance	2	-11	6	-4	-2	-19	4	-8	-5	-1	3.55

Table 40 allows for performance analysis both by key Priority Area and by Service/ Clinical Board.

CONCLUSION

The Annual Report considers trends in incidents, training and management processes. It demonstrates significant progress in the improvement of staff and patient health and safety risks.

Incident Data collated from the Datix system is showing high level of close out and management involvement (94% of the staff health and safety incidents were closed out and only 6 of nearly 3600 remain as awaiting review).

Whilst the number of RIDDOR events have remained constant there has been a continued increase in the number of patient behavioural incidents which has doubled over the last 2 years and up 28% on the previous period.

The Health Board received its second HSE enforcement action since 2001 relating to compliance to Legionella requirement. An action plan was put in place and the Enforcement Notice was subsequently revoked by the Inspectors.

The HSE were also active in visiting the Health Board and applying “Fee for Intervention”. They also continue to pursue the investigation into the Contractor Fall with no decision if legal action is warranted.

Advice given to the Health and Safety Committee about changes that came into force in February 2016 to the revised health and safety sentences charges meant a significant potential risk of a fine being brought against the Health Board could result in a cost of between 1 to £2million.

The number of Prosecutions and other Police inventions were significantly lower than previous years, however the Health Board is working closely with the Police, Crown Prosecution Service and Shared Services Legal to improve the Memorandum of Understanding between all parties.

Training compliance for both manual handling and violence and aggression has improved, although this mostly relates to e-learning module A and not tutor led training.

Although training has improved, it is still not at the target level of compliance overall with some Clinical Boards demonstrating low compliance or poor progress in improving the percentage of their staff trained. This is being pursued by the Mandatory Training Steering Group.

Tutor led training continues to show a very high level of failure to attend on the day this is being considered by the Health and Safety Operational Group.

With the appointment of a new Staff Safety Representative Chair and Deputy the workplace inspection regime was reviewed and enhanced local representative’s involvement.

Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period

It also reports on the improvement in the management of health and safety aspects through the priority action plan and the control of policy schedule, keys areas of progress include:

(1) Acquiring approval from Welsh Government for renewal of £420k of patient hoists for implementation in early 2017/18.
(2) Implemented improved re-usable glide sheets reducing injury risks whilst resulting in a saving.

(3) Introduced new lone worker devices and improved usage from 20% - 74%.
(4) Revised all health and safety policies within their required reviewed period.
(5) Needle stick and sharp incidents were again lower than the previous period justifying the safer sharps devices introduced.

Finally, performance has been summarised into a benchmarking type format, which allows for comparison by area and Clinical Board. This may be helpful in progressing assurance when Clinical Board's Health and Safety performance is considered as part of the Committee's work programme.

21.3

SUBSTANCE MISUSE AREA PLANNING BOARD 2016-17 ANNUAL REPORT
Name of Meeting : Board Meeting **Date of Meeting** 28th September 2017

Executive Lead : Director of Public Health
Author : Head of Partnership Strategy and Commissioning Tel 029 2183 2138
Caring for People, Keeping People Well: This report underpins the Health Boards commitments to "Delivering Outcomes to People that Matter" and to the "Mental Health service priority" within the Health Board's Strategy.
Financial impact £ 2.54m (NHS ring-fenced budget for substance misuse) £3.46m Substance Misuse Revenue Grant Funding
Quality, Safety, Patient Experience impact : Compliance with Welsh Government National Core Standards for Substance Misuse
Health and Care Standard Number … Compliance with Welsh Government National Core Standards for Substance Misuse
CRAF Reference Number 2.5
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by**:**

- The quarterly APB Executive board meetings that include a review of the APB risk register as a standing agenda item.
- An independent Treatment, Therapies and Clinical Governance advisory group to the APB executive board.

The Board is asked to:

- **APPROVE** the Annual Report of the Substance Misuse Area Planning Board

SITUATION

This is the fifth annual report from the Substance Misuse Area Planning Board (APB) since reconstitution of the board structure in 2012.

The Board is asked to acknowledge the primary achievements of the APB over the course of the year, and to note the areas of performance and development where further work is needed

BACKGROUND

The APBs were established by Welsh Government in 2010 as multi-agency partnerships to deliver the national substance misuse strategy at a local level. The boards have responsibility for commissioning and performance managing substance misuse services using revenue and capital grant funding, as well as an expectation that the board will exercise influence across all substance misuse services commissioned by public sector agencies.

The APB for Cardiff and Vale has been chaired by the Executive Director for Public Health, and includes cross-departmental representation from both local authorities, representation from the Third Sector, from South Wales Police and the Police and Crime Commissioner's office, the National Offender Management Service (NOMS) and the National Probation Trust Wales.

During the course of 2016-17 the vice chair of the board and head of the local delivery unit for the probation service assumed the role of interim chair.

The APB is working to a new five year commissioning strategy that was agreed in 2015 and came into operation during the course of 2016-17. Delivery is achieved through an annual business plan.

ASSESSMENT AND ASSURANCE

There have been a number of key achievements through 2016-17 including the following:

- Waiting times improved from a RED to AMBER performance level against the national KPI target.
- National KPI performance is either at, or exceeding, the national target for three out of the remaining four indicators, and is less than 1% away from target for the fourth.
- The assessment service has been designed in 2016-17 and now operates on a walk-in basis
- Aftercare services commissioned in 2013 have contributed to a significant rise in planned case closures.
- The Cardiff Alcohol Treatment Centre continues to deliver a nationally recognized service and is now at the centre of a collaborative research programme between Cardiff and Sheffield universities.

Areas requiring further work include the following

- Waiting times remain below target. An independent review of patient pathways completed in summer 2017 is intended to form the basis of a system-wide service improvement programme to deliver sustainable improvement to waiting times for all services.

Statement of Assurance

The APB has delivered evidence to Welsh Government that demonstrates how all national substance misuse core standards are being achieved across all services. Welsh Government have accepted this submission in full.

The Board is undertaking a full review of its Memorandum of Understanding in 2017-18 that will include membership, structures, terms of reference, risk management, governance and financial risk sharing to be agreed by March 31st 2018.

The APB is supported by an independent clinical governance group that provides assurance to the work programme of the board and which delivers an annual programme of audit against key themes.

21.3

Cardiff & Vale APB

Achieving better substance misuse outcomes

ANNUAL REPORT

2016 - 2017

http://cardiffandvaleapb.org/

@ApbCardiffVale

http://www.facebook.com/pages/Cardiff-and-Vale-APB/

Cardiff and Vale APB Service User Involvement website

http://asfacarduf.org/

FOR ACCESS TO LOCAL SERVICES:

e-das
entry to drug & alcohol services

http://www.e-das.wales.nhs.uk/home

0300 300 7000

Foreword

From the Chair and Vice Chair of the Area Planning Board

We are pleased to jointly present the fifth annual report on behalf of the Cardiff and Vale Substance Misuse Area Planning Board (APB) for the 2016-17 financial year. The year has see some changes in management of the board with Peter Greenhill from the National Probation Service stepping into the role of chair for the second half of the year, and my thanks go to Peter for ensuring the continued high quality delivery of the APB work programme.

There have been significant structural changes in how we deliver substance misuse treatment and support services across Cardiff and the Vale of Glamorgan, and we are proud to have seen that by the end of the year, all access to services shifted to a new operating model that now enables people in need of support to simply walk in to EDAS - our single point of contact - with no appointment necessary. Changes of this nature are critical for the success for an area of service that is so dependent on what is often sporadic and short-lived motivation of individuals to address their support needs, and we have seen the volume of contacts via EDAS nearly double since the new model was introduced.

This year we were able to shift our performance on waiting times from RED in 2015-16 to AMBER in 2017-18. In addition to this the APB continued to maintain performance at a GREEN level against national targets across three other key performance indicators, and only falling short of the target for case closures by less than 1%.

The year commenced with the launch of our new five-year commissioning strategy. We would urge as wide an audience as possible for this document as it sets out a clear vision for the development of our responses to substance misuse going forward. Our commissioning approach has been informed by the Adverse Childhood Experiences (ACEs) work championed by Public Health Wales, and the APB has embraced a more inclusive wellbeing agenda around substance misuse; recognising that a wide range of social issues such as housing, employment, mental wellbeing and our environment can all contribute to the outcomes that substance misuse services and interventions are able to achieve.

Individual services continue to deliver to exceptionally high standards. This was the first year for the new criminal justice treatment service contract that our colleagues in the Police and Crime Commissioner's team developed and implemented. It has been a priority for the APB to ensure that an effective interface between criminal justice services and community services has been established, and is delivering seamless provision to some of our most vulnerable service users. The APB was also successful in introducing Time Credits to all substance misuse services across Cardiff and the Vale – to date service users have earned over 1359 time credits with spend on a wide range of activities including shows at the Millennium Centre, theatre and cinema tickets, family activities, and sports matches.

The board is now looking forward in 2017-18 to a year that will focus on some of our corporate responsibilities as well as supporting the improvement of our NHS substance misuse services. We are reviewing our Memorandum of Understanding that defines the APB structures, membership, terms of reference, governance arrangements and risk management processes. The Commissioning and Finance Group will also be carrying out an exercise during the year that is intended to reschedule our service portfolio according to urgency, and provide increasing assurance with regards to how our resources are allocated. In respect of the NHS services, the APB is committed to helping the service make best use of the available resources to deliver the highest quality clinical treatment and support, whilst enabling service users to move through and out of treatment into aftercare and recovery support in a seamless, structured and supported manner.

I am proud that the APB has achieved so much during my five-year tenure as Chair. The role of Chair will shortly move on, with Peter Greenhill continuing to support the board as Vice Chair. We are confident that under new leadership, the APB will achieve even greater success and the work programme will continue going from strength to strength – improving the lives of our service users, their families, carers and our communities across Cardiff and the Vale.

Dr Sharon Hopkins Executive Director of Public Health (APB Chair)	**Peter Greenhill** Head of Local Delivery Unit National Probation Service (APB Vice Chair and Interim Chair)

Cardiff and Vale APB Members

Name	Organisation	Role / Title
Peter Greenhill (Vice Chair)	National Probation Service Wales	Head of Local Delivery (Cardiff & Vale)
Fiona Kinghorn	Cardiff and Vale UHB	Deputy Director of Public Health
Rachel Evans	Vale of Glamorgan Council	Head of Children and Family Services
Gareth Hopkins	Commissioning Manager	South Wales Police
Mark Brace	Assistant PCC	South Wales Police
Dr Neil Jones (APB Treatment, Therapies & Clinical Governance Group Chair)	Cardiff and Vale UHB	Consultant Psychiatrist
Stephen Jones	South Wales Police	Eastern Division
Sarah Capstick	Cardiff Third Sector Council (C3SC)	Health and Social Care Facilitator
Sheila Hendrickson-Brown	Cardiff Third Sector Council (C3SC)	Chief Executive
Joseph Raey	Cardiff Council	Head of Performance and Partnerships
Stephanie Kendrick-Doyle	Cardiff Council	Community Safety Manager
Debbie Gibbs	Vale of Glamorgan Council	Community Safety Manager
Paula Barnett (APB Commissioning & Finance Group Chair)	Vale of Glamorgan YOS	YOS Manager
Sue Schelewa	Cardiff Council	Adult Social Services
	Officers	
Ben Davies	Cardiff and Vale UHB	APB Project Manager
Conrad Eydmann	Cardiff and Vale UHB	Head of Partnership Strategy & Commissioning
Chris Jones	Cardiff and Vale UHB	APB Systems Information Officer
Hilary Williams	Cardiff Council	APB Accountant

Performance

Overall there has been a marginal decline in Key Performance Indicator (KPI) activity throughout the course of 2016/17 since the previous report was published in 2015/16.

Due to exhaustive back populating of data and ongoing cleansing, information compliance and validity has also noticeably improved across the board; facilitated by the transfer of all existing third sector agencies to the PARIS health care application for performance reporting and case management.

The summary headlines for the year are as follows:

- A 1.7% reduction in the number of clients failing to attend their appointment with a Substance misuse agency as numbers have fallen from 17.8% in 2015/16 to 16.1% in 2016/17.

- The number of clients accessing treatment within 20 working days of referral was 71%; 9% outside of the national target and 2% fewer than recorded in 2015/16.

- In regards to Treatment Outcome Profile (TOPs) which measures client attainment in reducing problematic substance misuse between start, review and exit evaluation, end of year figures highlighted the Board achieved 72.2% (5% in excess of the minimum national benchmark of 67%).

The percentage of clients for which quality of life had improved is 65.7%. Despite a reduction (13.8%) in contrast to figures reported in 2015/16, Cardiff and Vale is still 9% in excess of the national benchmark and in line with attainment reported in other APB areas.

- In 2016/17, 71.2% of clients exited substance misuse services in a planned way albeit onward referred to an additional support service or marked ‘treatment completed’. This is a marked improvement of 3% in comparison to our position last year which was 68.4%. However, despite this encouraging outcome the Board ended the year cumulatively achieving ‘amber’ status; marginally missing out on the national target of 72% by 0.8%.

ALL DATA IS SOURCED FROM THE WELSH NATIONAL DATABASE FOR SUBSTANCE MISUSE (WNDSM)

Analysis

1. Post assessment DNA (Did Not Attend) rates

DNA rates are a good indication of service effectiveness. The Welsh Government has included this as a national Key Performance Indicator, as it is a reasonable assumption that fewer service users will disengage from services that are effectively meeting their needs. Of course, this is not the only reason why service users may disengage from treatment, and we would never expect to completely eliminate DNA rates, but seeing a general downward trend in DNA rates is a good indicator that services are improving, and achieving positive outcomes.

Whilst not the most important consideration for the APB, value for money remains a priority across services, and reducing DNA rates significantly increases value for money, with fewer specialist service appointments going unattended, with the associated consequences of wasted staff time. Therefore, reducing DNA rates improves service efficiency, as well as indicating improved service effectiveness.

The Welsh Government Key Performance Indicator measures the percentage of all case closures that identify DNA as the reason for the case being closed. In rating local performance levels, a recorded level of 30% or more of closures as a result of DNA results in a **RED** rating; a recorded level between 20% and 30% of closures due to DNA results in an **AMBER** rating, and a recorded level below 20% of all closures due to DNA is rated **GREEN**.

This year we have largely been able to sustain a low number of DNA's (16%) despite a concerted effort by the APB to focus on enhancing referral to treatment times and the number of planned treatment closures.

Table 1, and ***figure 1*** demonstrate the **percentages** of all closures that were attributable to DNA for each year from 2008/09 to 2016/17, whilst ***table 2*** and ***figure 2*** illustrate the **numbers** of closures that were attributable to DNA over the same timeframe.

21.3

Table 1: Percentage of Case Closures attributable to DNA: 2008-2017

Locality	2009/10 Percentage	2010/11 Percentage	2011/12 Percentage	2012/13 Percentage	2013/14 Percentage	2014/15 Percentage	2015/16 Percentage	2016/17 Percentage
C&V APB	35.40%	24.58%	35.96%	32.88%	19.81%	23.37%	17.8%	16.1%
Cardiff	37.32%	24.79%	35.81%	34.99%	20.6%	24.67%	18.9%	18%
Vale	30.41%	23.89%	36.46%	25.98%	16.61%	18.62%	13.4%	9.1%

Figure 1: Percentage of Case Closures attributable to DNA (2009-17)

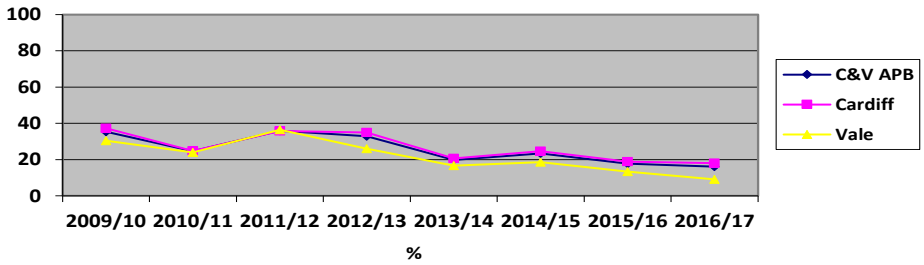
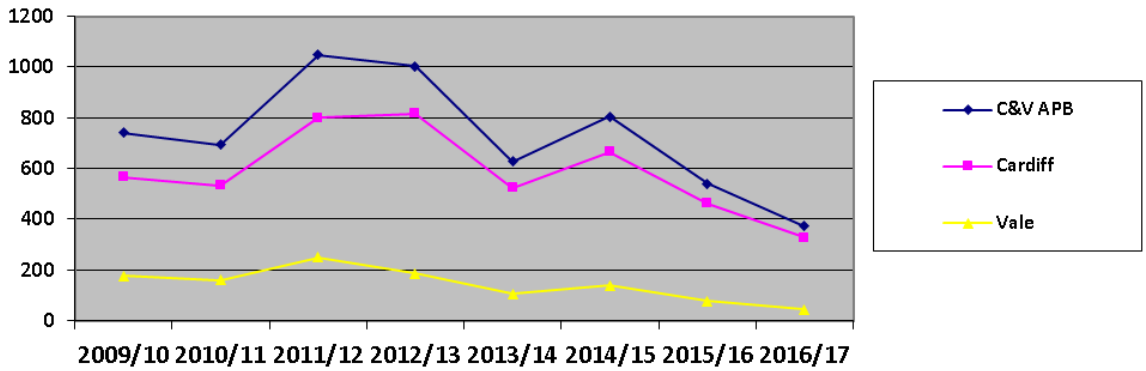


Table 2: Number of Case Closures attributable to DNA (2009-17)

Locality	2009/10 Number	2010/11 Number	2011/12 Number	2012/13 Number	2013/14 Number	2014/15 Number	2015/16 Number	2016/17 Number
C&V APB	742	694	1048	1002	628	804	539	373
Cardiff	565	533	799	817	523	666	462	328
Vale	177	161	249	185	105	138	77	45

Figure 2: Number of Case Closures attributable to DNA (2009-17)



2. Waiting times from referral to treatment

Waiting times are a popular headline indicator of service accessibility across all health services. Substance misuse services have a unique challenge in managing waiting times due to the often fleeting motivation to engage in treatment that service users can demonstrate. If a service isn't available for a several days when a service user expresses an interest to engage in treatment, there is a strong likelihood that by the time the appointment comes around, that motivation to address their substance use has changed. Cardiff and Vale has achieved significant waiting time improvements over the last 5 years, which have seen the average wait, reduce from lengths in excess of 18 months back in 2008/09, to averages of a few weeks. In 2016-17 access to the single assessment service became available on an appointment-free walk-in basis.

The Welsh Government target for waiting times in substance misuse is 20 working days from referral to treatment. When rating local performance levels, the Welsh Government classes less than 70% of service users accessing treatment within the 20 working day target as **RED**, between 70% and 80% of service users accessing treatment within 20 working days is rated **AMBER**, and more than 80% of service users accessing treatment within 20 working days is assessed as **GREEN**. Despite efforts to alleviate lengthy waiting times between referral and assessment in 2016/17, Cardiff and Vale missed out on the national target of 80% by 7.5% subsequently achieving 'amber' status. KPI 2 still remains a continuous area for further development.

Table 3 – Percentage of referrals accessing treatment within 20 working days (2009-17)

Locality	2009/10 Percentage	2010/11 Percentage	2011/12 Percentage	2012/13 Percentage	2013/14 Percentage	2014/15 Percentage	2015/16 Percentage	2016/17 Percentage
C&V APB	**60.17%**	**70.56%**	**68.50%**	**72.08%**	**64.04%**	**62.92%**	**73%**	**71.05%**
Cardiff	**58.63%**	**68.39%**	**66.16%**	**70.89%**	**65.22%**	**62.81%**	**72.8%**	**72%**
Vale	**64.76%**	**76.56%**	**76.73%**	**75.88%**	**59.17%**	**63.382%**	**73.4%**	**67.4%**

Figure 3 – Percentage of referrals accessing treatment within 20 working days (2009-17)

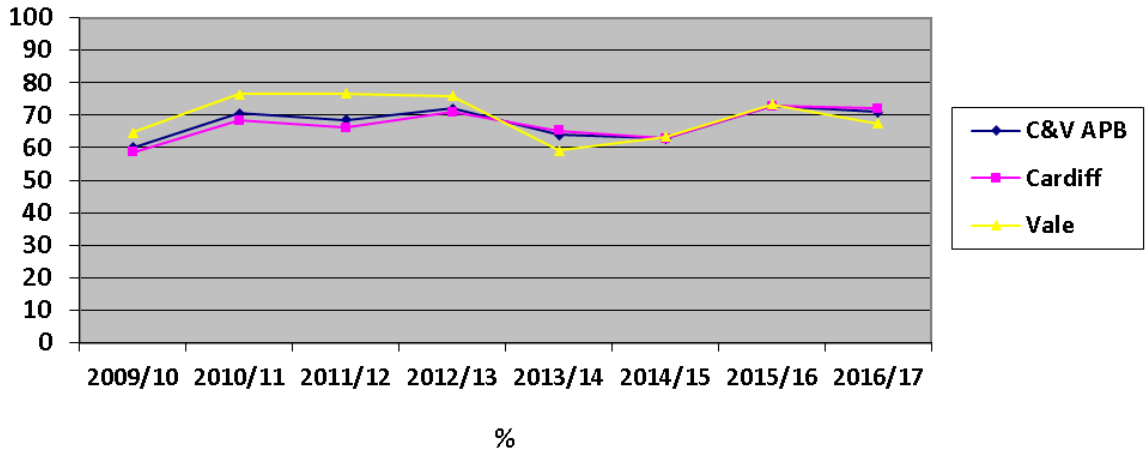
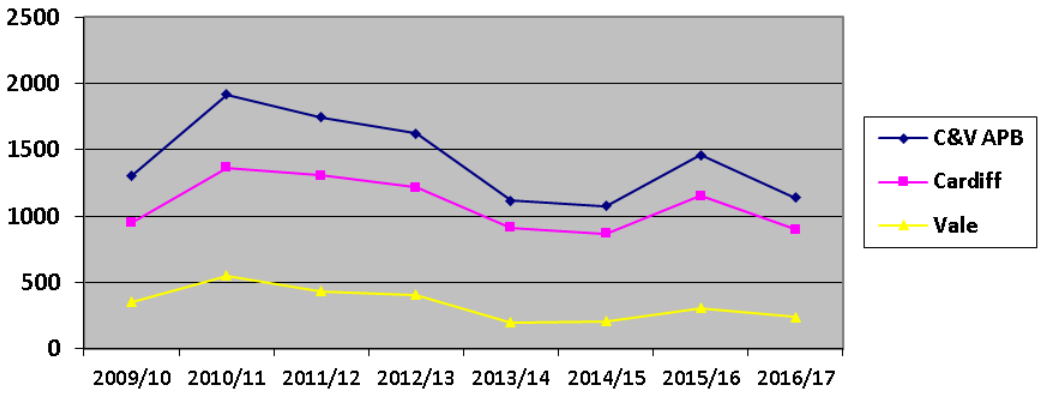


Table 4 – Number of referrals accessing treatment within 20 working days (2009-17)

Locality	2009/10 Number	2010/11 Number	2011/12 Number	2012/13 Number	2013/14 Number	2014/15 Number	2015/16 Number	2016/17 Number
C&V APB	1299	1915	1742	1624	1115	1074	1460	1139
Cardiff	948	1363	1306	1215	915	868	1153	899
Vale	351	552	436	409	200	206	307	240

Figure 4 – Number of referrals accessing treatment within 20 working days (2009-17)



3. Planned case closures (Treatment complete)

Planned case closures rates are one of the best measures of success in substance misuse services. There are a wide range of reasons why an individual's contact with services may end in an unplanned way; however, it remains a goal of the APB to continuously increase the number of service users accessing treatment and support who successfully complete their episode of care in a planned manner. The Welsh Government target for planned closures has recently

been revised. Whereas previously a red performance level would have been the result of a poorer level of performance when compared with the previous year, amber for a static level, and green for an improvement, target percentages have now been set, with a national performance target of 72%. In either case, the Cardiff and Vale performance level scores as **AMBER** for 2016/17 with the final data showing an improvement of 3% in comparison to figures published the previous year and 1% below the All Wales national performance figure. The APB has been working closely with commissioned providers and NWIS to resolve a spate of historic data validation discrepancies which has consequently had a positive surge on performance of the year. Furthermore, the APB has been working closely with Welsh Government and regional APB leads to revisit the classification of service users entering prison or custody to be more appropriately classified as planned discharges if their treatment and care plans follow them seamlessly into that custodial setting.

There will always be a small cohort of clients who will inevitably withdraw from clinical prescribing services – it is a matter of good clinical governance that service users need to come back into service and undergo a clinical assessment if they miss three consecutive collections of their medications. Additional work is planned for 2016-17 to improve re-engagement of service users at risk of having their prescription suspended through the commissioning of a unique re-engagement service which will serve to improve retention for these service users at risk of having their treatment withdrawn.

Table 5 and in ***figure 5*** show the **percentage** of case closures that were planned increased from 68.4% in 2015-16 to 71.2% in 2016-17. ***Table 6*** and ***figure 6*** show that the **number** of case closures that were planned were comparable between 2015/16 (925) and 2016/17 (923).

Table 5 – percentage of case closures that were planned (2009-17)

Locality	2009/10 Percentage	2010/11 Percentage	2011/12 Percentage	2012/13 Percentage	2013/14 Percentage	2014/15 Percentage	2015/16 Percentage	2016/17 Percentage
C&V APB	**53.33%**	**70.83%**	**56.94%**	**50.40%**	**55.70%**	**52.87%**	**68.4%**	**71.2%**
Cardiff	**50.54%**	**70.81%**	**58.07%**	**46.79%**	**55.50**	**50.97%**	**66.3%**	**67.1%**
Vale	**60.09%**	**70.91%**	**53.66%**	**61.33%**	**56.56%**	**60.20%**	**76.4%**	**83.7%**

Figure 5 – <u>percentage</u> of case closures that were planned (2009-16)

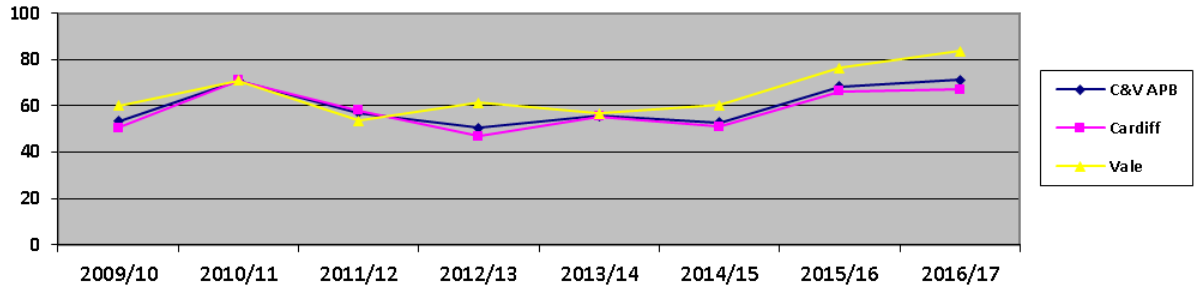
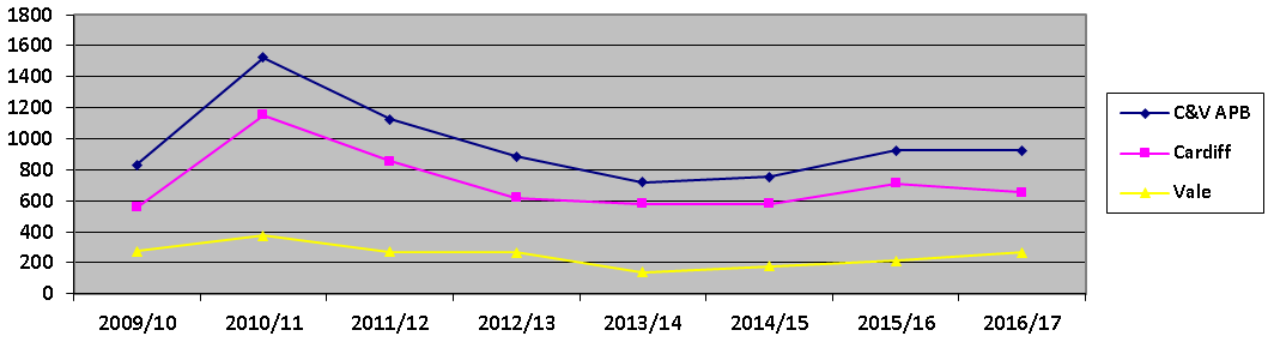


Table 6 – <u>number</u> of case closures that were planned (2009-17)

Locality	2009/10 Number	2010/11 Number	2011/12 Number	2012/13 Number	2013/14 Number	2014/15 Number	2015/16 Number	2016/17 Number
C&V APB	**832**	**1525**	**1124**	**887**	**718**	**755**	**925**	**923**
Cardiff	**558**	**1152**	**853**	**619**	**580**	**578**	**711**	**655**
Vale	**274**	**373**	**271**	**268**	**138**	**177**	**214**	**268**

Figure 6 – <u>number</u> of case closures that were planned (2009-17)



Treatment Outcome Profile (TOP)

The Treatment Outcome Profile (TOP) is the national outcome measurement tool that is designated for use in Wales. The tool assesses service user progress against 10 domains that include level of substance use, wellbeing, offending behaviour, quality of life, and risky behaviour. TOP assessments are carried out at the start of an episode of treatment, and every three months thereafter as a part of routine quarterly care reviews with service users. On completing treatment, or leaving the service, a final exit TOP assessment is carried out.

For the purposes of Welsh Government targets, a reduced level of performance against the national average is classed as a **RED** performance level, and **GREEN** is a performance level at, or over, the national average. In Cardiff and Vale, the number of clients reporting a reduction in their problematic substance misuse between start, review and exit has marginally declined from 73.8% in 2015/16 to 72.2% in 2016/17. This positions Cardiff and Vale in line with the national benchmark and provides a strong evidence base to support the effectiveness of the services being delivered.

In reference to KPI 4 (the nationally monitored domain which measures the number of clients in receipt of support reporting improved quality of life) there was a decline in numbers by 13.8% as 65.7% reported improved quality of life in 2016/17 in contrast to 79.5% the previous year. Nonetheless Cardiff and Vale is still in excess of the national target by 9%.

Again, in practical terms, this means that in nearly 3 out of 5 review or exit TOPs, service users are recognising and reporting an improvement in their quality of life. Given that quality of life can be influenced by such a broad range of holistic factors, the APB are assured that the new open access and aftercare services, both of which deal with much broader issues than simply clinical treatment, are contributing to this overall trend.

Summary

The performance of the substance misuse sector across Cardiff and the Vale has seen some improvements in 2016-17, with the number of areas requiring further improvement much reduced compared with the position the APB was in last year. The work undertaken to make improvements in waiting times has delivered commendable results, with Cardiff and Vale moving closer to the national target in its level of performance. Equally encouraging has been the ability to sustain the lower levels of DNA rates that were achieved in previous years, and the performance against the treatment outcome profile that has seen green performance levels across the board.

The final challenge of the board and all our commissioned services going forward will be around performance sustainability. We have seen sharp fluctuations in performance levels both up and down over the last five years, and it is still not clear how much resilience there is in the substance misuse treatment and support system to maintain target performance levels in light of changes

such as increased referral rates, population growth, the impact of welfare reform, and the increase in use of new psychoactive substances.

The trajectories indicate that the APB will achieve a green status across all five indicators by the end of this year. However a significantly more challenging tasks will be securing the assurance that these levels of service capacity and quality can be sustained going forward.

Delivery

Report from the APB Commissioning and Finance Group

The commissioning group completed its fourth year of a comprehensive commissioning programme and the benefits of the redesigned treatment system are clearly evident in the performance data for the APB since 2013.

The year started with the launch of a new commissioning strategy and an accompanying new 2016-20 commissioning programme. There has been measurable progress in both commissioning new service developments, as well as delivering improvements and efficiencies across the portfolio of existing services.

The most notable change has been the implementation of the new contract for the emotional wellbeing service for children and young people that combined needs around substance misuse with a range of other mental health and wellbeing needs such as behavioural issues, low self-esteem, anxiety, and depression. This new services operates through pooled resources with CAMHS funding to provide assessment, triage and lower threshold intervention services that deliver all the functions of the previous substance misuse service, but with a more holistic approach which considers all aspects of a young persons' emotional wellbeing.

The APB has also renewed the contract for substance misuse support within the two youth offending services with the existing provider – this ensures that substance use issues for young people within the criminal justice system are identified and receive an appropriate response as an integral part of their care plan.

The board saw the introduction of a new substance misuse liaison nurse as part of the existing psychiatric liaison team for the emergency unit – this has enabled all members of the team to improve their knowledge and skills in responding to individuals who present with drug or alcohol use as a contributing factor, as well as creating additional leadership and expertise on substance misuse within the team. This was also the first full year of delivery for the new criminal justice substance misuse contract, and the APB has been working closely with the office of the South Wales Police and Crime Commissioner to ensure a seamless interface between these services and community provision.

The last annual report mentioned that the new commissioning strategy shifts the emphasis of the board away from managing the consequences of substance use (although that remains at the core of our business) towards a renewed focus on the causes of substance misuse, with priorities on prevention, early intervention, and working with families to address the underlying causes of substance use, misuse and addiction. The APB has undertaken some pilot work to see how substance misuse can be better integrated into generic community services, with new open access sessions being run from local GP clinics across Cardiff and the Vale in order to encourage access by people who may be resistant to accessing a traditional drug and alcohol service.

The APB achieved all of its milestones in the first year of the new commissioning strategy, and is set to continue to make progress at pace in 2017-18.

Alcohol

Cheryl Williams
APB Alcohol Group Chair

During 2016-17 progress has continued to be made against the APBs alcohol action plan. Addressing the harmful consumption of alcohol amongst sections of the population is a key public health concern. High consumption levels are often a major contributing factor to crime, violence, domestic abuse and has an impact on employers through days lost and productivity. The key drivers around alcohol consumption levels are affordability, accessibility and marketing, and addressing these issues is crucial to tackling the rise in alcohol-related harm.

The latest alcohol consumption data from the Welsh Health Survey (2015) indicates that the steady decline overall in the levels of drinking amongst the population of Cardiff and Vale has continued, particularly amongst younger people. This is positive news, but there are sections of our population that are still drinking at hazardous and harmful levels and putting themselves at risk of future harm. According to the data, people aged 45 and upwards have either kept the same level of drinking or increased it since the previous survey.

It is the broad population at higher risk that Alcohol Brief Interventions (ABI) aims to reach. ABIs are an evidence based approach to screening for level of risk and providing a brief, targeted conversation to provide support and advice about how to reduce the risk levels. There is strong evidence about ABIs being used in primary care. In 2016-17 there has been a continuation of the focus on training GP practice staff to use them, as well as training offered to a wide range of other organisations. 196 people received Alcohol Brief Intervention training in 2016-17, 17 training sessions delivered, including 5 GP practices. 31 GP practices have now received training across Cardiff and Vale. Alcohol awareness is included within Making Every Contact Count training, which has been delivered to hundreds of practitioners across the Health Board and other organisations.

Prevention remains at the centre of the APBs approach to tackling alcohol, and the *Switched On* team that is part of the package of Universal Services commissioned by the APB is a key service in driving forward prevention amongst young people. The team delivered 209 alcohol and

substance education sessions to 3,610 young people across Cardiff & Vale during 2016-17. These sessions were delivered in a wide variety of settings, including schools, youth service provisions, hostels, colleges, training providers, and in pupil referral units. 93% of the young people taking part demonstrated an increase in knowledge around substance misuse after the group awareness sessions. This year the team have been training peer educators in two schools to give them the skills to be able to pass on messages to their peers by delivering lessons themselves. The Switched On team also deliver training to practitioners to enable them to have skills and knowledge to work with young people around substance misuse.

Alcohol awareness board used in school sessions

Cardiff University Freshers Fair 2016

Year 10 pupils trying out 'beer googles'

Cardiff and Vale UHB is a responsible authority under the 2003 Licensing Act. This means it is able to make representations against new or amended applications or request reviews of existing licenses if there are concerns regarding particular premises. Whilst public health is not a licensing objective, the UHB is able to make representations under other objectives, most

notably crime and disorder and public safety. Using data collected from hospital admissions and ATC attendances, the UHB is able to highlight where premises are causing concern with regard to the health of the community and increasing the likelihood of alcohol related violence. During 2016-17 the public health team have continued to make good progress in working alongside the police licensing team and local license holders to influence their practice within the licensed establishments, mainly in Cardiff city centre. This year the work with partners included involvement with the preparation for Fresher's Week, Christmas parties and summer events such as Pride Cymru.

The Alcohol Treatment Centre (ATC) in Cardiff continues to provide an approach to supporting the night time economy in Cardiff that is recognised as best practice at an international level. The centre is now at the centre of a national study of similar services that is being jointly undertaken by Cardiff and Sheffield Universities. The APB is on the steering group for this research, and we hope that the results will significantly add to the evidence regarding how best to manage alcohol in the night time economy.

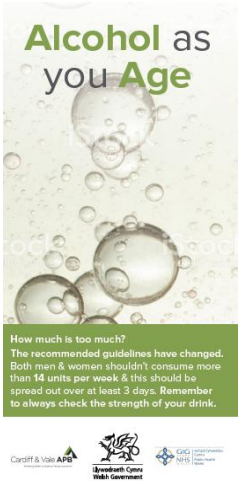
Cardiff Alcohol Treatment Centre (ATC)

The APB once again supported the Alcohol Awareness Week and Dry January campaigns to highlight issues around alcohol consumption. This year, the Alcohol Awareness Week toolkit was once again hosted on the Alcohol Concern Cymru website.

There were 343 page views of the English toolkit, and 28 views of the Welsh toolkit on the site. 27 organisations took part in the Dry January workplace challenge by ordering resources, and the workplace wall chart to track alcohol consumption across the month. Some positive feedback was received from participants in the challenge:-

"The team enjoyed it as an activity they could do together and some said that were impressed that they made it through the month." and "The wall chart raised lots of conversations about alcohol use and how it impacts on our lifestyle".

In 2016-17 there was more of a focus upon older people, due to the fact that many older people (aged 65+) are drinking at hazardous or harmful levels and putting themselves at higher risk of harms such as falls. A sub-group of the alcohol group was formed to look specifically at this issue and several actions were put in place:-



1) Development and production of a leaflet for older people, with local Cardiff & Vale service information.

- This leaflet has been distributed to organisations working with older people and substance misuse organisations

2) Delivery of alcohol awareness training to organisations working with older people.

- This was developed and delivered by NewLink Wales with the objective of providing information and increasing the confidence of practitioners to speak to older people about alcohol consumption, carry out a brief intervention and signpost if appropriate.
- 30 participants took part, from a range of organisations across Cardiff & Vale including local authorities, housing associations and third sector providers working directly with older people
- Feedback was positive: "very informative and interactive and I learnt so much that wouldn't have normally crossed my mind in relation to alcohol and older people" "got me thinking about how I need to approach the subject and gave me more knowledge and confidence to tackle these issues" "really makes you think of these everyday situation that we are missing because we see it as 'normal', a real eye opener for me".
- It was clear from the delivery of this course that further training is needed in this topic as we have recognised a lack of knowledge in the sector about alcohol awareness generally and specifically around how it impacts upon older people.

3) Delivery of a pilot initiative with Taith

Towards the end of 2016-17 an initiative was put into place with Taith to trial a service offered directly in GP practices to target people who may have been referred to EDAS due to alcohol consumption but not attended, or people that GPs identify that would benefit from having a service offered locally. The pilot was aimed at older people primarily, and working age women, as these two groups are often non-attenders at service when referred. For older people in particular, the service is also able to signpost to community activities, additional support or organisations who can offer further support.

By the end of March, Taith was offering the service in 3 GP practices (plus one branch surgery), one in each of the three localities in Cardiff and Vale, and had seen 14 patients. The APB have agreed to extend the funding for the initiative for 2017-18 to give the project more time to become established and to be able to monitor outcomes.

Harm Reduction and Recovery

Gail Smith – Substance Misuse Worker with The Huggard Centre, and group Chair

The Harm Reduction & Recovery Group had a work plan for 2016/17, which it performed well against.

The work plan included:

- Naloxone - Implementing a smooth transition to Prenoxad kits
- Development of Harm Reduction information on ASFA.Cymru website
- Implement Spice Time Credits for service users to encourage volunteering their time in meaningful activities and engagement in support process.
- Working in partnership with Alcohol Concern to develop and deliver Blue Light Project training package

- Development of Task & Finish Group to create evidence based, user friendly, harm reduction information relating to Psychoactive Substances
- Roll out BBV testing for substance misuse service users

The group also contributes to, and considers, harm reduction information highlighted through the Fatal Drug Poisonings Reviews. One of the actions from 2016/17 the group achieved was to ensure adequate supply of storage boxes for services, particularly for storage of methadone.

The Non-Fatal Drug Poisonings Information Sharing Protocol has progressed through Quality Assurance stages and is now ready for final sign off. Cardiff and Vale are leading the field in Wales with regards to information sharing for non-fatal; overdoses. Given that almost all fatal overdoses are preceded by one if not more non-fatal incidents, this is a significant step towards saving lives and providing early intervention for those at greatest risk of overdose. The new information sharing process will be implemented in 2017/18. Services should then be in a position to look at innovative ways in which to provide engagement and support to reduce the risk of future repeat overdose.

The APB continues to prioritise the issue of discarded injecting equipment that is a cause for community concern in a number of areas, and will be prioritised in 2017-18.

Service User and Carer Involvement

This year has seen a steady service user involvement cohort establish itself in Cardiff & the Vale of Glamorgan. This has enabled the APB to empower service users through a number of its groups. Two service users had a strong input to the Area Planning Boards Development Day in December. It is hoped that ASFAcarduf will have input into all appropriate Area Planning Board groups by the end of the next financial year. It is also hoped that ASFAcarduf can develop outreach sessions in hostels to highlight the work of ASFAcarduf. ASFAcarduf is always looking for new innovative ways to engage with service users, particularly those who are difficult to

contact. This will recognise their views on substance misuse services in Cardiff & the Vale of Glamorgan, helping to identify gaps and needs.

Tearing Your Hair Out – the carer involvement group for substance misuse - has also been reconfigured with a stronger input from the Area Planning Board. This includes a rebrand and re-launch. It is intended that this will empower carers and loved ones to influence Area Planning Board decisions.

A new ***Bronze*** training module has been finalised and the first cohort of service users will receive the initial training early in the next financial year. It is planned for both ***Silver*** and ***Gold*** levels of training to be developed and delivered by the end of March 2018. This will give ASFAcarduf members the skills to help make informed decisions in partnership with the Area Planning Board.

Members of ASFAcarduf have been heavily involved in the development of AWSUM. The All Wales Service User Movement (AWSUM) previously was just a conference planning group. Alongside Western Bay ASFAcarduf members have helped to develop it into a service user network, hopefully in partnership with the other 5 Area Planning Boards. Although still in its infancy ASFAcarduf members have helped to identify clear outcomes and a Mission Statement for AWSUM.

Criminal Justice

The APB is closely involved in the commissioning and operational delivery of all the criminal justice substance misuse services that operate in Cardiff and the Vale. Strategic management of these services sits with the office of the Police and Crime Commissioner (PCC). The board also have dedicated substance misuse nursing staff within the HMP Cardiff healthcare team.

This was the first year of deliver for the new criminal justice substance misuse services contract, and the new provider delivered an exceptional level of performance as well as managing a smooth transition of service from the previous model of delivery to the new arrangements.

Headlines for Cardiff and the Vale is 2016-17 are as follows:

- The lowest caseload for Cardiff and Vale at any point for 204, with the highest reaching 246
- The average gender split for the caseload was 26% female and 74% male
- There were 2245 assessments undertaken in HMP Cardiff, with 489 individuals taken onto the caseload of the service, and a further 317 provided with either on-the-spot intervention, or signposting and referral on to other services.
- Across all four South Wales custody suites there was a strong indication of the growing prevalence of cocaine for those tested on arrest for Class A drugs, especially among the female and male offenders in Cardiff. Cardiff custody suite saw 305 men testing positive for cocaine, 229 for both cocaine and opiates, and 71testing positive for opiates. Among females tested on arrest, there were 72 positive cocaine tests, 107 positive for both cocaine and opiates, and only 17 positive tests for just opiates.

This last set of data in particular shows how the criminal justice services are able to inform the APB with regards to how we prioritise areas of service for improvement – this clearly shows that we need to ensure that there are sufficient support mechanisms in place for individuals who are primarily cocaine and other stimulant users.

Finance

Update for the 2016-17 Financial Year
Prepared by Hilary Williams;
Area Planning Board Accountant

	Initial Allocation 2016/17	Additional Allocations 2016/17	Final Spend 2016/17	Balance 2016/17	Comments
Funding	**£**	**£**	**£**	**£**	**Status as at close of accounts 2016/17**
APB Generic SMAF Revenue	2,983,289	0	2,983,289	0	
APB Tier 4 Ring Fenced	163,800	0	163,800	0	all ring fence requirements met
APB CYP Ring Fenced	450,450	0	450,450	0	all ring fence requirements met
APB Counselling	49140	0	49140	0	all ring fence requirements met
REVENUE SUB-TOTAL	**3,646,679**	**0**	**3,646,679**	**0**	
SMAF Capital (WG**)**					
Recovery Cymru 218 Cowbridge Rd East Lease	48,352.66	0	48,000.00	-352.66	Recoverable VAT
Harlech Court Lease	159,907.00	0	147.832.00	-12075.00	Recoverable VAT
Universal Services Lease	136,779.00	0	136,779.00	0	
CAPITAL SUB-TOTAL	**345,038.66**	**0**	**332,611.00**	**-12427.66**	
TOTAL SMAF FUNDS	**3,991,171.66**	**0**	**3,979,290.00**	**-12427.66**	
SMAF Training Bursaries	5,733.00	0	5,733.00	0	
Naloxone Grant	18,360.00	3060.00	21,418.50	-1.50	
AWSUM	3,500.00	0	3,500.00	0	
Total Other Funds	**27,593.00**	**3060.00**	**30,651.50**	**-1.50**	

NB: Expenditure as reported and claimed by service providers – subject to final audit

Looking forward to 2017-18

The APB in Cardiff and the Vale has a clear work programme during the course of 2017 that focuses on both performance improvement and consolidation of some of the corporate functions of the board as follows:

- As a result of a service pathways review, the APB will be implementing a service improvement plan to address all of the recommendations that arise from the review report.
- The APB will be implementing the new information sharing protocol for non-fatal overdoses
- We will seek to establish community based liver support services where alcohol is a primary factor
- The board will complete a full review of its Memorandum of Understanding, including terms of reference, membership. Support group structures, governance, risk management and financial risk sharing.
- The commissioning group will develop a new prioritisation framework for the APB to assist in contingency planning for any future pressures on budgets

We look forward to continuing to report on our work programme into the future.

FURTHER INFORMATION AND CONTACTS

Cardiff and Vale APB Support Team

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CF11 0SN

02921 832110

21.4

DIRECTORS OF PRIMARY, COMMUNITY & MENTAL HEALTH 2016-17 ANNUAL REPORT
Name of Meeting : Board Meeting **Date of Meeting** 28th September 2017

Executive Lead : Chief Operating Officer
Author : Deputy Director of Primary, Community & Mental Health
Caring for People, Keeping People Well: This report underpins the Health Boards commitments set out within the 10 year strategy of "Shaping Our Future Well-being".
Financial impact Nil
Quality, Safety, Patient Experience impact : Delivery against the Primary Care Plan for Wales
Health and Care Standard Number Delivery against the Primary Care Plan for Wales
CRAF Reference Number
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by**:**

- Monthly representation at the All Wales Directors of Primary, Community & Mental meetings where progress against delivery of the Welsh Government Primary Care Plan is monitored. This, in turn, informs the development of the Annual Report.

The Board is asked to:

- **NOTE** the Annual Report of the Directors of Primary, Community & Mental Health.

SITUATION

This is the second annual report of the All Wales Directors of Primary, Community & Mental Health. It sets out the progress against the work programme defined by the Directors of Primary, Community & Mental Health to deliver the requirements of the Welsh Government 'Our plan for a primary care service for Wales up to March 2018'.

The Board is asked to acknowledge the achievements of the work programme in 2016-17 on an All Wales basis and locally in Cardiff and the Vale of Glamorgan.

BACKGROUND

Following the publication of 'Our plan for a primary care service for Wales up to March 2018' (Welsh Government). The Directors of Primary, Community & Mental Health were tasked with leading on taking forward the actions set out in the plan. In doing so, workstreams were established and a forward workplan agreed. Where is has been identified as useful, a Health Board will take the lead on behalf of the All Wales group. For noting, Cardiff & Vale UHB lead on the primary care quality and delivery measures for Wales.

Given the pace of change for primary care and the increasing profile, the Directors peer group agreed that an annual report would be an effective way of communicating to a wide range of stakeholders the progress made.

ASSESSMENT AND ASSURANCE

The Annual Report comprehensively covers the progress against the work programme and provides assurance of delivery to date.

For 2016/17, there are two themes that emerge as significant and therefore inform the forward work programme. These are:

- Sustainability
- Cluster Development

Primary care stability forms the basis of 'The Emerging Vision for Primary Care in Wales' with effective cluster working being an essential element of this.

The 'Emerging Vision' together with sustainability and cluster development are a key priority locally in Cardiff and Vale.

Version 7 – Final 30.08.17

21.4

Annual Report

2016 – 2017

'Our plan for a primary care service for Wales up to March 2018'

Directors of Primary Community and Mental Health

2017

Version 7 – Final 30.08.17

Version 7 – Final 30.08.17

Contents

Part 1		**Pages**
Section 1	**Overview of 2016**	6
1.1	Introduction	6
1.2	Increase in portfolio	6
1.3	Leadership and supporting groups	6
Part 2	**Portfolio/work programme 2016/17 and governance arrangements**	8
Part 3	**Progress of work programme 2016/17**	10
3.1	**Priorities**	10
3.1.1	Sustainability	10
3.1.2	Workforce and OD	11
3.1.3	Cluster Development and Support	11
3.1.4	Pacesetters and Innovation	12
3.1.5	Mental Health	13
3.2	**Primary Care ICT and Information Board**	14
3.2.1	Quality and Delivery Measures	14
3.2.2	MHOL	14
3.2.3	GMS IT	14
3.2.4	WCCIS	14
3.3	**The PCCDI Hub Programme**	14
3.3.1	Cluster Development	15
3.3.2	Access to Information and Intelligence	15
3.3.3	Innovations in Healthcare	16
3.3.4	Quality Improvement and Safety	16
3.4	**Strategic Development Agenda**	17
3.4.1	GMS contract negotiations and enhanced services	17
3.4.2	Capacity and demand modelling	17
3.4.3	OOH/111	17
3.4.4	National Primary Care Board	18
3.4.5	Primary and Community Care Reference Group	18
3.4.6	Unscheduled care Board and Clinical Reference Group	18

Version 7 – Final 30.08.17

3.4.7	Planned Care Board	19
3.5	**Coordination of Local Activities**	19
3.5.1	Joint working with WAST	19
3.5.2	Primary Care Estate	19
3.5.3	Risk stratification, ICL, PRISM	20
3.5.4	Research and Development	21
3.5.5	Transgender Project	21
3.5.6	BSL Project	21
3.5.7	Welsh language	22
3.5.8	Monitoring of local actions	22
3.5.9	Low Vision Services and Eye health Examination	22
3.5.10	PMCAT	23
3.5.11	Delivery Groups	23
Part 4	**Forward Work Programme 2017/18**	24
4.1	Proposed priority areas 2017/18	24
4.2	Outline plans for priority areas	24
4.2.1	Implementing the Emerging Model (IEM)	24
4.2.2	GMS Contract 2017 - 18 High Level Action Plan	26
4.2.3	Mental Health	26
4.3	Extension of ongoing work	27
4.3.1	Quality and Delivery Measures	27
4.3.2	Roll out of 111	27
4.3.3	Transgender project	27
4.3.4	British Sign Language online project	28
4.3.5	Welsh Language	28
4.3.6	Risk stratification/ICL/predictive modelling	28
Part 5	**Challenges 2017/18**	29
Part 6	**Financial Summary**	30
Part 7	**Summary of achievements/change**	34

Version 7 – Final 30.08.17

	Appendices
1.	Terms of Reference National Board
2.	Terms of Reference Primary and Community Care Reference Group
3.	Overview of workforce and OD high level plan
4.	Primary Care IT Developments 2017-18
5.	Primary & community Care Development & Innovation Hub
6.	Mapping of priorities to meet national themes/priority areas
	Diagrams
1	Primary Care Leadership Team
2.	Portfolio of National Work Programme 2016/17
3.	Primary Care Programme Governance Arrangements
4.	PCCDI Hub Model
5.	DPCMH Portfolio 2017/19

Version 7 – Final 30.08.17

PART 1

Section 1- Overview of 2016

1.1. Introduction

This is the second Annual Report produced by the Directors of Primary Care, Community and Mental Health (DPCMH). It provides a summary of progress in all areas prioritised for action as part of the 2016/17 work programme. Additional funding has continued to enable innovation and development of primary care services contributing to the pace of change and the emergence of a model for whole system care.

1.2. Increase in portfolio

In January 2016, Vice Chairs requested the coordination of additional work to lead on Mental Health issues not covered by the implementation of *Together for Mental Health* arrangements.

In addition, all Wales Chief Executives requested the development of terms of reference for Executive peer groups alongside evidence of the contribution to a National Policy and Improvement Programme[1] which incorporates the implementation of the *Social Services and Well Being (Wales) Act (2014)*, and the *Wellbeing of Future Generations Act (2015).*

1.3. Leadership and supporting groups

During 2016, three supporting structures were established to take forward elements of the overall plan. A workforce and OD task and finish group had been set up following the publication of the '*A Planned Primary Care Workforce for Wales'.* Membership and terms of reference for this group changed in year on completion of the initial task which included a scope of ongoing work and groups. The Primary Care Workforce and OD Group is now jointly chaired by a DPCMH and a Director of Workforce and OD. In September 2016, Welsh Government established a Ministerial taskforce to address recruitment of GPs and wider professionals in primary care. Progress in year is summarised in section 3.1.2.

In April 2016 it had been agreed to establish an overarching Primary Care ICT and Information Board to oversee related primary care actions including development and implementation of Quality and Delivery Measures, My Health on Line, the roll out of WCCIS and the work of the GMS IT Board.

Terms of reference and membership were revised in January 2017 and a forward work plan developed with NWIS. A project manager was appointed in October 2016 to support the work. See Section 3.2.

Following the appointment of the Programme Director to the Primary and Community Care Development and Innovation (PCCDI) Hub within Public Health Wales; governance and working arrangements were revised and a PCCDI Hub Programme Board established to oversee the work programme. The breadth of work is now structured across four work themes - cluster development (leadership and skills / social prescribing); access to information / health intelligence; innovation in healthcare (Pacesetter projects); and quality and safety. The contribution of the PCCDI Hub to the primary care

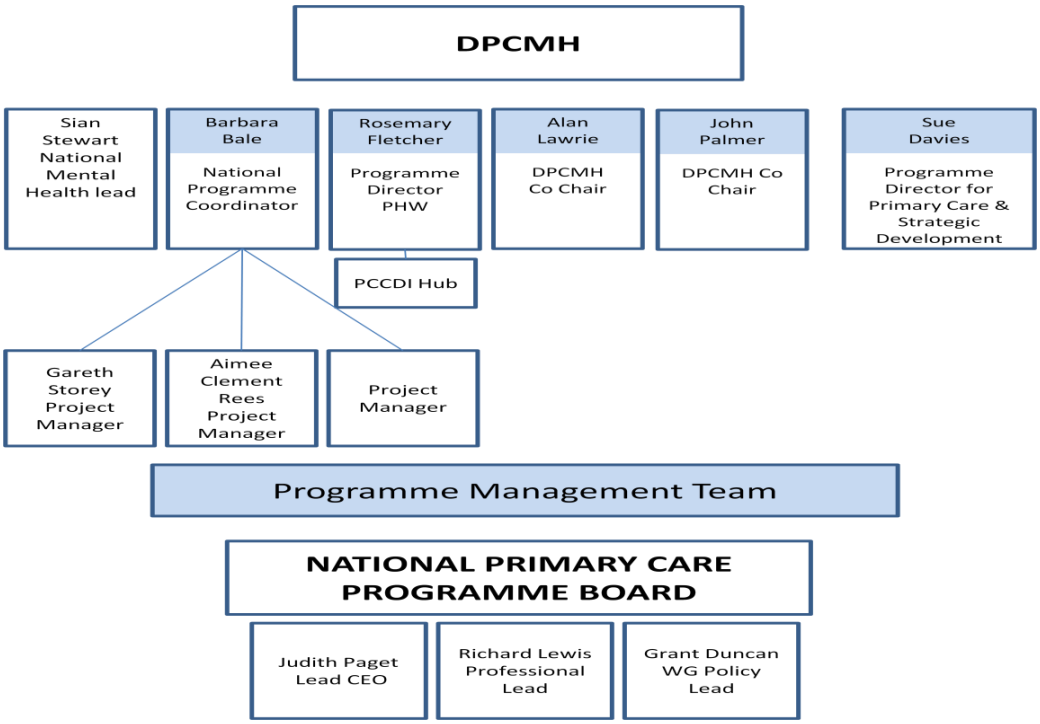
[1] (Documents available on request)

implementation plan is presented throughout this report. An organisational model to show how the PCCDI Hub interfaces with other groups has been developed and is detailed in Section 3.3, Diagram 4.

The Annual Report for 2015/16 did not attempt to capture progress in relation to the whole portfolio of the DPCMH. However, the need to coordinate and lead additional all Wales priorities became increasingly important in year. As a result, in October 2016 a Programme Director for Primary Care Strategic Development was appointed with a lead for; the GMS contract and negotiations of enhanced services (including diabetes); capacity and demand work linked to USC as well as the expansion of the CAREMORE approach to primary care; Out of hours; Low vision services; National Delivery Groups and comparability of actions within the Primary Care Plan being taken forward locally.

The appointment of additional leaders to the DPCMH peer group including the joining of a National Director for Mental Health/ Programme Director T4CYP, enabled a Programme Team to be set up to coordinate activities. See below. The leadership team meet monthly between DPCMH meetings to plan the agenda and monitor actions.

Diagram 1 Primary Care Leadership Team (as at May 2017)



Version 7 – Final 30.08.17

21.4

PART 2 – PORTFOLIO/WORK PROGRAMME 2016/17 AND GOVERNANCE ARRANGEMENTS

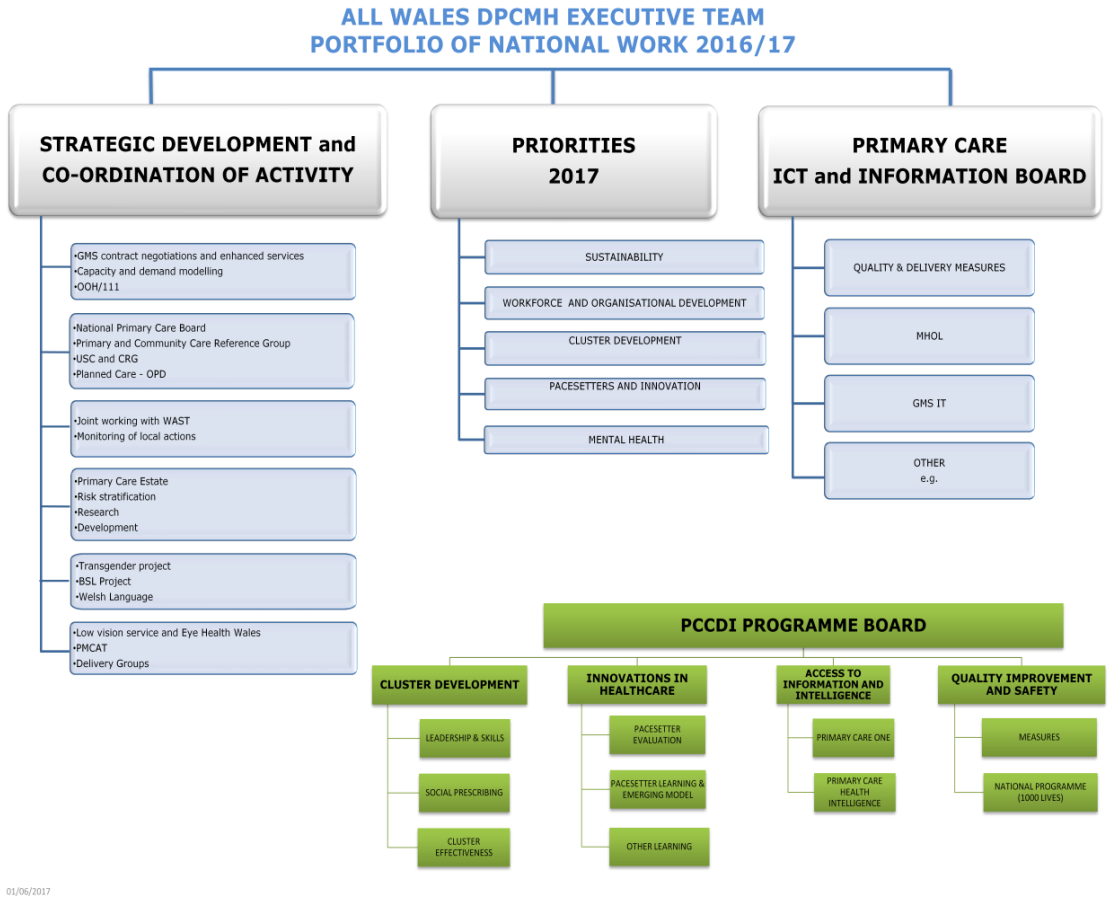
The portfolio of activities agreed for 2016/17 is shown below. Five areas of work were prioritised for action as part of the forward work plan for 2016/17 and summarised in the 2015/16 Annual Report, i.e. Sustainability; workforce and OD; cluster development; pacesetters and innovation, and mental health.

In addition, work continued led by the Primary Care ICT and Information Board and activity at national and local level co-ordinated. Strategic working with other National programmes and negotiations of GMS enhanced services were added to the portfolio of work overseen monthly by DPCMH.

Collectively, the work programme encompasses all the themes specified in the National Plan, i.e.

- Planning care locally
- Improving access and quality
- Equitable access
- A skilled workforce, and
- Strong leadership

Diagram 2 All Wales DPCMH Executive Team Portfolio



Version 7 – Final 30.08.17

Oversight of a widening portfolio led to the requirement to specify governance arrangements to ensure appropriate levels for decision making.

In addition, WG set up '*Triangulation meetings'* to bring together the National Programme Directors and Clinical leaders from the USC, Planned Care and Primary Care programmes. Issues of shared interest requiring joint working were identified for the NHS Executive Board to agree a 'joint agenda' for national oversight.

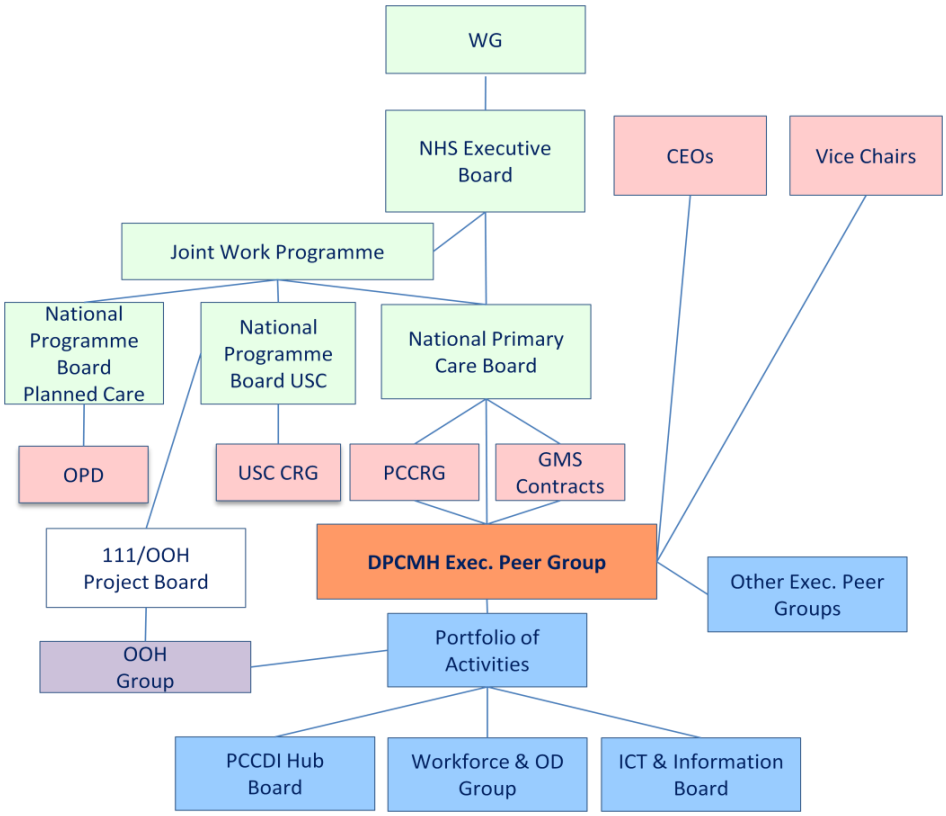
To provide parity of Board structures it was agreed to establish a Primary Care National Programme Board which met in full for the first time in March 2017. (See Appendix 1 for terms of reference and membership).

A preliminary meeting of the National Board proposed that a Primary and Community Care Reference Group should be set up to advise all the structures/groups supporting the implementation of the Primary Care Plan as well as the National Board. The first meeting was held May 2017.

DPCMH continue to have representation on a number of National Boards and Committees which are reported to the Directors monthly. Primary Care membership of revised National Delivery Groups and Network Implementation Groups is under review for 2017/18

Revised groups and governance arrangements are shown below.

Diagram 3 Primary Care Programme Governance Arrangements (at May 2017)



Version 7 – Final 30.08.17

PART 3 – PROGRESS OF WORK PROGRAMME 2016/17

3.1 Priorities

3.1.1 Sustainability

Following a collation of suggestions for addressing issues of sustainability, a small task and finish group agreed priorities. Initially it was proposed that sustainability would be best supported by a greater emphasis on workforce and OD issues until a project manager could be recruited to take alternative suggestions forward.

A project manager was appointed from November 2016 and an initial scope of suggestions from DPCMH, HoPC and other stakeholders informed initial work in relation to the emerging model of Primary Care; development of all Wales guidance; estates planning and collation of a sustainability dashboard. Changes have been made for the forward work plan for 2017/18. Challenges with workforce and OD continue to remain a significant factor influencing sustainability therefore the project addresses both workforce and non workforce solutions.

At local level all LHBs have developed support mechanisms for those practices facing challenges who have requested support via a revised sustainability framework. Examples are outlined in the boxes below:

Hywel Dda University Health Board:

Scheme: Primary Care Support Team

The scheme aims to build a strong foundation upon which other primary care services sit, through investing in skill mix, infrastructure and proactive conversations with our population on their care and treatment and embedding new models for delivering services closer to communities.

As a result of this investment:

- Primary Care Support Team continues to support practices through GP, AP and Medicines Management Support. The team has supported 11 practices either due to workforce challenges within the practice or as trial days for practices to experience. Feedback from practices has been positive.

Powys Teaching Health Board:

Scheme: Sustainability of high risk practices

Funding has provided support packages to enable practices to pilot a number of safe alternative clinical models to support GPs to ensure practices future sustainability.

As a result of this investment:

- No practice in 2016/17 has returned their contract.
- 1 practice has returned to independent contract status on 31 March 2017

3.1.2 Workforce and OD

A workforce task and finish group set up in 2016 reviewed the actions set out in '*A Planned Primary Care Workforce for Wales',* as well as the number of additional groups delivering on the agenda. As a result a number of existing groups stood down and in November 2016 a revised Primary Care Workforce and OD group was established jointly chaired by a Director of Workforce and a Director of Primary Care.

The revised group has since considered progress on each of the actions and made recommendations for changes or closure. The remaining actions have formed part of the forward work plan and will involve delivery by the WODs, DPCMH, WEDs NWSSP, WG, the deanery and the PCCDI Hub. A process to monitor progress from each of the groups/organisations involved is being developed. A closure report summarising progress and changes 2016/17 is available on request.

In addition progress at local level needs to be monitored and good practice shared. As a result a separate sub group with operational membership of each LHB has been set up and a monitoring process proposed. Management of this group is being facilitated as part of the sustainability project.

Changes to the Primary Care Workforce Plan together with proposals for future work based on improvements and developments in year will be approved by the Cabinet Secretary at the end of 2017.

During 2016, WEDs working with the primary care service developed a Compendium of new roles and models being used in primary care. The web based tool will be launched in 2017 and provides Clusters with worked examples of new roles and models of care with links to job descriptions and useful information regarding challenges faced etc.

Numerous examples of new and extended roles have been introduced at local level. Examples are provided in Part 7.

3.1.3 Cluster development and support

Cluster support has been offered through the PCCDI Hub in relation to education and training for leadership and skills responding to needs identified by Clusters. Two Confident Leaders Programmes for cluster leads and aspiring cluster leads are ongoing and skills training has been provided on health needs assessment, coproduction and project management.

Significant work has been undertaken to develop and support the 64 clusters and practice groupings. Many cluster teams are already recruiting to new multi-professional roles and, with the support of their health boards, proactively developing new services and pathways both within primary care and across the interface with the acute sector.

Investment at local level has been used to meet local needs. Examples are outlined in the boxes overleaf:

Version 7 – Final 30.08.17

Cwm Taf University Health Board:

- Practice-based pharmacists working across eight practices in one cluster. Work includes patient medication reviews which could be by telephone, face to face, in care homes and for housebound patients.
- Community co-ordinators attend all cluster meetings and regularly deliver 'clinics' from practices to engage with patients to assist in health promotion initiatives and signposting
- The piloting of a physiotherapist assessing patients who present with an acute musculoskeletal problem in the GP practice commenced in January to coincide with winter pressures. The service is currently being delivered from two practices who have had difficulties recruiting GP's.

Cardiff and Vale University Health Board:

- 12 month agreement with Cardiff MIND to support patients with low level mental health conditions – 192 referrals made since mid December 2016.
- Health Care Support Workers embedded in post and working with 2 qualified primary care nurses for older people across 11 cluster GP practices.
- Acute physio service pilot uptake has increase from 80% to 100%.

Betsi Cadwaladr University Health Board:

- Funding for a GP to attend Care Homes within the cluster to meet with patients, families and carers to implement Treatment Escalation Plans
- The 3 Wrexham clusters are joint working on a project to develop a website to act as a portal with bespoke health and wellbeing information and a local service directory at area, cluster and practice level for use by all patients, residents and staff within the 3 clusters.
- Advanced musculoskeletal physiotherapists working across to work across a cluster.

3.1.4 Pacesetters and Innovation

The Pacesetter Programme aims to promote and evaluate innovation across Primary Care in Wales. Evaluation by health boards and clusters has been supported by the PCCDI Hub and 1000 Lives Improvement with many projects demonstrating early benefits and outcomes. These were shared at a Pacesetter peer review event in September 2016 which enabled DPCMH to assess progress against the agreed aims of each project and consider the next steps for the Programme as a whole.

There was general agreement that the Programme has been effective in bringing together Primary Care colleagues from around Wales to share the learning and develop a future vision for Primary Care. It is becoming evident that a key catalyst for change across the NHS is the development of practice clusters, which now need to progress from a collection of GP-based services into fully functioning organisations that draw in the full range of agencies, professionals and services to collaborate in improving health outcomes for their community. This emerging model of holistic care has been produced in video format to

discuss with Clusters, Executive Teams, Local Health Boards and other stakeholder groups. Results from discussions will inform the future models for services in Wales. As implementation of the emerging model is taken forward, leadership at local level will be through each DPCMH.

Key elements of the emerging model include; multi disciplinary teams, clinical triage, new and extended clinical and non clinical roles, integration with other sectors and with secondary care with ongoing support for cluster development and workforce planning to ensure complex care can be managed safely in the community.

In addition to the Pacesetter projects, a range of other Primary Care initiatives are ongoing in Health Boards, supported by different Welsh Government funding streams. Outcomes of these developments will also be incorporated into the evidence base for future Primary Care services.

Part 7 provides examples of Pacesetter projects which support the elements of the emerging model. Examples of use of integrated care funds include:

- **Gwent** utilised £150,000 to provide intermediate care beds to help facilitate hospital discharges. This has resulted in 40 admissions to Step Up/Step Down beds with an estimated 1928 bed days saved.

- In the **Western Bay** region, the Neath Port Talbot Home Care Service received £180,000 to provide basic care and support to people who are at risk of being admitted to hospital or are occupying a hospital bed despite being medically fit. Nearly 300 people have benefitted from the service, 120 hospital discharges facilitated and 175 hospital admissions were avoided.

3.1.5 Mental Health

In February 2016, Vice Chairs requested an all Wales review of the management of mental health (MH) breaches.

Following negotiation a proposal for the standardisation of reporting and management of MH Act detentions and the development of a MH activity core data set was presented to DPCMH. Cardiff and Vale LHB agreed to lead the collection of all Wales data from January 2017 to be collected twice a year initially as a pilot. From April 2017 it is intended that the new model will be used by all organisations and definitions adopted. Following the first data collection for the period October – December 2016, anonymised results from 4 LHBs were collected. Cardiff and Vale are working with the remaining 3 LHBs to overcome any difficulties in data collection.

During 2016 it was also suggested that MH services in Wales may have suffered from a paucity of infrastructure to support data collection and information systems development to demonstrate a shift to integrated services incorporating the views of service users.

Work was commissioned to consider the development of a new MH Dashboard. In January 2017 clinicians and managers working in the mental health field were consulted on the

potential components of an All Wales high level core data set.

Tools available to monitor the health, well-being and social outcomes for service users both on entry and receiving care and treatment have been included.

3.2 Primary Care ICT and Information Board

The Primary Care plan identifies a number of national ICT and information developments to support the approach to Primary Care. Early discussions with NWIS identified the need to establish an overarching ICT Board to oversee the progress of each of the elements to be prioritised. The revised terms of reference agreed in January 2017 states that the purpose of the Board is to identify the primary care elements of the NHS Informatics Service programme within the areas of; Information for you, Supporting professionals, Improvement and innovation and A planned future. The Board will prioritise the primary care elements of the NWIS programme and will consider any in year business cases to extend the agreed scope of the work. Key projects during 2016 were My Health on Line (MHOL), the development and implementation of Quality and Delivery Measures and introduction of a portal and reporting arrangements, implementation of the Wales Community Care Information System (WCCIS) and the re procurement of GP systems.

3.2.1 Primary Care Information Portal - Quality and Delivery Measures

The agreed set of quality and delivery measures collected via the Primary Care Portal was rolled out across NHS Wales during 2016. A reporting template for Boards was developed and all LHBs now receive regular updates. Improvements to the process are ongoing. Development of a set of further measures has been led by the PCCDI Hub and were approved in May 2017. Proposals for the continuation of this work is detailed in the forward work plan.

3.2.2 MHOL

Work during 2016 focussed on the development of the technical systems to extend the functionality and accessibility of MHOL. Plans for 2017 are contained within the forward work plan and are aimed at better access via smart phones and online registration as well as patient access to summary records.

3.2.3 GMS IT Board

The main focus of the group has been the requirements for the GMS systems and services procurement. The process is expected to take 12 months with the award of the contact early 2018.

3.2.4 WCCIS

Plans for roll out during 2016 were delayed due to non completion of health modules, and interoperability and governance issues. Continued membership of a DPCMH has enabled a higher profile for NHS requirements to be accommodated. Local agreements are still under negotiation with a revised timetable for implementation to be agreed for 2017, commencing April.

3.3 The PCCDI Hub Programme

The PCCDI Hub was established by Public Health Wales to coordinate

support for health boards and clusters, at a national level, in the delivery of the national plan for primary and community care in Wales.

The PCCDI Hub's work plan is overseen and directed by a Programme Board with senior representatives from health boards, Public Health Wales, NHS Wales and Welsh Government. The work plan includes a range of projects to support the delivery of local and national priorities, which collectively aim to support the transformation and sustainability of primary and community care.

Projects fall within four themes:

3.3.1 Cluster Development

- Providing leadership and skills development training, and facilitating networking.
    - Confident Leaders Programme: developed for cluster leads and aspiring cluster leads and being delivered by Primary Care Commissioning, a not for profit organisation. The programme is being delivered through nine monthly modules to two cohorts, each of which will conclude in 2017/18.
    - Skills based workshops were delivered on a regional basis aimed at anyone working in or with clusters. Topics were *Health Needs Assessment, Co-production and Principles of Project Management* (the latter run in association with the NHS Wales Health Collaborative and Eliesha Training).
- Promoting social prescribing through mapping evidence and sharing of activity.
- Providing direction and support for primary care nurse development.
- In October 2016 a National Primary Care Conference was held at the request of the Cabinet Secretary for Health, Well-Being and Sport to support implementation across Wales of the Welsh Government Primary Care Plan. As well as providing an opportunity for people from across Wales to shape national strategy, the event helped to spread good practice by giving delegates the chance to hear from others about the progress they have made in developing primary care clusters. In addition to the conference, the Cabinet Secretary met with Local Health Boards throughout the day to discuss individual progress and plans for primary care.

  Key themes from the conference were the need for a much greater emphasis on making integration a reality and for a focus on social prescribing, co-production and a community asset based approach.

3.3.2 Access to Information and Intelligence:

- Establishing a cluster website, Primary Care One Wales, to promote collaborative working and support cluster development. Launched in January 2017 as a "beta-site",this website will:
    - Be a central source of information for clusters and primary care professionals.
    - Enable clusters to collaborate and share best practice.

- Reflect the needs of primary care professionals in developing cluster working.
- Have a public facing website and a secure login section for forum discussion.
- Provide or signpost to information to support cluster needs assessment, service planning and quality improvement

3.3.3 Innovations in Healthcare

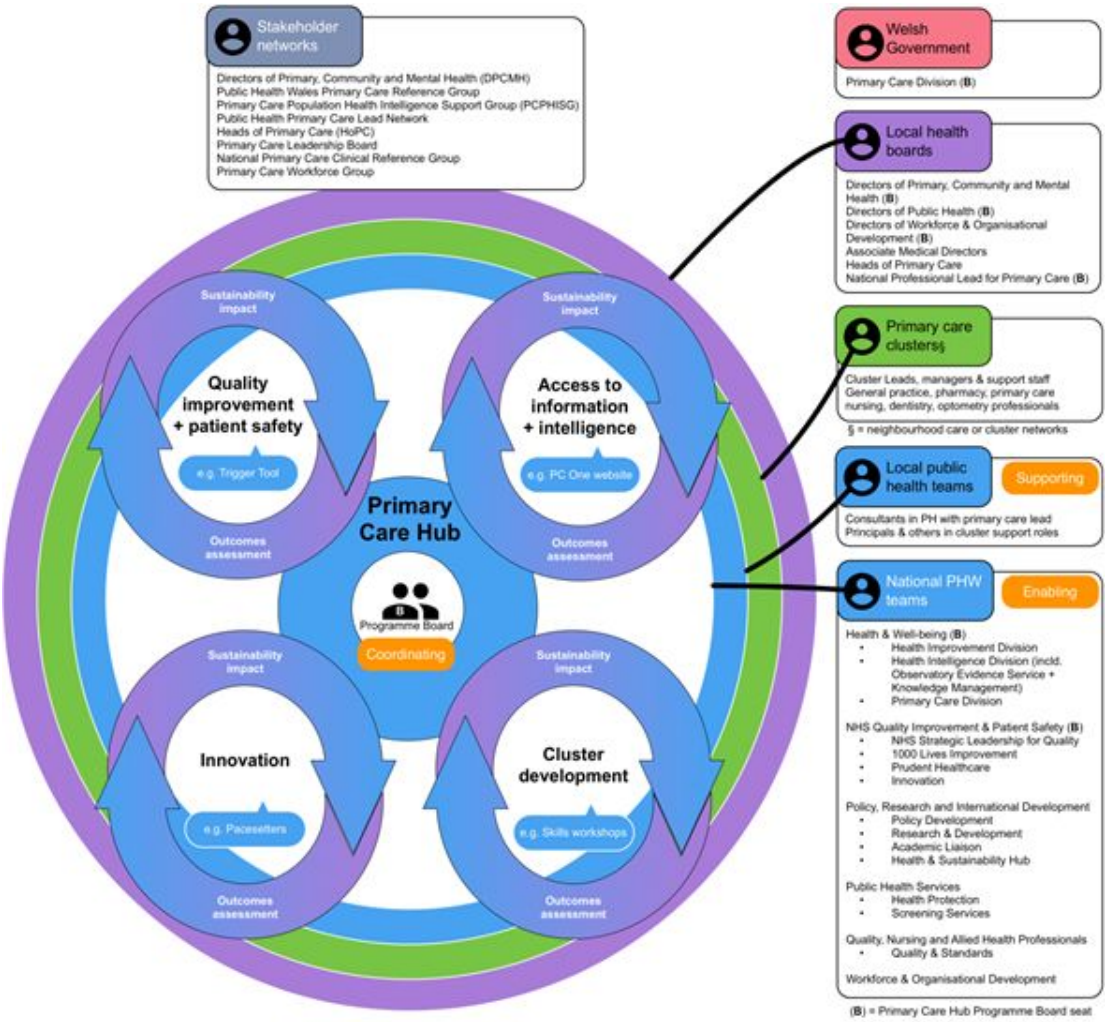
Supporting and promoting evaluation of new ways of working in primary and community care.

3.3.4 Quality Improvement and Safety

Supporting 1000 Lives Improvement Service in the delivery of a national programme for quality improvement and safety.

The structure of the PCCDI and its relationship with its stakeholders are described in Diagram 4.

Diagram 4 – Primary Care Hub



3.4 Strategic Development Agenda

3.4.1 GMS contract negotiations and enhanced services

Negotiations have been ongoing throughout 2016 on enhanced services as part of the current GMS contract and on the arrangements for 2017/18 and plans for re negotiation in year.

In summary, Health Boards will be directed to offer an enhanced service to GP practices to provide care to residents in residential care homes and nursing homes in Wales from 1 April 2017.

A Warfarin Management Directed Enhanced Service (DES) has been agreed to offer a level 4 Warfarin management service. Five health boards will offer the new enhanced service from 1 April 2017 with the remaining two from 1 October 2017.

In relation to Phlebotomy Services, the payment per patient has been agreed for secondary care initiated phlebotomy tests, with a continuation of the current mixed funding model as required.

A Diabetes Enhanced Service is being negotiated in accordance with an agreed common service specification. The agreed common service specification, together with an estimate of the cost of delivery is to be agreed by 30 June 2017.

Plans for the negotiation of future GMS Contract changes are outlined in Part 4.

3.4.2 Capacity and demand modelling

The Average Day Capacity and Demand Mapping framework identifies patient activity and flow processes to gain a more accurate understanding as to what constitutes an average day in primary care and the ability to model opportunities to improve the flow and effectiveness of the system as a whole.

Initial work has commenced in conjunction with the Delivery Unit and based on a similar approach undertaken in USC focuses on mapping access routes into primary care as a basis for data assessment and analysis. The development of this work drawing on UK wide best practice will be aligned with the implementation of the emerging model.

3.4.3 OOH/111

The 111 telephone number and accompanying advice and OOH service went live in one LHB in 2016[2] The OOH/111 Programme Board has continued to lead the introduction and timetable for roll out of 111, working with DPCMH. Work continues on the development of up to date directories of service alongside promoting awareness and development of community pathways and services.

In January 2017 an OOH workshop was held to remind participants of the '*Checklist for OOH actions'* produced by DPCMH in partnership with the USC CRG which was issued in March 2016. In addition, each LHB shared the top issues that need to be addressed as well as sharing any initiatives and good practice. As a

[2] A full report is available from the 111/OOH Programme Board

number of action areas for joint work were proposed an OOH group will continue the work reporting directly to the 111 Programme Board.

3.4.4 National Primary Care Board

The National Primary Care Board (NPCB) was set up in March 2017 to provide a strong collaborative mechanism to enable solutions to barriers which impact across Wales on the pace and scale of the delivery of the national primary care plan.

The NPCB reports to the NHS Wales Executive Board and is a partnership to:

- Increase the focus and traction of primary care as part of an integrated sustainable health and care system
- Prioritise and oversee the Primary Care Directors' Programme of Work, key priorities will include unscheduled care, cluster development, integrated pathways, integrated workforce and contracting
- Triangulate with other relevant National Programmes of Work and activity such as the Unscheduled Care and Planned Care Boards.
- Increase the focus on integration – horizontal and vertical – in the health and care systems

Terms of reference and membership is at Appendix 1. The Board requested the establishment of a reference group to provide clinical and professional advice to the programme.

3.4.5 Primary and Community Care Reference Group

The purpose of the Primary and Community Care Reference Group (PCCRG) is to support the work of the NPCB, the DPCMH national work and the delivery of the Primary Care Plan by:

- Providing advice on professional and care standards and the work of the Primary Care Programme in Wales
- Considering the implications of emerging policy and practice and advising on the appropriate professional response in Primary and Community care
- Developing appropriate linkages to the national programmes for planned and unscheduled care
- Helping to join up work across professional and representative groupings.

The first meeting was held May 2017. Terms of reference and membership is at Appendix 2.

3.4.6 Unscheduled Care (USC) Board and Clinical Reference Group

The USC Board is attended by a DPCMH. Joint work, in addition to capacity and demand planning has focussed on providing the Board with the contribution that primary and community care can make to USC. In addition, work is continuing on the development of a framework of care standards, outcome indicators and performance measures for an integrated whole system pathway for older people with long term conditions and/or frailty based on the CAREMORE model.

During 2016 the USC CRG produced '*A Prudent Approach to Urgent and Emergency Hospital Care'* with the contribution of DPCMH to ensure a seamless model.

3.4.7 Planned Care Board

Primary Care is represented on this group with additional input into the development of a vision for outpatient services and the development of Patient Reported Outcome Measures (PROM) and Patient Reported Experience Measures (PREM). Plans to introduce PROMs and PREMs in primary care are ongoing.

To promote synergy of activity between the 3 National Programmes WG held 'triangulation' meetings resulting in agreement of joint priority areas and reporting to the NHS Executive Board on joint work on a regular basis.

3.5 Coordination of local activities

3.5.1 Joint & collaborative working between Primary Care and the Welsh Ambulance Services NHS Trust (WAST)

The Welsh Ambulance Services NHS Trust have fully engaged with Primary Care during 2016 – 2017. Through the work of Public Health Wales, and the evaluation findings of the Pacesetter programme, opportunities to jointly develop new models of care have been revealed. To support the emerging model for a sustainable Primary Care Service, 'Plan Do Study Act (PDSA)' cycles have been agreed to test different models of multi-disciplinary team (MDT) working between Primary Care and WAST. For example:

- Cwm Taf – In Hours model with 4 Advanced Paramedic Practitioners undertaking home visits for Aberdare Primary Care Centre
- Hywel Dda – Primary Care Support Team model with Advanced Paramedic Practitioners supporting struggling GP practices by doing home visits.

In an addition to the above MDT models, WAST has developed a collaborative working arrangement with the Cardiff and Vale Health Board. This is a community based model, where a Paramedic (in a response car) is geographically linked to the Western Vale Cluster. The Paramedic continues to provide 999 responses, but will also be the point of contact for the Cluster to respond to patients triaged by GPs as suitable for initial assessment by a Paramedic. This provides opportunities for identifying alternative pathways of care, other than Emergency Departments (EDs), for patients who can receive safe and timely care within their community.

Early data analysis has indicated that these new models / ways of joint working have already had success. The majority of the patients responded to by the Advanced Paramedic Practitioners and the Paramedics (supported by GPs) have not been transported to EDs. A full evaluation of the various models has commenced, and a report will be published in July 2017 (to be able to include six months of data analysis). Further PDSA cycles of MDT working and community based collaboration are planned for 2017 in the health board areas of Aneurin Bevan, and Powys.

3.5.2 Primary Care Estate

During 2015/16 developing '*a strategic approach on securing new methods of financing service developments and facilities, including accessing funding from wider sources and ownership*

models' (Primary Care Plan National Action), has been focussed on work with WG on short and long term improvements to the primary care estate. A project overseen by WG has led to the allocation of small grants for immediate renovations and work with NWSSP has focussed on releasing storage space within practices. Development of a long term vision of the primary care estate working cross sector and accessing a range of sources for funding has been taken forward locally depending on needs and future capital development plans for the area. DPCMH have worked with Directors of Planning to agree local arrangements. Any further need for a national approach is part of ongoing negotiations with CEOs and WG.

3.5.3 Risk stratification

'Our Plan for a Primary Care Service for Wales up to March 2018' (WG/NHS 2015) proposed;

'A nationally led evaluation of local approaches to assessing those people at risk of unplanned care, such as people with long term health conditions by March 2016'

During 2015, examples of good practice and different approaches to risk stratification were shared and presentations made to DPCMH on,

- The original work of PRISM
- The PRISMATIC Study by Swansea University
- NWIS Audit + and the BMJ Informatica Health Checks+, and
- Updates shared regarding the Inverse Care Law (ICL) projects in Aneurin Bevan LHB and Cwm Taf LHB.

Due to ongoing nature of the work as listed above, approaches to risk stratification at a national level was not prioritised for the 2016/17 DPCMH forward work plan. Sharing of the approach to the ICL work in ABLHB and CTLHB is continuing and has been showcased in year at Primary Care Stakeholder events and will be introduced throughout Wales during 2017/18.

Anuerin Bevan University Health Board and Cwm Taf University Health Board:

Cardiovascular Disease Inverse Care Law Programme

This a joint programme between Aneurin Bevan UHB and Cwm Taf UHB. The programme aims to address the impact of the inverse care law by embedding a sustainable, holistic cluster model for identifying people at risk of cardiovascular disease through population based risk assessment; and systematically delivering evidence based interventions in primary care at a scale that will achieve a percentage change in population outcome. The aim is to have activity in every Health Board area by 2018, with initial work prioritised for the most deprived community areas.

As a result of this investment:

- In Aneurin Bevan, 9000 citizens have attended a full health check in 1475 sessions held in 49 community venues across 4 cluster areas and 25 GP practices.

- In Cwm Taf, Over 2000 health checks have been conducted with roll out complete in 7 practices a further three commence in April 2017.

3.5.4 Research and Development

'Our Plan for a Primary Care Service for Wales up to March 2018' (WG/NHS 2015) recommended that;

'From 2015-16, health board directors of primary, community and mental health will deliver a co-ordinated national approach to supporting innovation in primary care, including structured support mechanisms, systematic evaluation of new ideas and good practice, and prioritised funding for innovative ways of delivering care and improving access.

The introduction of Pacesetter/pathfinder projects in 2015 provided focus for the implementation of this action. In addition it was agreed that an external critical appraisal would be commissioned; this will commence in 2017 and will review learning from Pacesetter projects, national and international learning, to identify key components of a whole system transformation of primary care relevant to Wales and how these can be successfully deployed in practice.

In addition, through work commissioned by PHW, Bangor University has undertaken a research project to study the functioning of clusters, which included a review of measurement tools designed for comparing primary care maturity and quality. This is being used to inform a further stage of the project aimed at prospectively measuring the strength and ongoing support needs of primary care clusters using repeated measurements.

In November 2016 DPCMH agreed to collate details of any primary care research studies being taken forward locally with an indication of resources and support to research and development in primary care. Results from the collation of activity were initially shared with the University of South Wales and Swansea University. It was apparent that the evidence provided only indicated a limited proportion of the ongoing studies which influence primary care.

The current and planned activity led by research and development units included within LHB IMTPS to inform the allocation of central research funding could be collated to inform the need for any further all Wales work if required during 2017/18.

3.5.5 Transgender Project

The primary objective of this work is to understand the issues faced by trans patients when accessing primary care services in Wales and the issues and barriers faced by primary care services in being able to offer good care, and to share examples of good practice.

Based on the issues identified, work has commenced with two clusters to implement necessary changes to improve service delivery. The outcomes of this work will then be shared with practices across Wales to provide guidance on how to improve practice.

3.5.6 British Sign Language Project (BSL)

This is a pilot project in one LHB focussing on the provision of online BSL interpreter services in primary care. Due to delays in recruiting

interpreters this work was due to commence in April/May 2017.

3.5.7 Welsh Language

In November 2016, the Welsh Language commissioner (WLC) met with DPCMH to discuss the implementation of *More than Just Words*[3] and ways of promoting the use of the Welsh Language in Primary Care. As a result, it was agreed to collate current developments/initiatives and to explore pragmatic improvements in Welsh Language provision that could be taken forward on an all Wales basis.

The WLC agreed the forward work plan for 2017 proposing the development of a Primary Care Tool kit to share available best practice.

3.5.8 Monitoring of local actions

During 2015/16 local actions were RAG rated and used to show progress at local level. During 2016/17 it was agreed to introduce a common criteria for RAG rating to better support all Wales comparison. An update of local progress will be completed July 2017.

3.5.9. Eye Healthcare Examination Wales (EHEW) Board and Low Vision Service Board (LVS)

Both Boards are chaired by a DPCMH.

EHEW

During 2016/17 the EHEW Committee has been working on a number of key issues, this has included increasing the numbers of EHEW accredited Optometrists, ensuring that Health Boards have access to reliable data on EHEW performance and working through the allocation of EHEW resources fairly to Boards. There has been a significant increase in EHEW activity over the year and future work for the committee will include working out where this is supporting the sustainability of GMS services and also moving work from secondary to primary care provision

LVS

During 2016/17 the LVSW Joint committee's work focussed on ensuring that all health boards have access to reliable performance and provision of data for the service as well as timely and indepth costs versus allocation breakdowns and a full understanding of how the service works and the benefits it promotes for both patients and health boards alike.

The Committee is also working on a strategic overview document highlighting the key priorities to take forward including:

- Working to understand, identify and overcome existing barriers to access – especially for children and residents in care homes.
- Raising awareness of the service – working with health boards and cluster groups to raise the profile and knowledge of the Low Vision Service Wales.
- Exploring workforce issues and models of working – in order to develop and support sufficient readily accessible local provision for patients right across Wales.
- Scoping out issues with regards to equality of access for ethnic minorities, homeless persons, refugees, asylum seekers and prison populations.

[3] '*More than Just Words*...' is the Welsh Government strategy to improve Welsh Language services in the health and social services sectors.

The Committee has also reviewed clinical audits around Geographical Workforce Spread, Children Accessing the service, Prescribing Habits of LVSW practitioners and the implementation of Peli Lenses. Learning from these audits will be incorporated into 2017/18's round of three yearly re-accreditation of all LVSW practitioners.

In addition, the Committee continues to support work to identify and locally signpost LVSW patients specifically at risk of falls and depression as well as the introduction of clinical interventions in cases of homonymous hemianopia (often found in stroke patients). Further indepth information about the service will be available in The Low vision Service Wales, Annual Report 2016/17.

3.5.10 Primary Medical Care Advisory Team (PMCAT)

During 2016 it was agreed that the PMCAT service would be transferred from PHW to the NHSSP and this took effect from January 2017.

It was not possible to review the current model prior to the transfer. The work has therefore been planned in 3 phases, i.e. the transfer of the resource and team under the existing model, followed by the implementation of a revised model within the current resource planned for April 2017, with a longer term review and establishment of a broader model to incorporate other professional groups as the final stage. This work will be ongoing during 2017.

3.5.11 National Delivery Groups (NDG)

DPCMH were alerted to changes to the terms of reference, membership and budgets for NDG. In advance DPCMH agreed to review membership to ensure a management and clinical representative of primary care were identified. NDG will now be required to report to the Director General WG on local progress. A process to ensure feed back to the DPCMH and enable advice to be sought in advance is being planned.

Other groups

DPCMH have membership of numerous all Wales groups which are reported monthly, e.g.

- Dementia strategy
- MH National Partnership Board
- Falls National Taskforce Board
- Hearing Well Project Board
- Senior Succession Planning
- Urgent Care National Groups
- Planned Care National Groups
- GMS IM&T
- WCCIS National Implementation Board

Version 7 – Final 30.08.17

PART 4 FORWARD WORK PROGRAMME 2017/18

The National Work Programme for DPCMH aims to:

- Ensure that recommendations from *'Our Plan for a Primary Health Care Service for Wales up to March 2018'* are implemented and monitored.
- Identify actions annually to meet the priority areas within the Plan, i.e. Planning care locally; Improving access and quality; Equitable access; A skilled workforce, and Strong leadership
- Incorporate actions and recommendations arising from changes made in year, including sharing of best practice and ensuring sustainability.
- Provide deliverables to support the local and national agenda and to help inform future policy development.
- Focus on the need to demonstrate benefits realisation for service users

The DPCMH forward work plan for 2017/18 is based on an assessment of the recommendations arising from the Pacesetter and Cluster development Reports 2016, alongside the original national commitments within the Primary Care Plan and the ongoing requirement of priority areas identified in 2016. Relevant recommendations were shared with the following groups for their consideration and inclusion in their forward work plans;

- The Primary Care Workforce and OD Group
- The ICT and Information Board
- The PCCDI Hub Programme Board

In April 2017 the draft forward workplan was further revised to address actions within the CEOs national policy and improvement programme indicating joint working areas with other national programmes.

Based upon current resources, future priority areas have been identified, (see below).

4.1 Proposed priority areas 2017/18

- Implementation of the emerging model of primary care to ensure sustainability – project scope to be finalised. To include;
  - Workforce and OD
  - Cluster development
  - Pacesetters and Innovation
  - ICT and Information
- Contracts negotiation initially GMS
- Mental Health

High level plans for Workforce and OD, ICT and information and the PCCDI Hub, including Pacesetter and innovation and cluster development are attached (Appendix 3, 4 and 5). Detailed project plans for each element are being finalised.

4.2 Outline plans for priority areas

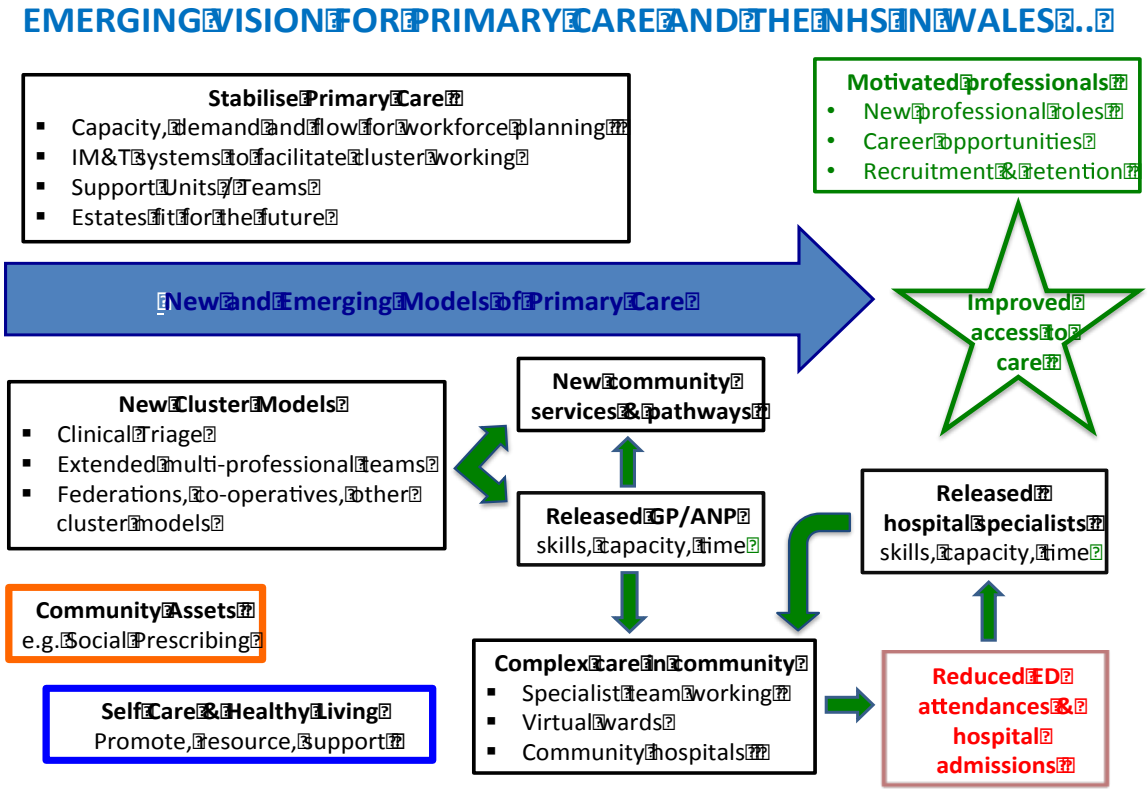
4.2.1 Implementing the Emerging Model (IEM)

Primary care stability forms the basis of the emerging model of care to ensure that practices and clusters can respond to future demands. Components of the model include;

- Effective Cluster working
- New roles, pathways and services
- An enhanced MDT to manage the workload, and

- The skills, time and resources for the management of complex care in the community

Pacesetter projects are currently focussed on each of these elements. Based upon the learning from the Pacesetter evaluation and support to cluster development, the vision for future primary care services has emerged as shown in the diagram below. A video version explaining the model has been made available to each Cluster and Health Board. A series of questions completes the video which provide an opportunity for not only assessing local progress but also to gather opinion to enhance the model and gather ownership and support. The next stage of taking the emerging model forward has been included as part of the Forward Work Plan.



An Implementation of the Emerging Model group was set up in June 2017. Following a review of recommendations from Cluster Development Reports, supporting groups will be established to take aspects of the model forward. The detailed plan is under development.
Sustainability of the current system will also be taken forward by,

- Monitoring local progress of workforce and OD actions
- Reviewing the potential impact of GP retirement predictions
- The collation of baseline data from the assessment of practices at risk of sustainability issues – to be updated periodically

Version 7 – Final 30.08.17

4.2.2 GMS Contract 2017 – 18 High Level Action Plan

The GMS Contract 2017-18 Action Plan sets out the changes to the GMS Contract for 2017/18 as agreed between Welsh Government, Local Health Boards and GPC Wales. Priority actions and delivery timescales are detailed below:

- GP professional indemnity and developing solutions for Wales.
- Initiatives to improve access to services and managing demand for services.
- The reform of the Quality Outcomes Framework (QOF), and new initiatives for enhanced services. Other contractual models and initiatives, including GP federations.
- The way in which social prescribing can be embedded in the GP consultation process. Initiatives to reduce GP non-core activity workload.

  Subject to agreement of an overarching Action Plan 2017-18 it is envisaged that a programme management methodology will be adopted to ensure detailed coordination, governance and delivery to agreed timelines. Action owners will be assigned to work streams and progress will be monitored and reported through the DPCMH Executive Peer Group with assurance to CEOs and the NHS Executive Board.

4.2.3. Mental Health

Activities to be agreed around the following 3 areas;

<u>Improving access</u>
To include;

- Delivery of all parts of the Measure
- Delivery of waiting times targets with a particular focus on the new targets for
- CAMHS and psychological therapies and improving access in the other areas where WG has provided targeted funding.

<u>Sustainability of service</u>
To include;

- Reviewing and learning from service models across Wales and beyond
- Implementation of the requirements of the Framework for Improvement for
- CAMHS
- Implementation of the requirements of the Dementia Strategic Action Plan
- Considering opportunities for further service integration- with physical health, with primary care and with social services
- Working with the Workforce and OD group to promote a fit for purpose modernised mental health workforce

<u>Performance</u>
To include;

- Improving data and understanding through participation in NHS Benchmarking UK for both CAMHS and adult services
- Implementation of a core mental health dashboard
- Monitoring of core mental health act reporting and annual audit
- Implementation of opportunities from the all Wales Commissioning Frameworks for mental health (Medium & Low Secure, Continuing Care)

Version 7 – Final 30.08.17

4.3 Extension of ongoing work

4.3.1. Quality and Delivery Measures

The focus during 2017 will be on improving reporting processes to Boards on existing measures via the primary care portal and the development and inclusion of further measures.

4.3.2 Roll out of 111 and consolidation of directories of service and pathway development

The 111 Wales service, which brings together NHS Direct Wales and local GP Out of Hours services, went live in ABMU in October 2016, and was extended to Carmarthenshire in May 2017. Patients in the 111 live areas are now able to access urgent unscheduled care, information and advice more easily via a free to call number. The next phases of roll out are planned for ABUHB and the remainder of HDUHB in early 2018 with wider debate about options for 2018 /19 being considered with Cwm Taf and Powys.

The Cabinet Secretary will be considering the nature and scope of a national 111 service roll out on receipt of a business case and report from the Programme team and formal evaluation in Autumn 2017.

Concurrent work is also progressing on the procurement of a new All Wales IT solution to support the delivery and expansion of the 111 service which will eventually replace the IT systems in place across NHSDW and GP OOHs. It is anticipated that the procurement will continue throughout 2017/18.

The national Directory of Service group is progressing their work programme to transition towards a single, comprehensive Directory of Services (DoS) across NHS Wales. In the first instance, the NHSDW DoS will be used as the platform on a once for Wales basis, with a new DoS product being commissioned in due course. LHBs are actively engaged in reviewing, updating and expanding their DoS entries and putting robust maintenance processes in place to ensure that the NHS Wales DoS remains up to date and reliable. This work is aligned with local pathway development to ensure that professionals and the public are directed to the right services to meet their needs.

LHB's are continuing their pathway development work with particular focus on key clinical scenarios to build a consistent level of provision and standard of response throughout Wales, albeit delivered in accordance with local arrangements. Significant and ongoing progress has been made to support 111 go live and there are wider ongoing efforts made in preparation for roll out.

4.3.3 Transgender project

The aim of this project is to understand and improve the primary care experience for trans people. NHS CEHR are working with Primary Care Clusters in Cardiff and Powys. To date three '*Have your say'* events have taken place to understand the primary

care experiences of trans and gender diverse people and their recommendations for how to improve the service they receive. An online survey has also been created for staff and the public to present their views and suggestions.

From April 2017 work will begin with participating practices to implement the recommendations from the events and survey.

4.3.4 British Sign Language

Online project and Sensory loss Information standard implementation.

The BSL online service will be piloted in Cwm Taf. The project will commence in April 2017 and learning will be shared.

DPCMH will also support the implementation of the new Sensory loss information standard from September 2017.

4.3.5 Welsh Language

Plans for 2017 were agreed with the Welsh Language commissioner in April. It is intended that national posters will be developed for primary care contractors, to encourage patients to confirm their preferred language and the development of a Welsh Language toolkit for primary care is being explored.

4.3.6 Risk stratification/ ICL/predictive modelling

An external evaluation of PRISM is awaited from Swansea University. Implications will be considered. Ongoing sharing of learning and model roll out from the Inverse Care Law projects in Aneurin Bevan LHB and Cwm Taf LHB will continue. Extension of predictive modelling will be explored with Assistant Medical Directors in May 2017. It is proposed that the work will become part of the taking forward of anticipatory care models as part of the forward work plan working with the USC programme.

Please note: The overarching forward work plan for 2017/2019 and detailed plans is available on request.

Version 7 – Final 30.08.17

PART 5 CHALLENGES 2017/18

Whilst significant progress has been made over the past 2 years, there remain a number of challenges.

- The development of whole systems thinking in future planning including estates, finance, HR, etc which may be limited due to current skill sets and experiences of corporate staff being focussed on secondary care activities.
- Achieving a balance in financial planning and allocation/transfer of funds when services are provided outside the hospital.
- The amalgamation of funding from numerous initiatives across health and social care and the impact of allocations of short term funding. Demonstrating progress in the short term can be a barrier.
- The focus on targets in secondary care which limits discussion and prioritisation of activity in primary care.
- There are clinical governance and accountability issues in relation to extended and emerging roles across health and social care.
- Promoting pace of change alongside ensuring safe delegation of care and appropriate supervision across professional boundaries.
- Increasing pressures of sustainability.
- Development of clusters brings challenges to traditional ways of working e.g. information governance.
- Consistent use of Primary Care measures across Wales.
- Developing the GMS contract offer.
- Sophisticated workforce planning accounting for new workforce being developed in primary care.
- Developing a coherent estates position immediate and long term.

Version 7 – Final 30.08.17

21.4

PART 6 FINANCIAL SUMMARY

The following summarises the funding allocated to health boards for primary and community care in 2016/17 (including general medical services, prescribing costs, dentistry and ophthalmic services) and where available information on spend.

Included within the section is information on spend from the National Primary Care Fund in 2016/17 (taken from health boards' end of quarter 4 progress reports for 2016/17), allocations for the Integrated Care Fund in 2016/17 and examples of how additional funding has been invested through the Efficiency Through Technology Fund and the National Delivery Plan Fund.

Primary Care Core Funding

(Figures are as per unaudited accounts for 2016-17 (as at 05/06/17)

General Medical services – total spend by Health Board in 2016/17

Health Board	Total Allocation £m	Total Spend £m
Abertawe Bro Morgannwg	74.458	75.948
Aneurin Bevan	84.959	87.368
Betsi Cadwaladr	115.568	119.337
Cardiff and Vale	64.339	72.499
Cwm Taf	45.351	48.109
Hywel Dda	60.467	64.604
Powys	30.689	33.344
Total	**475.831**	**501.209**

GP Prescribing costs – total spend by Health Board in 2016/17

Health Board	Total Spend £m
Abertawe Bro Morgannwg	96.045
Aneurin Bevan	98.821
Betsi Cadwaladr	106.960
Cardiff and Vale	74.116
Cwm Taf	55.536
Hywel Dda	69.714
Powys	17.828
Total	**519.020**

Version 7 – Final 30.08.17

General Dental services – total spend by Health Board in 2016/17

Health Board	Total Allocation £m	Total Spend £m
Abertawe Bro Morgannwg	29.191	27.137
Aneurin Bevan	28.351	28.353
Betsi Cadwaladr	28.044	24.742
Cardiff and Vale	25.987	25.987
Cwm Taf	13.239	11.455
Hywel Dda	18.264	15.591
Powys	5.807	5.557
Total	**148.884**	**138.822**

General Ophthalmic services – total spend by Health Board in 2016/17

Health Board	Total Spend £m
Abertawe Bro Morgannwg	7.121
Aneurin Bevan	8.400
Betsi Cadwaladr	7.603
Cardiff and Vale	5.139
Cwm Taf	4.795
Hywel Dda	4.969
Powys	1.006
Total	**39.033**

National Primary Care Fund 2016-17

The Minister for Health and Social Services announced in March 2016 the allocations for the National Primary Care Fund in 2016-17. This included an increase in investment in primary care clusters from £6m to £10m and the remaining funding was allocated as follows:

- **£26.081m** recurrently for your IMTP primary care and workforce delivery agreements;
- **£3.8m** in 2016-17 for the national programme of pathfinders and pacesetters;
- **£0.72m** recurrently to support joint work in Aneurin Bevan and Cwm Taf university health boards for the inverse care law pathfinders;
- **£0.428m** in 2016-17 for the primary care wet AMD treatment pathfinders in Aneurin Bevan, Cwm Taf, Powys and Hywel Dda health boards;
- **£0.38m** recurrently to Public Health Wales for its primary care innovation and development hub to support local delivery.

Version 7 – Final 30.08.17

21.4

National Primary Care Fund by Health Board in 2016/17

(Figures are as per health board end of quarter four reports for 2016-17)

Health Board	Total Allocation in £ms	Total Spend in £ms
Abertawe Bro Morgannwg	6.699	6.322
Aneurin Bevan	8.200	8.133
Betsi Cadwaladr	8.698	7.771
Cardiff and Vale	5.776	5.493
Cwm Taf	4.936	4.936
Hywel Dda	4.859	4.841
Powys Teaching	1.864	1.864
Total allocation	**41.032**	**39.360**

To note:
*****allocation includes funding for – IMTP/workforce schemes, pathfinder/pacesetter programmes including inverse care law and wet AMD and primary care cluster allocations.

******total spend is based on the end of 2016/17 quarter four reports received from each of the health boards.

Integrated Care Fund (ICF) 2016-17

The Integrated Care Fund in 2016-17 has been used to complement the Primary Care Fund to maximise benefits to citizens particularly in relation to schemes to help unnecessary hospital admissions and help keep people living safely and independently in their own homes.

Regional Partnership Board	Total Allocation for 2016-17 £M
Cardiff and Vale	6.372
Cwm Taf	5.056
Gwent	9.238
North Wales	11.426.
Powys	2.466
West Wales	6.417
Western Bay	8.371
Total allocation	**49.346**

Version 7 – Final 30.08.17

Efficiency through Technology Fund (ETTF) – 2016-17

Two examples of primary and community care related projects which received investment through the ETTF in 2016/17 are:

Managing Chronic Oedema in Community Settings

The introduction of Video Prescription Apps and a dedicated on the ground educator with Microsoft Lync communication aids to improve the current management of chronic oedema, improving efficiency of prescribed dressings and bandages to more effective products from the All Wales Lymphoedema Compression Garment Formulary and Wound Care Formulary. This project will ensure that patients are treated at home, reduce waste, harm and variation empowering people and their community nurse to deliver outcome based solution.

National Delivery Plans – additional £10m investment in 2016-17

An example of primary and community care related projects which received investment in 2016/17 are:

Cardiology e-referrals, diagnostic requests and clinical communications

This project will fund additional specialist resource within NWIS to work in collaboration with cardiology clinicians and informatics staff in all health boards to develop an integrated functional electronic referral system between primary, secondary and tertiary care and across health boards.

Version 7 – Final 30.08.17

PART 7 SUMMARY OF ACHIEVEMENTS/CHANGES AT LOCAL LEVEL

This section provides examples of changes/innovations which form part of the emerging model. Examples are given for each element.

Elements of emerging vision.

1. Stability of Primary Care
2. New Cluster models
3. Community assets and self care
4. New community services and pathways
5. Complex care in the community
6. Motivated professionals and multi disciplinary teams

1. Stability of primary care

All LHBs have worked with individual practices as well as clusters to identify appropriate support to improve and/or stabilise services. LHBs have also established primary care support teams/units to provide additional help to practices struggling with increasing demands. Examples of supporting initiatives include;

Hywel Dda University Health Board – Patient Participation Groups:

The aim of the patient participation group is to work with the practice to improve the patient experience at the surgery, this might be done through a variety of ways such as reporting back from concerns patient are aware of in the community, bringing ideas forward which they think could improve the patient experience as well as giving opinions on services/developments that the practice has introduced or would like to introduce. The Primary Care Team are keen to support practices to establish a PPG as they move through some challenging times across Primary Care and have a variety of resources that they can offer, as well as practical support and a invite to the PPG development network.

Betsi Cadwalder University Health Board:

Betsi Cadwalder UHB are taking forward a scheme for recruiting and retaining GPs who have recently completed traditional GP training schemes but who want to further develop their skills, portfolios or general career ambitions within a supported environment.

The GPs are employed by the Health Board and provide a core minimum service commitment to support practices which have GP capacity concerns and for remaining sessions to select from various clinically focused specialist areas eg palliative care, ENT, dermatology, as well as take up opportunities in leadership, or further academic studies.

Powys Teaching Local Health Board - Urgent Care Practitioners working in Powys:

Addressing patient demand has led to medical practices in Powys having to adopt an imaginative approach to developing its workforce.

With practices struggling to fill vacant GP posts, they have helped meet patient demand by calling on the services of a range of health care professionals working as Urgent Care Practitioners (UCPs). Give practices in north and mid Powys now have regular access to UCP.

Working with Shropdoc, the local not-for-profit GP-led out of hours provider, a team of UCPs has been established. The majority are trained paramedics, with trained nurses now joining too. When fully competent, UCPs undertake duties such as minor illness clinics as well as undertaking home visits under GP instruction.

Abertawe Bro Morgannwg University Health Board:

The Health Board is committed to promotion a sustainable model of Primary Care in Gwent. It is generally acknowledged that the current model and configuration is no longer sustainable for a number of reasons including those relating to demography, disease burden, workforce, public expectation and changes in society.

A series of six sustainability workshops for GP practices across Gwent have concluded. The workshop supported a more in-depth conversation with GP Practices to allow the Health Board and Practices to begin the shared design for solutions to these imminent challenges. The format of the afternoon meetings was in two parts:

The first part of the meeting outlined the challenges in broad terms and the solutions that are being implemented elsewhere e.g. working at greater scale, altering skill-mix, use of technology. The second session was a facilitated, NCN-Level discussion, of the specific challenges in each individual NCN based on current vacancies, projected retirements, population changes and other specific local issues.

The aim was to allow the local professionals to explore with the LHB leadership the solutions that might address local challenges. This has already results in some practices discussing possible mergers, sharing of resources/staff and exploring new roles which can support the sustainability of the practice.

2. New cluster models

- Federations, cooperatives, other cluster models
- Clinical triage

In response to increasing demand on a traditionally medical model of general care from the GP, a variety of organisational forms for delivering sustainable and accessible care are evolving. Models include “super” GP practices, co-operatives, corporate partnerships, social enterprises, limited companies and federations. Examples include the federation of GP practices in Bridgend and the Red Kite social enterprise in the South Powys cluster.

Version 7 – Final 30.08.17

Abertawe Bro Morgannwg University Health Board – Federated working across Bridgend: East cluster network project:

Six GP surgeries in Bridgend have joined together to offer a range of new community services for their patients including a bespoke new website aimed at cluster network patients.

Pen-Y-Bont Health (PYB) is the first federation of GPs in Wales and includes all six practices in the Bridgend East Cluster Network: Ashfield, Newcastle, Oak Tree, New Surgery Pencoed, Pencoed Medical Centre and Riversdale (five of which are training practices varying from a single handed practice to an eight partner practice serving a population of 70,484). As a federated cluster of GP surgeries, the Bridgend East Network has developed Wales' first not-for-profit social enterprise consortium with an NHS Pacesetter status. This allows PYB to bid for public sector contracts to provide local healthcare solutions for local need. Crucially this overcomes restrictions which usually limit contracts to individual surgeries. One GP from each of the six practices was nominated by their partners as 'directors' to attend board meetings, discuss, negotiate and report outcomes of planning meetings to establish the federation.

The federated model allows resources to flow in a sustainable way improving access to services and improved pathways for patients. Engaging with the Third Sector and other agencies should allow for a more diverse way of tracking some of the communities' health concerns. As part of the project the Federated pacesetter will publish resources including a learning log and a toolkit to assist clusters in the future if they wish to follow the federated route.

One of the initial joint projects was the website development www.pybhealth.com which not only contains local information but a wealth of information on common illnesses, dos and don'ts, childhood complaints and health and wellbeing topics (including stopping smoking and diet and exercise). The website will also empower patients to be better informed about health issues before they see their GP. PYB patients can use the website as an aid to help make informed choices.

The federation has also set up a joint mental health, counselling service for PYB patients over the age of 18. Before this, patients were usually signposted to local charities for support but now the federation is able to offer direct counselling services. A service is also planned for patients with diabetes who are prescribed injectable agents.

Powys Teaching Local Health Board: Nurse Triage pacesetter:

A nurse triage model combined with enhanced multi-disciplinary team working is being piloted to release GP capacity and ensure patients are seen by the most appropriate healthcare professional.

As a result of this investment:

Recent progress reports have shown:

- 20.34% of **all** contacts (telephone and nurse triage) resulted in advice only.

- 8.68% of **all** contacts were provided with a routine GP appointment, this has continues to reduce since the December report (9.85%).
- A total of **4,852 GP** appointments have been avoided for the accumulative period up to February 2017.

Cwm Taf Health Board - General Practice Support Officers:

Merthyr Cluster is piloting the use of GPSOs within GP Practices to become part of the community multi-disciplinary team (MDT). The GPSOs are employed by the Local Authority, which has been commissioned by the Cluster via an SLA. The overarching objective is to influence cultural and behavioural change by providing a front line resource that identifies and resolves social issues whilst educating service users that frequently attend the GP practice for non medical intervention. The GPSOs will actively engage with and refer to the Third Sector.

3. Community Assets and Self Care

Examples include:

Cardiff & Vale University Health Board:

Some clusters are investing in posts to link people systemically to the wide range of non-clinical care and support available locally. Terminology varies; some posts are called community connectors, others are termed link workers. The Torfaen clusters have appointed social prescribing co-ordinators working with GP practices to address wellbeing issues that underlie clinical presentations. This has led to people accessing finance and housing advice improving their mental wellbeing which in turn has reduced demand for GP appointments.

Wellbeing coordinators have commenced in clusters across Cardiff and Vale to promote the social model of care and public health priorities within clusters.

The service received 236 referrals in the first 9 months of operation, covering general health and wellbeing, finance, housing and relationship issues, exercise and nutrition, mental health and crisis events.

Signposting activity showed engagement by 79.5% of patients, and 45 community workshops have been held, which were attended by 317 people.

Within surgeries, 309 contacts have been made with patients regarding immunisations, 86 contacts have been made about screening programmes, and 156 contacts have been made concerning other opportunities

Hywel Dda Health Board - Early Years Obesity Prevention:

This scheme is implementing actions at levels 1 and 2 of the all Wales Obesity Pathway prioritising Maternal Women and Early Years, particularly the first 1,000 days, will contribute to preventing obesity in children and subsequent associated morbidity and service demand.

Version 7 – Final 30.08.17

As a result of this investment:

Across the three counties of Hywel Dda the Baby Let's Move service is now operational within nine Leisure Centres and a total of 247 referrals have been received in the first nine months.

Cwm Taf University Health Board – Your Medicines Your Health:

The overall aim of Your Medicines Your Health is to generate and embed a cultural change with respect to the responsible use of medicines by patients and the wider public. "Helping you to make the most of your medicines".

Through co-production, Your Medicines Your Health delivers a philosophy that improves and promotes self-reliance and independence both individually and collectively.

As a result of this investment:

- Methodology and sampling for analysing of returned medicines completed preliminary data available.
- Medication awareness for sheltered housing residents determined.
- Local communications team has developed social networks to support Your Medicines Your Health. 4 Facebook adverts to support the campaign have had a reach of 25,000 people across Cwm Taf and has received a good response. Twitter has also been used.

Aneurin Bevan University Health Board - Diabetes Pathway:

The model supports patients to successfully self-manage their diabetes as far as practically possible, by supporting practices and community services to deliver care closer to home. The community Diabetes Specialist Nurses after completing training offer an insulin initiation service to patients when referred by practices.

As a result of this investment

- March 2016-February 2017 showed a 14% reduction in new attendances at Aneurin Bevan University Health Board emergency department sites.
- Patient Review Groups have been involved in improving the "patient interface"
- Patient experience survey in every primary care cluster show 10% improvement in satisfaction with care provider

Version 7 – Final 30.08.17

4. New community services and pathways

Examples include;

Betsi Cadwaladr University Health Board Heart Failure Service:

The goal of the scheme is to improve access to heart failure services and related diagnostics, and support the shift of services to out of hospital settings.

- Builds capacity in community and Primary Care to manage the heart failure population through support, education, training and an interface with the MDT.
- Improves access to diagnostic clinics in the community. Patients are identified and treatment is commenced appropriately and timely.
- Ensures a specialist service for patients with the highest degree of clinical complexity are managed by a team of ANPs.
- Ensures quality care is delivered consistently and equitably across North Wales. Access to echocardiography, early diagnosis and clearer referral pathways.
- Reduction in the number of admissions of patients with primary heart failure by 50%.
-

First year achievements;

- Recruitment of a number of highly trained staff; nurses, cardiac physiologists and pharmacists.
- Integration with other chronic conditions teams to increase knowledge and skill base. This ensures that both specialist and generalist staff manage patients more effectively along a case management approach.
- The new service has improved the competencies, training and education of community and Primary Care staff.
- Supports GP Practices in the management of an ageing population.
- Better health and wellbeing outcomes for heart failure patients.
- Reduction in the number of emergency hospital admissions.
- Increase in the community based workforce.

1467 patients attended the Echo diagnostic clinics; 348 diagnosed with LVSD ranging from mild to severe; 225 diagnosed with HFNEF; 919(63%) had changes made to management or medicines plan; 224 referred to heart failure specialist nurses; waiting times for the clinics reduced to between 2 to 4 weeks.

Cwm Taf University Health Board - Direct Access One Stop Cardiology Community Clinic:

- Merthyr Tydfil Cluster is provided by a multi-disciplinary team consisting of a broad range of specialist staff. The concept of the clinic is that the majority of patients will have appropriate tests on the day and then have their management plan and diagnosis explained
- At present, patients who require investigations are referred into secondary care and can wait up to and in excess of 26 weeks for an investigation and subsequent outpatient appointment if required. The One Stop Cardiology Clinic is reducing waiting times for both diagnostics and outpatients and reduces the referral to treatment time for patients suitable for the service. To further improve

communication, an interoperable solution that allows the Cardiology Clinic to write directly to the GP record is being launched in May 2017. The solution is called Vision360. It fully interfaces with Vision and EMIS and provides all participating GP practices within Merthyr to view all consultations undertaken in the Cardiology Clinic within minutes of the consultation ending.

Abertawe Bro Morgannwg University Health Board - The Primary Care Vasectomy Service:

This service is provided by General Practitioners with Special Interests (GPwSI) and demonstrates a successful pathway re-design from a hospital delivered model to one that is based in and delivered by primary care. The new pathway commenced in November 2014 and is delivered by two providers from GP premises in Swansea and Bridgend for ABM registered patients via referrals into a single access point (WCCG). Patients are referred and accepted into either service location and it is expected that the total patient pathway does not exceed 15 weeks in total from the initial receipt of referral. Patients are able to access an efficient service that has shorter waiting times and provided in convenient modern community premises which has helped to improve patient experiences. The service has released capacity both in outpatient and day theatre as a result of the safe, effective transfer and has developed positive working relationships between primary and secondary care colleagues.

Cardiff and Vale University Health Board - Care Home Medications Review Pilot:

Prescribing advisors support medication review and medicines management process review within care homes. 121 reviews took place in three care homes. A planned roll-out for 2017-18 is in place.

- The care home medications review pilot has resulted in patients needing to take fewer medications (67 medicines were stopped whilst 47 were changed), which has reduced the risk of harm and led to staff spending less time administering medication – one site reported this has freed up approximately 5 hours of staff time a week.

Cardiff & Vale University Health Board & Welsh Ambulance Services:

WAST has developed a collaborative working arrangement with the Cardiff & Vale Health Board. This is a community based model, where a Paramedic (in a response car) is geographically linked to the Western Vale Cluster. The Paramedic will continue to provide 999 responses, but will also be the point of contact for the Cluster to respond to patients triaged by GPs as suitable for initial assessment by a Paramedic. This will provide opportunities for identifying alternative pathways of care, other than Emergency Departments, for patients who can receive safe and timely care within their community.

Version 7 – Final 30.08.17

Community Pharmacy

Hywel Dda Local Health Board:
Emergency supply of Medication

In March 2016, 27 pharmacies commenced the Emergency Supply of Medication Service. This service provides urgently required repeat medication to patients who are unable to obtain a prescription before they need to take their next dose. This relieves pressure on GP out-of-hours services, A&E departments and GP appointments from visitors to the area. During 2016/17 the number of pharmacies offering the service increased to 39.

In 10 months during 2016/17 (Apr16 to Jan17), almost 2,500 items were supplied to just over 1,700 patients. 764 of these patients were diverted from attending the GP Out of Hours Service or A&E Department to obtain medication.

The aim is to increase the number of pharmacies offering this service to 2017/18 to at least 50.

Palliative Care Medication

A new community pharmacy service was put in place in December 2016 to enabled 9 community pharmacies (3 in each county) to hold specific End of Life drugs. The nature and strengths of some of these drugs means that they are not routinely stocked by community pharmacies. Situations in which end of life drugs are needed are sometimes unexpected and not being able to source the required drugs swiftly can place unnecessary stress on family or carers and also the health care professionals who attend the patient. Whilst pharmacies can usually obtain most drugs required for palliative care, they would need 24 or 48 hrs to have them delivered from their suppliers. Nine pharmacies were identified for the service based on their opening hours and locations.

Triage & Treat

The Triage & Treat Service, which is unique to Hywel Dda UHB was extended to more pharmacies. A maximum of 17 pharmacies offered the service during 2016/17 with a drop to 16 by the year end. Training was provided to pharmacy staff, to enable them to deal with low level injuries with the aim of preventing unnecessary visits to a GP or A&E Department. To date (Jan 17) 213 people have accessed the service with, 175 of these treated. When asked which other service would have been used if the pharmacy Triage & Treat service wasn't available, 100 would have attended A&E and a further 53 would have presented at a medical practice. The service was recognised by the Health Service Journal and made the shortlist for the 2016 HSJ Awards category of Innovation in Primary Care.

Version 7 – Final 30.08.17

Dental Care

Hywel Dda Local Health Board:
Oral Health Promotion

The Community Dental Service Oral Health Promotion Team has enjoyed a very productive year in 2016-17, as it has continued to focus on the delivery of evidence based activity to improve the Oral Health of the population. The Team has concentrated on 3 main work streams, the delivery of the Designed 2 Smile programme, the delivery of WHC 001 to improve Oral Health in care homes and the modernisation of the training in mouth care delivered to other health workers
.
Designed 2 Smile has concentrated on getting Fluoride into contact with teeth through its tooth brushing and fluoride varnish programmes. Recent statistics show 14% of 3 year olds in Wales presenting with dental caries and therefore the programme will now look at supporting this age group with continuation of tooth brushing in settings and application of fluoride varnish. There has been a 12% decrease in dental decay nationally which has coincided with the introduction of Designed 2 Smile.

WHC 001 care home work has focused on undertaking mouth care risk assessments and developing care plans for people in care homes. Although only at the pilot stage, the Team are supporting a number of care homes enabling staff to ensure each resident have an oral health risk assessment and individual care plan within 7 days of being admitted.

The Oral Health Promotion Team has developed excellent links to those trainers delivering mouth care training to ward nurses, HCSW's, student nurses, HV's, school nurses and Drug and Alcohol teams.

Opthalmology

Cwm Taf Local Health Board – Welsh Eye Care Scheme:

Patients with an eye problem often attend their GP. One aim of the Welsh Eye Care Scheme (WECS) service is to direct many of these patients to Optometrists when appropriate. Each Cluster has been given a presentation on the WECS service and the Clusters are actively working to identify those patients attending for eye problems and signposting them to the WECS accredited Optometrist. This is in line with prudent healthcare and ensuring the patient sees the most appropriate health professional.

Hwyel Dda Local Health Board – Low Vision & EHEW:

Forty two practices are Eye Health Examination Wales accredited to provide enhance eye examinations. In 2016/17, we:

- Introduced new evening and weekend hospital slots to address cataract waiting lists.

- Sent some hospital patients to external providers while new capacity is developed.
- Addressed capacity issues within the hospital by developing glaucoma suspect and ocular hypertensive services and cataract post-operative discharge services, provided by Eye Health Examination Wales optometrists within their high street practices.
- Undertook feasibility work in Ceredigion to move services into better accommodation in Bronglais by November 2016.
- Provided a new community Acute Macular Degeneration (Wet AMD) service in Tenby and Cardigan to reduce the 100 mile journey time for patients in Pembrokeshire and south Ceredigion who were travelling to Amman Valley or Bronglais Hospital to access services.
- Provided a new shared care follow up Wet AMD service based on optometric practices in Haverfordwest and Carmarthen to address capacity issues within the hospital and allow follow up care of patients closer to home.

Low Vision Service Wales (LVSW)

In 2015/16 a total of 1,322 Low Vision assessments were carried out by accredited Low Vision practitioners in primary care opticians (and in some cases in the patients own home) in the HDUHB area. Of these 1,221 were for patients aged 60 years + with 876 of these patients aged 80+. There are currently 34 practices offering the service across the area with a thriving domiciliary service also in place. During an hour long annual assessment the LVSW practitioner will measure the patients vision, demonstrate and prescribe suitable visual aids (including electronic magnifiers) as well as discuss the patients particular eye condition/s and the difficulties it causes them day to day. The practitioner can also signpost and refer to a number of other health and social care providers, education and local sources of voluntary help and support as necessary. This service combined with Eye Health Examinations Wales (offered by over 90% of optometry practices in the area) enables a significant number of patients with conditions such as Dry AMD to be fully managed solely within primary care.

Aneurin Bevan University Health Board - Ophthalmic Diagnostic Treatment Centres:

The aim of this scheme is to provide assessment and diagnosis for Glaucoma and Ocular Hypertension conditions in a community setting to improve access to ophthalmology services and reduce the risk of harm as a result of long waits.
As a result of this investment:

- 3 centres went live on 1 February 2017. 2211 letters have been sent with 1567 people assessed.

Version 7 – Final 30.08.17

5. Complex care in community e.g. Virtual wards

The success of the virtual ward model in Powys at avoiding unnecessary admissions to hospitals is well known. There are many other examples of similar models across Wales. In Cardiff and Vale University Health Board, a number of clusters have created nursing posts to help support the most frail, elderly and vulnerable people across the cluster population. This streamlined and coordinated delivery of care at cluster level benefits from the economies of scale brought about from working across a cluster population rather than at individual GP practice population.

Cwm Taf University Health Board:

A virtual ward model initiated by a Cynon Practice has been identified to host a team of Advanced Emergency Practitioners and an Occupational Therapist. Patients are identified for the 'Virtual Ward' due to frailty and multiple and complex health and social care needs. The MDT meeting currently has representation from: GPs; Community Nursing; The 'At Home' Service; Third Sector – Care & Repair, Interlink; Pharmacist; Nurse Practitioner; Social Services; Practice Manager.

This model is providing a platform from which to explore and develop the role of Occupation Therapists in a Primary Care General Practice setting

Abertawe Bro Morgannwg University Health Board - Acute Care in the Community - GP Outreach/Acute Clinical Response:

The pathfinder project aims to demonstrate the key role of GPs in managing people with an acute exacerbation of multiple complex conditions on an ongoing basis and the subsequent impact this has on demand on primary and secondary services.

As a result of this investment:

- For the last 3 months of the year (January – March 2016) the service saw on average 31 patients per month after triage. An unnecessary hospital visit was avoided on average for 7 patients per month.

Betsi Cadwalder University Health Board - Community Diabetes Services:

The scheme supports a new model of care for people living with diabetes or who are at risk of developing diabetes. The intention is to provide more specialist diabetes support services away from a hospital setting and to reduce the reliance on traditionally secondary care based specialist services, in particular within the Outpatient setting.

- Enhance the relationship between Primary, Community and Secondary Care services, improving access to quality, coordinated care, closer to the patient's home.
- Improve access to services, and support self care. Move away from traditional prescriptive workforce design to Structured Diabetes Education (SDE).

Version 7 – Final 30.08.17

- Increase the provision of XPERT to meet the increase of newly diagnosed Type 2 diabetes (7% growth in North Wales).
- Move services out of hospital settings – DAFNE education programme to be offered in community venues to integrate and improve specialist and Cluster based services.
- Reduce the 'frequent flyer' demand on Unscheduled Care and Welsh Ambulance Service – reduction of admission, readmission and improve the stability of diabetes care for this vulnerable group.

First year achievements;

- Increase in the number of community based staff, including specialist nursing and health technicians.
- Services are delivered 9-5, Monday to Friday; 25% reduction in diabetes admissions from each cluster; 40% reduction in diabetes length of stay; reduction in insulin prescribing costs, with 25% increase in the use of NPH insulin (compared to analogue insulin); reduction in referrals into the acute Outpatient service.
- Joint clinics in the Primary Care setting.
- New patients seen and assessed in Primary Care setting who would have traditionally been seen at a hospital Outpatient clinic. Initial data is indicating a 15% reduction in GP referrals to a Secondary Care based Consultant led service (West Area Clusters).
- Reduction in the number of referrals to Acute Hospital based specialist care.
- Increase in repatriation from the Outpatient follow up system.
- Reduction of Unscheduled Care activity for patients at high risk of admission to hospital.
- Increase in satisfaction from stakeholders and patients.

Cardiff & Vale University Health Board - Expansion of Community Resource Team in Cardiff:

There are three Community Resource Teams operating across Cardiff and Vale. These are joint health and social care teams, which also have voluntary sector input. The main focus of the teams is to provide community based support to individuals who are identified as failing in the community and who, without support, may require either admission o hospital or referral into ongoing social services support.

As a result of this investment the team in Cardiff are able to provide 7 day working. During winter pressure period of 1st November 2016 to 28th February 2017 – Community Resource Team in Cardiff supported 161 patients at weekend and bank holidays – 134 early discharge and 27 admissions avoidance.

Hywel dda LHB - Locality Frailty Care Home Service:

The aim of the service is to provide a proactive care and support for patients and enhancing the provision of quality care to a defined group of vulnerable patients in the Amman Gwendraeth area. Since the service commenced on 28th February 2016 up to the period 31st October 2016, 133 reviews were undertaken with 78 DNACPR's

completed. Every patient has had a medication review with recommendations to stop or reduce medications being sent to the patients GP practice. Questionnaires were issued to patients, families, care homes and GP practices. Feedback received states that there is a high family and patient satisfaction rate, improved relationships with care homes and anecdotal evidence of avoided admissions.

The feedback from patients and families has been overwhelmingly positive with 87% strongly agreeing that they had been positively engaged in the future care of their family member and 79% strongly agreeing that their relatives would benefit from the review meeting which took place.

"I was able to talk about Mum, how she was prior to the dementia, to discuss feelings and best wishes for Mum's care"

6. Motivated professionals and Multi disciplinary teams

Pharmacists, physiotherapists, paramedics, occupational therapists, social workers and other professionals are increasingly being appointed to provide support across the cluster population, working alongside individual GP practice teams. There are examples where pharmacists and physiotherapists are training to become prescribers.

Aneurin Bevan Health Board:

This extended general primary care team model is resulting in better access ensuring people are directed to the right professional within the team without unnecessary delays. It also releases GP capacity to improve access for those who do need to see a GP including those people with more complex needs. Aneurin Bevan University Health Board has reported in a three month period, pharmacists replaced 1842 hours of GP time.

Betsi Cadwaladr University Health Board:

Betsi Cadwaladr UHB are taking forward a scheme for recruiting and retaining GPs who have recently completed traditional GP training schemes but who want to further develop their skills, portfolios or general career ambitions within a supported environment.

The GPs are employed by the health board and provide a core minimum service commitment to support practices which have GP capacity concerns and for remaining sessions to select from various clinically focused specialist areas eg palliative care, ENT, dermatology, as well as take up opportunities in leadership, or further academic studies.

Version 7 – Final 30.08.17

Cardiff and Vale University Health Board - Dedicated Prescriber time:

The additional prescribing advisor time in practice will enable:

- Medication review of patients on polypharmacy.
- Pharmacy expertise aligned to care homes to provide specific support to patients at risk of falls/requiring medication management as part of care package.
- Support of the practice in reviewing repeat prescribing processes to ensure that they are safe and reduce waste.
- Bespoke work in practice on prescribing issues specific to that practice.

Powys Teaching Local Health Board – Physician Associates:

Since 2015, Powys Teaching Health Board has been leading the way in Wales in the development of the Physician Associate role.

A qualified Physician Associate is a graduate who has undertaken full time post graduate training for a further two years. The training is based on a competence and curriculum framework and consists of intensive theoretical learning in medical sciences, pharmacology and clinical reasoning as well as over 1,400 hours of clinical placement experience in both community and acute care setting.

There are currently three qualified Physician Associates employed directly by medical practices in Powys, all providing valuable assistance to medical practices keeping pace with the needs of their patients.

In an early collaboration between the University of Birmingham and the mid Wales Health Care Collaborative, three Physician Associate students were offered bursaries to support them with the cost of their studies. In return the students have undertaken both primary care and acute placements in mid Wales and will, post qualifying, come back to mid Wales to work for a minimum period of time.
In addition, the health board is providing direct support to a Physician Associate student at the University of Birmingham. When they qualify in 2018, they will be working in the mid Powys area for a minimum of two years.

When Swansea University commenced training Physician Associates in October 2016, the health board was keen to support students with an interest in working in south Powys. In collaboration between the health board and the south Powys cluster, two students are being supported with bursaries. They too will spend a minimum period of time working in the area when qualified.

EVIDENCE OF CHANGE

During 2017 Dr Richard Lewis, National Professional Advisor completed an informal survey of cluster developments using a set of measures applied in 2016. Key messages are;

- No cluster lead vacancies in 2017- there were **4** in 2016.
- A broader range of cluster lead type - as well as GPs which still predominate - now nurse, practice managers, pharmacist, Public Health consultant, third sector and non-clinical.
- A broader range of primary healthcare membership - 64% in 2016, 80% in 2017.
- Local authority representation increased from 63% in 2016 to 72% in) 2017.
- Third sector membership increased from 57% in 2016 to 73% in 2017.

Maturity and Organisational maturity of clusters on scale of 1 to 3 - 1 is lowest
2016 -
Stage 1 = 17 (29%). Stage 2 = 28 (46%) stage 3 = 15 (25%)
2017 -
Stage 1 = 0. Stage 2 = 47 (78%) Stage 3 = 13 (22%)

CONCLUSION

Plans for 2018 are contained in a separate document together with deliverables and timescales. Plans for the implementation of the emerging model will exceed the current period covered by the original strategic plan – *'Our Plan for a Primary Care Service for Wales up to March 2018'*. Over the next 6 months the Final Report from the Parliamentary Review for Health and Social Care will report to help inform future arrangements. All plans are intended to be dynamic and will be amended as required in year.

SUMMARY

Since April 2015 DPCMH have led the implementation of the Primary Care Plan. The Annual Report for 2015/16 summarised the achievements aligned to the 5 key themes of the Plan i.e.

- Planning Care Locally
- Improving access and quality
- Equitable access
- A skilled workforce, and
- Strong leadership.

The 2016/17 annual report has developed priority areas based upon the pace of change emphasising the need for sustainability; development of the workforce and organisations, cluster development including support for pacesetters and innovation and mental health. In year negotiations of GMS contract enhanced services and

plans for the future negotiation of contracts with independent contractors added to the portfolio of activity.

Based upon learning to date and requests from CEOs and Vice Chairs, the emphasis for the forward work plan for 2017/18 has encompassed the original themes of the *'Our Plan for a Primary Care Service for Wales up to March 2018';* the ongoing priorities identified for 2016/17; the introduction of the CEOs National Improvement Programme, and the management of the negotiations for the GMS contract. Progression over the past 2 years together with plans for 2017-18 have been mapped to demonstrate delivery of the themes within the National Plan. Appendix 6 shows a table mapping the core themes of the National Plan related to the priorities set for 2016/17 and 2017/18 outlining the planned actions within the FWP for 2017/19 which will continue to develop the priority areas.

Version 7 – Final 30.08.17

21.4

Appendix 1 DRAFT TERMS OF REFERENCE

National Primary Care Board

Background

There is international evidence that primary care is the core element of an accessible, sustainable and social model of health and care. A priority is to move our health system to a more social model based on well-being care and support delivered locally and improving access to services.

In 2015, Welsh Government published the National Primary Care Plan and associated Workforce Plan. Strong leadership is one of the key themes.

There is an NHS Wales primary care leadership team made up of a Lead Chief Executive, the Health Board Directors of Primary, Community and Mental Health (Primary Care Directors) and the National Professional Lead for Primary Care. The Primary Care Directors have agreed a Programme of Work best done once for Wales to support health boards to deliver the primary care plan locally, through their 64 Primary Care Clusters.

The Primary Care Directors Group has established a Programme Board to commission and monitor a programme of work from Public Health Wales' newly formed Primary and Community Care Development and Innovation Hub (the Hub). The Primary Care Directors commission support from NHS Wales Informatics Service (NWIS) through the National Primary Care IT and Information Board.

Purpose

The purpose of the Board is to provide a strong collaborative mechanism to enable solutions to barriers which impact across Wales on the pace and scale of the delivery of the national primary care plan.

Reporting to the NHS Wales Executive Board the National Primary Care Board is a partnership to:

- Increase the focus and traction of primary care as part of an integrated sustainable health and care system.
- Prioritise and oversee the Primary Care Directors' Programme of Work, key priorities will include unscheduled care, cluster development, integrated pathways, integrated workforce and contracting.
- Triangulate with other relevant National Programmes of Work and activity such as the Unscheduled Care and Planned Care Boards.
- Increase the focus on integration – horizontal and vertical – in the health and care systems.

Core Functions

The Board will:

- Ensure stakeholders are fully engaged through establishing a formal Stakeholder Group whose co-chairs are members of the Board

- Agree with stakeholders a compelling narrative and supporting communication plan on 'what good looks like'

- Agree on a set of metrics which reports progress on delivering more care closer to home

- Enable solutions to barriers which require a national or strategic solution and resolve dependencies

between and with other programmes and projects

- Identify variation and action to address it in the safety, quality and delivery of services, cluster development, investment and integration

- Give strategic oversight to the Primary Care Directors' Group, including the work of Public Health Wales' and the Primary and Community Care Development and Innovation Hub.

- Agree the priorities to shape the direction and monitor delivery of the National Work Programme ensuring it:

    - supports the delivery of the Primary Care Plan, the new strategy for NHS Wales, other national delivery plans, IMTPs and Cluster Plans,
    - links with other national programs of work, such as the Ministerial Taskforce for Primary Care Workforce, the Planned care Board, and the Unscheduled Care Board,
    - links to the work of the Regional Partnership Boards
    - meets the needs of a reformed primary care service
    - drives change at scale

- Identify action at a national and local level to help create an environment in which service development and innovation can thrive

- Commission discrete pieces of prioritised work and advice on which services and parts of the patient pathway can appropriately be delivered in a community setting and any other work deemed relevant

-
- Facilitate resource and specific commitment to support delivery

- Undertake 'horizon scanning' to inform and influence future policy, priorities for action and strategic direction

- Ensure there are effective interfaces with the National Programme for Unscheduled Care Programme Board and Planned Care Programme Board

Board Membership

The Membership of the Board comprises:

- Lead Health Board Chief Executive for Primary Care
- National Professional Lead for Primary Care
- Lead Health Board Chair / Vice Chair
- Co-chairs of the Primary Care Directors Group
- Nominated Primary Care Cluster Lead
- Lead Health Board Director of Workforce and Organisational Development
- Lead Health Board Director of Planning
- Lead Health Board Director of Finance
- Lead Health Board Medical Director
- Lead Health Board Nursing Director
- Lead Health Board Director of Therapies and Health Sciences
- Executive Director of Health & Well-being, Public Health Wales
- Representative of Directors of Public Health

- Co-chairs of Stakeholder Group made up of Professional and Representative bodies
- Representative of Directors of Social Services
- Representative of Chief Professional Advisors (Dental, Pharmacy, Optometry) etc.
- Representatives of the Planned Care and Unscheduled Care Boards
- Representative of NHS Wales Shared Services Partnership
- Deputy Director, Primary Care Division, Welsh Government
- Director of NHS Wales Informatics Service
- CEO Welsh Ambulance NHS Trust
- Nominated Members of the Primary Care and Community Reference Group

In attendance

- Lead Health Board Associate Medical Director
- Lead Health Board Head of Primary Care
- Programme Director of Primary Care Strategic Development
- Programme Director of Primary and Community Care Development and Innovation Hub
- National Coordinator Primary Care Plan
- Representative of Community Health Councils
- Welsh Government policy and Professional leads, depending on agenda

The Board will be jointly chaired by the Lead Chief Executive for Primary Care and the National Professional Lead for Primary Care.

Members will be expected to communicate to and from their respective executive peer groups, directorates and organisations.

Quorum and Attendance

A quorum shall consist of 50% of members and must include a Primary Care Director and a Deputy Director from Welsh Government.

Whilst members will make every effort to attend, should any member be unavailable to attend, they may nominate a deputy to attend in their place, notifying the joint chairs and Programme Director of Primary Care Strategic Development in advance. Deputies will be assumed to have the full delegated authority of the member they represent.

Additional representatives may be invited to attend, where appropriate, and subject to agreement with the joint chairs.

The Board may ask anyone in attendance, who are not members, to withdraw to facilitate discussion of any sensitive matters.

The Board will meet in private but its papers will be subject to the Freedom of Information Act. The Board will approve reports for publication.

Accountability

The Board is responsible for overseeing and monitoring a programme of work to support the transformation of primary care. In this respect, the business of the Board will be accountable to the NHS Wales Executive Board.
Members of the Board will be collectively accountable for the delivery of the National Primary Care Work Programme.

Partner organisations are responsible for the delivery of the programme of transformation through their respective roles on the Board and those they represent.
The lead chief executive for primary care will be the overall Programme Senior Responsible Officer (SRO).
Members will take decisions on behalf of those they represent.

Where significant decisions are required, which may impact on Health Board or NHS trust responsibilities and resources, the Board will make a collective recommendation for consideration by each NHS organisation independently.

Agenda and Papers

The secretariat support to the Board will be provided from nominated Project Manager.

The agenda will be based on the National Work Programme, matters arising, and requests from Board members and proposals from stakeholders for work to be undertaken through the National Work Programme.

Standing agenda items will be:
- Review of action log
- Highlight and exception reports from the Primary Care Directors Group

Papers will be approved by the Joint Chairs. Agenda and papers will be distributed five working days prior to the meeting.

Action points will be circulated within five working days of the meeting. Minutes will be agreed between the secretariat and the joint chairs.

Frequency and Make up of Meetings

The full Board will meet initially on a bi-monthly basis to establish momentum and, thereafter, on a quarterly basis. A schedule of meetings will be agreed. Additional meetings will be arranged as determined by the Joint Chairs and where agreed, papers and decisions will be made 'out of committee'.

The representatives of Local Health Boards will meet immediately prior to each meeting to provide a forum for discussion/decision on those matters which require collective agreement of Health Boards.

Reporting

The Board will:

- Receive reports from the Primary Care Directors' Group on delivery of the agreed Work Programme
- Report regularly and on a timely basis on its activities to NHS Wales Executive Board
- Report on its activities at meetings and events, where this is deemed appropriate.

Review Date

These terms of reference shall be reviewed at least annually and approved by the Board.

Received/revised: March 2017

Agree: March 2017

For review: April 2017

Version 7 – Final 30.08.17

Appendix 2 TERMS OF REFERENCE

Primary and Community Care Reference Group

PURPOSE

The purpose of the Primary and Community Care Reference Group (PCCRG) is to support the work of the National Primary Care Board, the Directors of Primary, Community and Mental Health's (DPCMH) national work and the delivery of the Primary Care Plan by:

- Providing advice on professional and care standards and the work of the Primary Care Programme in Wales.
- Considering the implications of emerging policy and practice and advising on the appropriate professional response in Primary and Community care.
- Developing appropriate linkages to the national programmes for planned and unscheduled care.
- Helping to join up work across professional and representative groupings.

National work in intended to contribute to, and not duplicate local initiatives and wherever possible align with e.g. Public Service Boards, Regional Partnership Boards, Wellbeing plans, work of Commissioners (Welsh Language, Older People and Children) etc

METHODOLOGY

The PCCRG will work with the National Primary Care Board to develop the elements of the programme plan to be taken forward. The following areas have been proposed;

- Modelling of sustainable Primary Care delivery.
- New workforce models.
- Integration of health and social care.
- Team working and leadership.
- Communication – including public engagement.
- Models of Primary care acknowledging variation including rurality and deprivation.
- Research, quality improvement and promotion of an evidence based culture.
- Service user focus incorporating a prudent approach to care and services.
- Anticipatory & preventative care.

(n.b. In addition, specific advice on Peer Review, Clinical Triage and USC standards has been requested)

This will be achieved by:

- Establishing or becoming members of small time bound task groups.
- Agreeing the top 3 products/areas for advice for delivery at any one time and the development of the subsequent 3.
- Sharing work with a wider group of stakeholders as appropriate.

Additional members will be co-opted as required.

ACCOUNTABILITY

The PCCRG is accountable to the National Primary Care Board and the DPCMH. They will be responsible for providing clinical, professional and service advice on the delivery of its work programme.

Members will be expected to '*bring the perspective'* of the various professions, it is acknowledged that consensus

Version 7 – Final 30.08.17

advice may not always be approved by all organisations represented.

The Group will meet bi-monthly and all meetings will be noted; actions recorded and monitored. Notes will be publically available following approval.

Up to four members of the PCCRG will be invited to attend the National Primary Care Board. Cross membership with the USC CRG and Planned Care Groups will be encouraged. Working arrangements with complementary reference groups will be established, e.g:

- The public health primary care reference group (PHW)
- 111/OOH Programme Board and OOH Forum

etc

PROPOSED MEMBERSHIP OF THE REFERENCE GROUP

	MEMBER	
1	Liam Taylor	Assistant Medical Directors Chair
2	Angela Phillips	Senior Nurse School Nursing
3	Gail Powell	Senior Nurse Health Visiting
4	Angela Roberts	Lead Nurse BCUHB
	Nominated nurse deputy Wendy Herbert	Assistant Director Quality and Nursing WAST
5	Alison Davies	RCN
6	Sarah Fox	RCM
7	Julie Denley	Mental Health
8	Anna Kuczynska	Cluster lead
9	Hannah Bird	Practice Managers
10	Nominations sought	Third sector Independent sector
	Alison Hulmes	BASW - Social Work
11	Natalie Vanderlinden (SALT)	Therapies and Health Science
12	Philippa Ford (Physiotherapy)	
13	Ruth Crowder (OCC Therapy)	
14	Healthcare science rep	
15	Paul Harris to nominate	WPC Pharmacy
16	Peter Garwood	PHW Optometry
17	Anup Karki	PHW Dentistry
18	Richard Lewis	Primary Care Professional Lead
19	Barbara Bale	National Coordinator (Primary Care Plan)
20	Sara Thomas	Primary Care Innovation and Development Hub (PHW)
21	Sue Davies	Programme Director for Primary Care and Strategic Development
22	Anne Marie Cunningham	NWIS
23	Andy Jones	College of Paramedics /WAST
	Via National Board	Representative of Planned Care Programme
24	Tracey Williams	Representative of Unscheduled

Version 7 – Final 30.08.17

		Care Programme
25	Richard Bowen	111/OOH
26	Joyce Kenkre	Academic link
27	Karl Bishop	Academy of Royal colleges
28	Charlotte Jones	GPC Wales
29	Rob Morgan	RCGP
30	Zoe Wallace	HoPC
31	Mark Griffiths	CAMHs CD
	Peter Gore- Rees	Deputy for Mark Griffiths

Version 7 – Final 30.08.17

Appendix 3 OVERVIEW OF WORKFORCE AND OD HIGH LEVEL PLAN

The approach and development of actions to be taken in support of the *Plan for a Primary Care Service in Wales up to 2018* was published in '*A Planned Primary Care Workforce for Wales (*July 2015).

The report set out 4 main areas where action is needed i.e.

1. Putting in place the foundation for a more robust approach to workforce planning
2. Supporting the continuous development of primary care clusters and the sharing of best practice
3. Investing in the development of the wider primary care workforce
4. Stabilising key sections of the current workforce.

Implementation of this agenda is being taken forward by a number of different groups/organisations including;

- A Primary Care Ministerial Taskforce
- WG Workforce and OD Division
- Workforce and OD Directors at local and national levels (WODs)
- The PCCDI Hub
- The Workforce Education and Development Service (WEDS)
- The NHS Shared Services Partnership
- The DPCMH led Primary Care Workforce and OD group
- Sub group to the above to monitor NHS progress at local level.

The full forward work plan identifying which organisation/group are leading and detailing the actual deliverables is available as part of the DPCMH final forward work plan.

In addition a number of areas are identified to demonstrate how the actions for 2017/18 will support the priorities identified by DPCMH.

Sustainability and the emerging model of primary care

Accelerated delivery of pacesetters and cluster development

The primary care workforce group will:
Ensure that Clusters have access to workforce planning skills development and resources. This will be achieved via Skills for Health and in house training, with best practice being shared (See Action 8 of plan).

Produce a compendium of workforce models and roles available on line by July 2017 accessed via Primary Care One (See Action 12 of plan).

Consider how HR recruitment processes can be improved to better support innovation and redesign in primary care.(Recommendation from the Cluster Development Report March 2017).

Ensuring sustainability of primary care workforce

The primary care workforce group via WEDs will ensure that the education commissioning recommendations support the sustainability of primary care workforce by:

GP recommendations to be agreed as part of Medical Workforce Planning recommendations to CEOs by June 2017 (See Action 2 of plan).

Wider PC workforce recommendations to be agreed as part of Non-Medical Education recommendations to CEOs by June 2017 based on needs identified in IMTPs to include advanced practice, physicians associates etc. (See Actions 13, and 14 of plan).

Investing in the wider primary care workforce by:

- Developing learning pathways for HCSWs in PC and rolling out best practice from pilot area (See Action 15 of plan), and

- Coordinating activities to establish a national leadership and development programme for practice managers (Recommendation from the Cluster Workforce Development Report March 2017).

Promoting flexible career schemes for GPs to increase recruitment and retention. To consider the potential to establish pools of salaried GPs to undertake locum work across each LHB area. (Recommendation from the Cluster Workforce Development Report March 2017).

Monitoring, review and reporting

The primary care workforce group will:
Monitor and report overall progress against the overall Primary Care workforce plan to DPCMH, WODs and WG. Full update on plan to be provided.

Monitor and coordinate actions being delivered at local level via a NHS primary care workforce sub group to promote sharing of good practice.

NB. All actions above encompass the needs of the MH workforce.

Version 7 – Final 30.08.17

Appendix 4 PRIMARY CARE IT DEVELOPMENTS 2017-18

Key Projects for 2017-8

- **MHOL** – This project has various updates due in 2017-18 including better access via smart phones and online registration. However the main development will see the pilot and full implementation of patient access to their summary GP record.

- **GMS IT –** The main aim within this programme is the re-procurement of GP systems suppliers. However other projects such as GP wi-fi, skype for business, printer refresh, IT hardware refresh and Office 365 are all ongoing during 2017/18.

- **WCCIS –** 3 Health Boards are due to go live with the system during 2017/18. Development of the health modules by Careworks, developing information requirements and integration of WCCIS with clinical systems by NWIS are all key ongoing tasks for the programme during 2017/18.

- **Primary Care Information Portal –** The priorities of this project are to: Further develop the functionality of the portal, ensuring it is user friendly via a summary dashboard; Increase usage of the portal by Health Boards including report production; Full extraction and analysis of the EMIS and INPS appointment data; Implementation of the agreed Primary Care phase 2 measures.

- **Eye Care EPR System –** Scope out system requirements, produce an options appraisal for identified products that are currently available and submit a business case leading to procurement of a new system.

- **Dentistry Referral System –** Scoping out and implementation of an all-Wales referral management system within the national architecture.

Version 7 – Final 30.08.17

Appendix 5 PRIMARY & COMMUNITY CARE DEVELOPMENT & INNOVATION HUB

Work Programme 2017/18

Introduction

The work programme for the Primary & Community Care Development & Innovation Hub ('the Primary Care Hub') is agreed and overseen by a Programme Board and focuses on four themes:

1. Cluster development
2. Access to information / health intelligence
3. Innovations in healthcare
4. Quality improvement and safety

Key projects and areas for action are described within each of these themes as follows:

1. Cluster development

Leadership, skills and development programme

A programme of events, leadership and skills development will be delivered to support development of primary care clusters across Wales and to further develop and share best practice.

Social prescribing

Coordinating delivery of three commitments in relation to social prescribing and linking with wider social prescribing activity:

- Commitment 1: Mapping of the evidence – report to be available in June 2017
- Commitment 2: Gathering and sharing social prescribing activity – local projects and approaches to social prescribing to be published on Primary Care One (cluster website)
- Commitment 3: Organising events to share the range of work and experiences already underway in Wales, and to learn from approaches outside of Wales

Workforce Development

With the Primary Care Workforce Group, provide direction and support for primary care nurse development focusing on workforce planning, education and training, empowerment and professional leadership.

2. Access to information/Health intelligence

Primary Care One Wales (PCOne)

Complete initial development and testing and then launch the Primary Care One Wales website. The Primary Care One Wales website will facilitate the promotion of primary care cluster collaborative working in Wales, and be a central source of information relevant to primary care clusters and other primary care professionals across Wales.

Primary Care Health Intelligence

Influence health intelligence product developments to meet requirements for cluster plans that are informed by both population health needs assessment and evidence on effective interventions.

3. Innovations in healthcare

Emerging model for primary and community care

Facilitate the rollout of learning from the Pacesetter programme and the emerging model for primary and community care, and capture feedback from health boards and clusters to

ensure continued development. Extend scope to capture learning from other innovation and good practice. Engage in actions to address pacesetter learning recommendations.

Pacesetter evaluation

Subject to contract award, oversee the delivery by an independent partner of an evaluation of the pacesetter contribution to understanding primary care transformation in Wales.

4. Quality Improvement and Safety
Safer Primary Care Programme

A Safer Primary Care Programme will be led by 1000 Lives in partnership with the Primary Care Hub, with activities informed by an Advisory Group.

Within this framework, the Hub proposes delivery of a quality improvement project with a focus on a trial fibrillation and the deployment of a Primary Care Trigger Tool designed to identify patient cases in GP clinical systems where unintentional harm may have occurred.

Primary Care Measures: Phase 2

The Hub has supported a national approach to the development and implementation of primary care measures and will provide a final report and indicator set to the National Primary Care Measures Group.

Version 7 – Final 30.08.17

Appendix 6 - MAPPING OF PRIORITIES TO MEET NATIONAL THEMES/PRIORITY AREAS

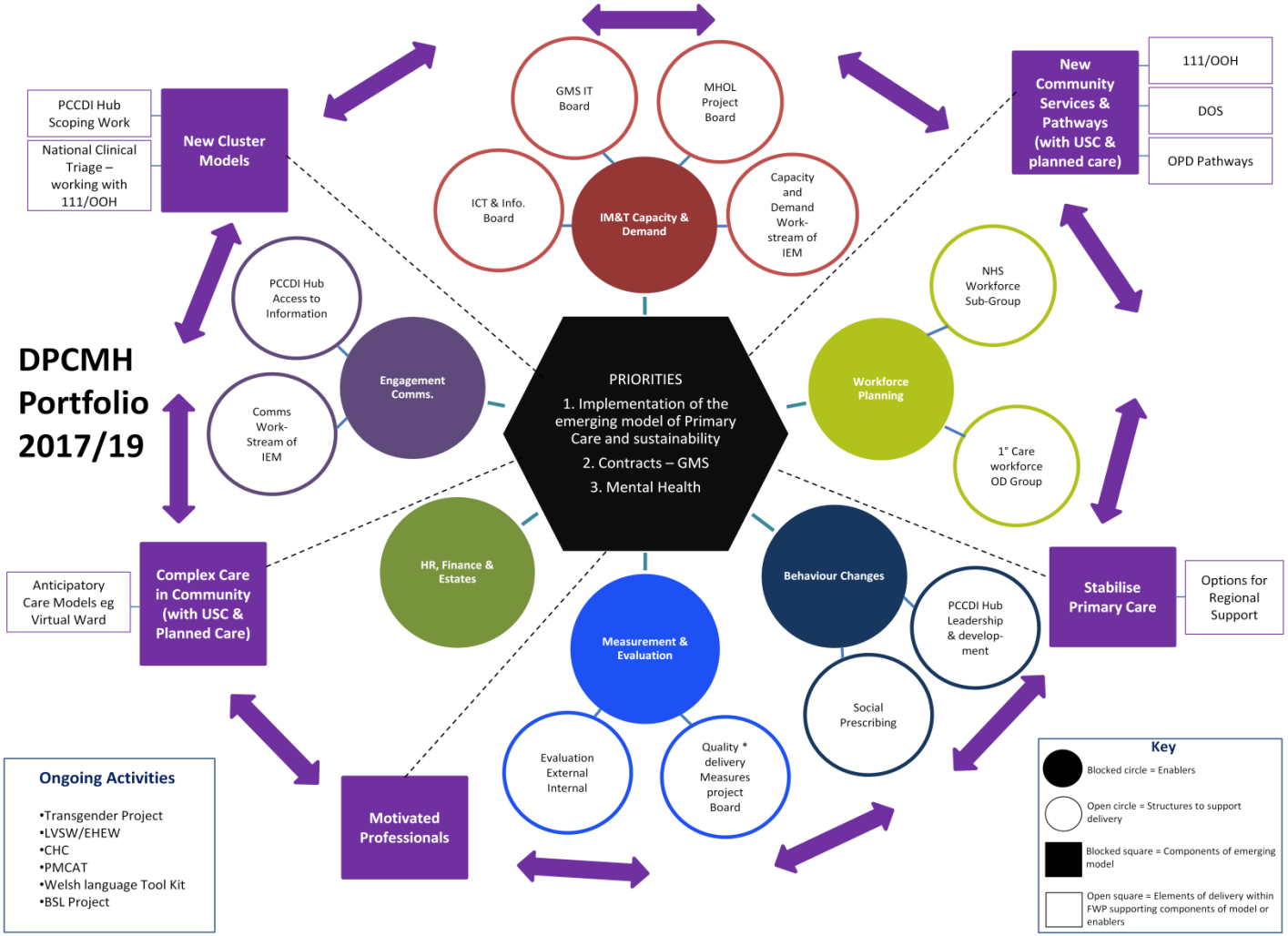
Themes/priority areas from *'Our Plan for a Primary Care Service for Wales up to March 2018'*.	**Priorities and actions 2016/17 (see Diagram 2 on page 8 of the report)** • Sustainability • Workforce and OD • Cluster development • Pacesetters and Innovation • Mental Health	**Priorities for 2017/18** • Implementation of the emerging model to ensure sustainability • Contract change GMS • Mental Health	**Components of the Emerging Model (see Diagram 5 on page 68 – portfolio for 2017)**	**Enablers to implement the Emerging Model**	**Actions in FWP 2017/19**
1. Planning Care locally	Cluster development Pacesetters support and evaluation Development and consultation on emerging model	IEM Group Capacity and demand modelling	Stability of Primary Care	IM&T capacity and demand	Framework for demand and capacity modelling Options for regional support to clusters
2. Improving Access and Quality	Quality and delivery measures MHOL 111/OOH Tender for national evaluation Primary Care One development	Work from 2016/17 cont. Identification of key indicators Roll out of 111/OOH National Critical Appraisal commenced	New community services and pathways working with USC and Planned care	Measurement and evaluation	Facilitation of clinical triage model Embed 18 measures and develop further 20 Monitoring of sustainability Board reporting and scrutiny

Version 7 – Final 30.08.17

3. Equitable access	ICL extension Welsh language good practice Transgender project BSL project	Work from 2016/17 cont. Communications workstream Social prescribing workstream	Complex care in community	Engagement and communications Behavioural change	Anticipatory care models e.g. virtual ward Identification of variation in services
4. Skilled workforce	Development of MDTs Working with WAST Compendium of new roles W&OD group established	Work from 2016/17 cont. PCCDI leadership and skills development ongoing Cont. Taskforce NHS W&OD sub group	Motivated professionals	Primary care workforce planning	See separate W&OD plan
5. Strong leadership	PCCDI National Programme Board PCCRG	Continue to develop existing arrangements at National level. ICT and Information Board to capture all relevant NWIS activity	New Cluster models	HR, Finance and Estates	Coordinated National support and leadership Delivery of CEMT National Improvement programme Closer working with USC and Planned care Closer working with Executive peer groups
Portfolio extended 2016	**Mental health**				See FWP for detail
	GMS Enhanced services	**GMS negotiations and enhanced services**			See FWP for detail

21.4

Version 7 – Final 30.08.17



22

REFORM OF THE WELSH LANGUAGE STANDARDS CONSULTATION RESPONSE	
Name of Meeting : Board Meeting	**Date of Meeting** 28/09/2017

Executive Lead : Interim Executive Director for Workforce and Organisational Development
Author : Welsh Language Officer Tel 029 2074 2265
Caring for People, Keeping People Well : This report underpins the Health Boards' "For our population" and "Culture" elements of the Health Boards' strategy
Financial impact : N/A
Quality, Safety, Patient Experience impact: Patients who prefer to speak Welsh will receive a better patient experience by communicating in a language they are most comfortable with.
Health and Care Standard Number 2.7, 3.2, 4.1, 4.2, 7.1
CRAF Reference Number 8.1.6
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The UHB is on target to meet the timescale to respond to Welsh Government's consultation

The Board is asked to:

- **NOTE** the response from staff members on the proposed changes to the Welsh Language Standards framework.
- **APPROVE** the organisational response to the Welsh Governments' consultation on the reform of the Welsh Language Standards.
- **PROVIDE** any further comments in the response

SITUATION

In August 2017, the Welsh Government announced its reform of the current Welsh Language Standards on how the Welsh public sector is to be monitored for their compliance. Under these changes, the position of the Welsh Language Commissioner will be replaced with a Welsh Language Commission. The role of the new body will be to monitor and advise organisations, such as Cardiff and Vale UHB, as to how they are complying with the Welsh Language Standards. Welsh Government will assume responsibility for determining which standards organisations have to comply with from 2018.

The reformed standards will focus mainly on services to the public. Operational standards (*focused on how to ensure that the Welsh language can be developed within the organisation*) will be replaced by Welsh language planning duties to increase the use of the Welsh language based on the area and the local population.

The new Commission will also only deal with complaints from service users after they have taken their concerns to the organisation and received an unsatisfactory response.

The Welsh Government has established a public consultation process and is asking whether these changes will lead to both improved quality of services for our patients/service users and the development of the Welsh language.

During early September, the organisation held a consultation process with key colleagues in Clinical Boards and corporate areas, asking for their opinions on the step change.

The development of our healthcare provision through the medium of the Welsh language is in-line with the UHB's strategic vision of providing person-centred care.

BACKGROUND

The Welsh Language Measure 2011 was proposed to replace the current Welsh Language Scheme with a framework of standards which all Welsh public sector organisations were expected to comply with. The idea behind the standards was that service users would be able to enjoy the same level of Welsh language service, regardless of where they are in Wales.

From the feedback about the setting and monitoring of the standards in other areas of the Welsh public sector and outside of health, the Welsh Government has acknowledged that the process has been complicated, bureaucratic and slow.

Concern was growing that the goodwill and consensus towards integrating the Welsh language into public services has been undermined as organisations perceived it as a 'compliance' and 'enforcement' issue rather than a positive change for the Welsh language in the sector.

As a result, the Welsh Government decided that the standards should undergo some reform to allow public sector organisations greater flexibility to improve their Welsh language services. For example, operational standards such as offering training/professional development opportunities in Welsh will be replaced with language planning duties, such as working with local education providers to develop staff with Welsh language skills.

Concern was also expressed about the Welsh Language Commissioner's powers of intervention. For example, under current standards as written,

service users were allowed to complain to the Commissioner as first point of contact instead that of the organisation itself. This led to concerns/complaints going through a protracted process of the Commissioner, instead of being dealt with efficiently under the organisations' concerns process.

ASSESSMENT AND ASSURANCE

To help the organisation to provide a robust response, colleagues from across the clinical boards and corporate teams have been consulted on how these changes will impact Cardiff and Vale UHB abilities to provide effective healthcare in Welsh. A consultation document was sent out to them with broad questions based on the consultation. The responses received from staff have been now used to formulate the organisational response (**annex 1)**.

The number of response from our colleagues, though limited, has been broadly supportive of the changes. For example, there was broad support for the establishment of the Welsh Language Commission because '*having a single body responsible will avoid duplication and waste and will be effective in monitoring compliance'* and *'it would help to ensure compliance over a period of time'.*

The proposal that the Commission should only intervene in a concern after the complainant was not satisfied with the response by the service provider was supported as well.

The suggestion of replacing the operational standards with language planning duties was met positively. Staff cited that focus should be on providing patient language choice rather than on the use of the language in internal processes, such as job interviews and staff tribunals.

However, some concern was noted on language planning being based on local population needs, whether using the low percentage of local Welsh speakers against the greater percentage of English speakers would be an effective measure of demand for Welsh language healthcare.

There was general agreement as to what sort of powers the Welsh Government should have, as well as broad agreement on such issues as a move away from a compliance and enforcement approach to one that is more cooperative and collaborative in nature.

The proposed full response that will be need to be submitted to the Welsh Government by 31st October, can be found in **annex 1**. The document contains proposed responses, including the response we've received from staff.

Over the last few years, the organisation has made significant progress in improving its Welsh Language provision for patients and service users. It has established a plan which integrates its expectations from the Welsh Language Scheme and the More than Just Words Strategy into one Welsh language

Organisational Plan. This has led to patient management systems, (such as PMS and PARIS), offering to register language choice and provide appointment letters in Welsh or English.

While progress should be celebrated, the requirements of the standards will still present a considerable challenge despite our best intentions and actions. For example, integrating the Welsh language into the patient pathway remains an issue. Patients and service users are not being asked their preferred language. In many cases, patients receive care in their chosen language through circumstances rather than design.

The proposed reform is a welcome step change by the Welsh Government on the Welsh Language Standards. The proposals will help Cardiff and Vale UHB to focus on providing better healthcare for Welsh speaking patients with a degree more of flexibility and pragmatism. The move away from the enforcement attitude of the current Welsh Language Commissioner to a more co-operative and supportive role of the Welsh Language Commission will be beneficial.

Members are asked to note the proposed response and provide any further comments for **Annex 1,** which will be submitted to the Welsh Government by 31st October.

Cardiff and Vale University Health Board response to the Welsh Language: Striking the right balance: proposals for a Welsh Language Bill

Questions	Agree/Disagree	Comments
1. In paragraphs 49-54, we have set out the role we propose the Welsh Government should play in promoting the Welsh language, i.e. the Government promotional functions. Do you agree with our proposal? Agree/Disagree/Neither agree nor disagree Supporting comments, including whether any fields should be added or taken away from the list in paragraph 53	Agree	We agree that the Welsh Government should undertake the proposed role of promotional functions. We would however, like to see closer co-operation between certain key organisation (such as Coleg Cymraeg Cenedlaethol and the National Learning Centre for Learning) and the Welsh Health sector. These organisation are a key part of how the sector can improve Welsh language skills within the services we provide.
2. In Table 1 we have outlined the resources related to general promotional functions which we think should be available to any body or bodies involved in promoting the Welsh language and monitoring and enforcing compliance with standards. Do you agree with our proposal? Agree/Disagree/Neither agree nor disagree Supporting comments	Neither agree or disagree	We suggest that establishing a central translation agency should be considered. It would lead to a gain from economies of scale and would lead to the development of consistency in language and form across all sectors.
3. Do you agree with our preferred option (Option 4) to have a single body responsible for promoting the Welsh language as well as monitoring and enforcing compliance with Standards? Agree/Disagree/Neither agree nor disagree	Agree	We have no further comment to make

If not, please state which option (including options we have not discussed in the White Paper) you believe we should consider. Supporting comments		
4. We have based our preference for a single body on the grounds of clarity, synergy and value for money. Do you agree with our rationale? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	Yes we agree with the rationale for a single body. However, the Welsh Language Commissioner role has already been established for nearly 5 years and is widely known. Having to establish a new institution, develop awareness, monitoring systems and working relationships would be time and resource consuming. An amended version of the role would be preferable to continue the synergy and the work which has already been done. It would also be the most cost-effective option.
5. What other relevant issues should we consider in making our final proposal as to which body or bodies should carry out work to promote the Welsh language and monitor and enforce compliance with Standards? Supporting comments	Neither agree or disagree	The body or bodies should establish positive working relationships of mutual support, collaboration and co-operation when monitoring the standards.
6. Do you have any further comments on Part 1 of the White Paper?	Neither agree or disagree	We have no further comment to make.
7. In paragraphs 93-95 we have set out some general requirements regarding the body's governance and accountability arrangements. What are your views on these general requirements, and are there other checks and balances you believe should apply to the proposed body? Supporting comments		We are satisfied with the general requirements that have been set. We support the notion that it is vital to involve the stakeholders and develop their confidence in any new structure.
8. Do you agree with our preferred option (Option 3 to establish a Welsh Language Commission to promote and facilitate the use	Agree	We have no further comment to make.

of the Welsh language and monitor and enforce bodies' compliance with Standards? Agree/Disagree/Neither agree nor disagree Supporting comments		
9. What are your thoughts on the analysis we have provided which supports our preference for Option 3? Are there any other considerations we should take into account in making any final proposal?	Agree	We would agree with the thoughts and analysis of the Welsh Government. Having a wide range of membership on the Commission would help the organisation develop expertise and skills that would prove beneficial.
10. Do you believe Option 3 provides sufficient safeguards in relation to the independence of the proposed Commission in exercising its functions in monitoring and enforcing bodies' compliance with Standards? Yes/No/Unsure Supporting comments	Agree	We would agree that option 3 provides sufficient safeguards when exercising its monitoring functions and enforcing bodies' compliance with the Standards.
11. Are there any additional matters to those listed in paragraphs 121-122 that we should consider regarding arrangements to establish the proposed Commission? Yes/No/Unsure Supporting comments	Neither agree or disagree	We have no further comment to make.
12. Do you agree with our proposal to move the requirement on the Welsh Government to produce a Welsh language strategy from the Government of Wales Act 2006 to the new Welsh Language Bill? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	The organisation would welcome this move as it would lead to greater collaboration between the Measures and the Welsh Language Strategy of the Welsh Government (the More than Just Words Strategy). It could also generate greater efficiencies by having to work to one set of the same objectives.
13. Do you agree with our proposal that the Welsh Government should report to the	Agree	This would provide the opportunity for organisations to develop longer terms plans and help to identify where organisations

Assembly on the Welsh language strategy every five years instead of annually? Agree/Disagree/Neither agree nor disagree Supporting comments		have been, where they are now and where they are heading. It will assist with more meaningful plans with a higher chance of success.
14. Do you agree with our proposal that the Welsh Government should publish a plan setting out how it will implement the strategy every five years instead of annually? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	The work towards developing the Welsh language into frontline services, providing our workforce with learning opportunities and welcome new staff with Welsh Language skills takes time. So we would welcome an opportunity to develop and action a long term plan. Furthermore, it would be easier for the 5 year strategic plan be fed into our own organisations Intermediate Medium Term plan.
15. Do you agree with our proposal to abolish the Welsh Language Partnership Council and provide the Welsh Government with a power to request advice from the proposed Welsh Language Commission? Agree/Disagree/Neither agree nor disagree Supporting comments	Neither agree or disagree	Not applicable to this organisation.
16. Do you have any further comments on Part 2 of the White Paper?	No	We have no further comment to make.
17. We propose that a reformed model of the Standards (Option 2) should be adopted as the best way to ensure people's rights to receive Welsh language services. Do you agree with this proposal? Agree/Disagree/Neither agree nor disagree Supporting comments, including (if relevant) any further reforms you would like to see made to the current system, or any alternative approaches you think we should consider	Agree	We would welcome the change to the standards. Focusing on the Standards which affect our patients/services users/public will have a greater impact on improving the services. We support the cost/benefit assessment of standards. The organisation has been concerned about Standards which had small impact but a high cost to comply with (e.g. Standards on providing bilingual management board papers). Due to the perceived 'compliance' culture of the Welsh Language Commissioner role, staff were worried that this culture might impede effective healthcare. For example, it could be that patients who have stated their preference for Welsh speaking staff would have to wait for that staff member to become

		available. This waiting time could potentially have a detrimental impact for the patient.
18. We have based our preferred proposal for reformed Standards (Option 2) on the grounds of the clarity, capacity for improvement and the costs of change associated with each option (paragraphs 163-165). Do you agree with our analysis? Agree/Disagree/Neither agree nor disagree Supporting comments, including (if relevant) any other factors we should take into account in making any final proposals	Agree	Yes we agree with analysis. We would agree with the practical solution and the potential improvement of the reformed Standards (Option 2). The organisation has been preparing for Standards for the last two years so we would welcome the continuation.
19. Do you agree with the proposal to abolish the current classes of Standards and differentiate between 'Standards' (which would relate to services) and 'language planning duties' (which would relate to corporate duties)? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	Yes. The organisation would welcome such a change to the Standards. Cardiff and Vale UHB has had long standing concerns about the 'operational' aspects of the Standards. So to develop corporate planning duties would provide flexibility on how the organisation can push the Welsh language agenda forward.
21. Are there any other matters which you believe should be included in the new legislation as language planning duties? Yes/No/Unsure Supporting comments	No	We have no further comment to make.
22. Do you agree that the proposed Commission should have general powers to conduct examinations into how bodies meet their Welsh language duties, which would include both the Standards and the language planning duties? Agree/Disagree/Neither agree nor disagree	Agree	We would expect that these powers would be open and transparent.

Supporting comments		
23. Do you agree with our proposal that the proposed Commission should monitor and support bodies in relation to their language planning duties, rather than enforce them? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	The Welsh Language Standards has been seen as a 'compliance' and 'enforcement' issue and not as something that is concerned with contributing to the improvement of healthcare in Welsh. Through offering a monitoring and supporting role, the Commission would aid the organisation to see the standards in a more positive light. Staff believed that the relationship between Cardiff and Vale UHB and the Commission should be one of co-operation not of compliance.
24. Do you agree with our proposal for the Welsh Government to be responsible for imposing Standards on bodies either through a compliance notice or other mechanism? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	Cardiff and Vale UHB already has expectations placed on us to comply with Welsh Government policies and the Language (Wales) Measure through the More than Just Words Strategy and the Well-being of Future Generations (Wales) Act. The organisation would agree if the proposal helps to ensure that there was clear correlation between the standards set and the other measures and policies.
25. Do you agree with our proposal that all regulations to make Standards should be subject to a full public consultation before seeking the approval of the Assembly? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	We would welcome any further public input into the standards set for Cardiff and Vale UHB. It would help to gather awareness and provide us with the opportunity to understand public expectations.
26. Do you agree with our proposal to abolish Standards Investigations? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	We have no further comment to make.
27. Do you agree with our proposal that the Welsh Government should be given powers to issue codes of practice or guidance relating to the Standards? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	Cardiff and Vale UHB would support the idea of codes of practice. In many cases, the organisation is unsure on how it can comply with many of the standards. Any advice and sharing of good practice would help the organisation meet its obligations.

28. Do you agree with our proposal that the Welsh Government should have a power to impose Standards on all the bodies in a sector directly through regulations without the need for a compliance notice or other such mechanism? Agree/Disagree/Neither agree nor disagree Supporting comments, including your views on the factors we should take into account in drafting Standards to be imposed directly on bodies within a sector, whether individual bodies should retain the right to challenge the imposition of a Standard, and whether there should be an enhanced consultation process	Agree	We have no further comment to make.
29. What factors should we take into account or what procedure should we follow in order to ensure the process for imposing Standards on the Welsh Government is fair and transparent? Supporting comments		The standards should be realistically set, they should be in line with other requirements the Welsh Government has placed on the health sector. They should aid the compliance of the other measures such as More than Just Words Strategy and the Wellbeing of Future Generations (Wales) Act.
30. Do you agree with our proposal that complaints should have to be dealt with through the relevant body's complaints procedure first before the proposed Welsh Language Commission can investigate an alleged failure? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	Cardiff and Vale UHB would strongly support this change. We have received concerns through the Welsh Language Commissioners' office. It has led the organisation being involved in a protracted process of their complaints procedure, but with the same outcome if the concern has been sent to us first. We would welcome the idea of referring to the commission if the complainant was unsatisfied with the response.
31. Do you agree with our proposal that bodies must adhere to an approved complaints procedure, such as the Model Concerns and Complaints Policy?	Agree	The Putting Things Right procedure is the one that the UHB and other Health Boards and Trusts currently adheres to as the model policy to follow.

Agree/Disagree/Neither agree nor disagree Supporting comments		
32. Do you agree with our proposal that the proposed Commission should only take further action regarding a complaint if it believes the alleged breach of a Standard or complaints procedure is serious? Agree/Disagree/Neither agree nor disagree Supporting comments, including any comments on our definition of a 'serious breach' in paragraph 219.	Agree	As stated previously, Cardiff and Vale UHB has been involved in complaints that could have been easily dealt with within the organisation's concern procedure. Instead we were drawn into the Welsh Language Commissioner's protracted process. For serious concerns, we would support the Commission to be involved with and provide advice to ensure that serious breaches are dealt with satisfactorily.
33. Do you agree with our proposal to allow the proposed Commission to conduct an investigation of its own initiative? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	Although we agree with the principle, we are also of the view that there should be an agreed process of investigation. Investigation should be a process of escalation, where the body investigated should be aware of the process and the work involved. For example, the Commission would start the process by requesting information/data. It would aid with the resource planning, improve co-operation with the organisation and lead to better outcomes.
34. Do you agree that the actions set out in paragraph 225 provide an effective range of enforcement action? Agree/Disagree/Neither agree nor disagree Supporting comments, including any thoughts on alternative enforcement actions that have been rejected or not considered in the White Paper	Agree	The organisation agrees that there should be clear steps of escalation. However, we take the view that there should be identification of what kind of failures would need to occur before the escalation of enforcement actions would take place.
35. Currently, the Commissioner has powers to impose a civil fine of up to £5,000 and in some circumstances to request a court order to require a body to comply. Do you agree	Agree	Cardiff and Vale would agree to these powers on the proviso that they are actions of the last resort. They should be used only when they are clear, continued failure by a body and have

with our proposal that these powers should be retained? Agree/Disagree/Neither agree nor disagree Supporting comments, including any comments on the maximum civil fine that the proposed Commission should be able to impose (if at all)		been subjected to repeated opportunities to make improvements.
36. Do you agree with our proposal to retain the Tribunal's role in relation to the proposed Commission's decisions regarding enforcing bodies' compliance with Standards? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	We would hope to avoid the need for a Tribunal to take place but recognise that it is a possibility. The Tribunal role should be continued as means of appeal for an organisation as long as it allows for impartiality and reason in its approach..
37. Do you agree with our proposal that the Tribunal should also deal with appeals against a decision of the Welsh Government to impose Standards on a body? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	We would hope to avoid the need for a Tribunal to take place but recognise that it is a possibility. The Tribunal role should be continued as means of appeal for an organisation as long as it allows for impartiality and reason in its approach.
38. We propose to introduce a mandatory first stage for the Tribunal in relation to appeals against the proposed Commission's decisions concerning enforcing Standards. The first stage would require the Tribunal to give permission on the grounds that an application has a reasonable chance of success or another compelling reason why the application should be heard. Do you agree with our proposal? Agree/Disagree/Neither agree nor disagree Supporting comments	Agree	When considering an appeal in the process, an organisation should be provided with clear guidelines and examples of what constitutes compelling grounds for success.

39. Do you believe that the proposed mandatory first stage should apply to appeals Againhaving promotionalst a decision of the Welsh Government to impose Standards on a body? Yes/No/Unsure Supporting comments:	Agree	We have no further comment to make.
40. Do you have any further comments on Part 3 of the White Paper?	No	We have no further comment to make.
41. Do you agree with our proposal to remove the constraints in the Measure so that the Welsh Government has the power to make Standards applicable to any body within the Assembly's legislative competence? Agree/Disagree/Neither agree nor disagree Supporting comments	Neither agree nor disagree	Not applicable to this organisation.
42. Do you agree with our proposal that private sector businesses should only be liable to comply with Standards that relate to the services they provide to their customers? Agree/Disagree/Neither agree nor disagree Supporting comments, including your views on any limits that should be placed on the powers to impose Standards on private businesses:	Neither agree nor disagree	Not applicable to this organisation.
43. Do you agree with our proposal that Standards should only be imposed on private businesses as part of a wider package of promotional and awareness raising initiatives? Agree/Disagree/Neither agree nor disagree	Neither agree nor disagree	Not applicable to this organisation.

Supporting comments		
44. If the Welsh Government is given powers to impose Standards on any body within the Assembly's competence, do you believe that Standards should be imposed on any body or sector that is not currently within the scope of Welsh language legislation? Yes/No/Unsure Supporting comments	Neither agree nor disagree	Not applicable to this organisation.
45. Do you have any further comments on Part 4 of the White Paper?	No	We have no further comment to make.
46. We have assessed the impact of our proposals on equality, children, young people and their families, and the Welsh language. Do you have comments on any of these assessments?	No	We have no further comment to make.
47. We would like to know your views on the effects that the proposals in our White Paper would have on the Welsh language, specifically on: i) opportunities for people to use Welsh; ii) treating the Welsh language no less favourably than the English language. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?	Neither agree nor disagree	We welcome the reform of the standards that will provide a more consensual/collaborative way to provide better Welsh language services. As stated above, there are concerns about the original enforcing and compliance aspects of the current framework. Using a more flexible and open approach would help to innovate changes. For example, encouraging staff members to use their limited Welsh during conversation with patient but retaining the right to use English if they are unsure.
48. Please explain how you believe the proposed options could be formulated or changed so as to have: i) positive effects or increased positive effects on opportunities for people to use the Welsh		More flexibility and a co-operative attitude by the Commission and Welsh Government will help to foster the use of the Welsh Language in healthcare. There has been concern on whether the enforcement nature of the standards meant more importance on compliance rather than progression on the Welsh Language agenda. By adopting a more supportive role

language and on treating the Welsh language no less favourably than the English language; ii) no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.		the proposed options will help the organisation to promote usage of the Welsh language. Our staff continue to voice their concern as to whether complying with the standard could have an adverse impact on healthcare. By focusing on the compliance to the Standards rather than to provide patient centred care, could lead to poorer patient experience.
49. We have asked a number of specific questions in this White Paper. If you have any related issues which we have not specifically addressed, please use this space to report them.		We have no further comment to make.

SERVICES FIT FOR OUR FUTURE, QUALITY AND GOVERNANCE IN HEALTH AND CARE IN WALES	
Name of Meeting: Board Meeting	**Date of Meeting** 28 September 2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well: This report underpins the quality and governance elements of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact : The White Paper is titled Quality and Governance in Health and Care in Wales
Health and Care Standard Number 1-7
CRAF Reference Number No. 1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Consultation with Board Members using Board Development Day in August plus additional comments received from Members.

The Board is asked to:

- **APPROVE** the Health Board's formal response to the White Paper

BACKGROUND

In July 2015 the Minister for Health & Social Services (Mark Drakeford) published a Green Paper setting out a number of proposed reforms to the Welsh NHS. The Health Board submitted a response to the Green Paper on behalf members in November 2015.

The White Paper "Services Fit for the Future, Quality and Governance in Health and Care in Wales", was launched on the 28th of June and it includes a number of proposals designed to support and encourage more integrated ways of working and better decision-making. NHS organisations and other Stakeholders have been asked to comment on the White Paper.

The proposals include common standards and joint complaints handling; better decision-making across health boards through a new Duty of Quality for the Population of Wales and a clearer process for service change; as well as further promoting a culture of openness in the health and social care system

through a new Duty of Candour. There are also proposals for strengthening the way the public is represented across health and social care, and for regulation and inspection.

ASSESSMENT AND ASSURANCE

The purpose of the Green Paper was to set out the current systems in place to support quality and governance in the NHS in Wales.

- Improving quality through duties and embedding it through common standards;
- Promoting openness, honesty and candour; and
- Improving the independence of the inspectorates, including the possibility of merging Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales and the future role and functions of Community Health Councils.
- Considering the alignment of the powers, duties and accountabilities of Health Boards and NHS Trusts; including whether we should give Health Boards borrowing powers; and
- Improving the leadership and governance of NHS Wales, including looking at health board and NHS trust board membership.

The White Paper was then prepared and a summary of the issues requiring consultation are shown below:

1. Effective Governance**:** Including Board Membership and Composition and Board Secretaries;
2. Duties to Promote Cultural Chance: Including duty of Quality of the Population of Wales and Duty of Candour. The introduction a Duty of Quality for the Population of Wales which will focus on health boards working together to meet the needs of the population in the planning and delivery of quality healthcare services;
3. Person-centred health and care: Including setting and meeting common standards and joining investigation of health and social care complaints; and
4. Effective citizen's voice, co-production and clear inspection: including representing the citizen in health and social care, co-production and services with citizens and inspection and regulation.

In August 2017 the Board held a Development Day to consider the questions raised in the White Paper. In addition, further comments from Board Members were requested. A summary of the responses received from Board Members is attached.

CARDIFF AND VALE UNIVERSITY HEALTH BOARD

COMMENTS ONTHE WHITE PAPER CONSULTATION DOCUMENTS "Service Fit for the Future – Quality and Governance in Health and Social Care"

1 Effective Governance

Board Membership and Composition

The Welsh Government believes that the Boards of both Health Boards and NHS Trusts should share some core key principles, including delivering in partnership to deliver person centred care and a strong governance framework to enable the Board to work effectively and meet its responsibilities.

All Boards should have Vice Chairs in order to support focussed and skilled leadership.

The Welsh Government believes that Board Executive Officer membership for local health boards should probably include some key positions which are consistent across local health boards but also allow some flexibility to appoint based on remit and priorities.

HEALTH BOARD RESPONSE:

- The current Health Boards have been in place since 2009 and require review. There is an opinion that the current size and configuration of Health Boards ' Membership is too large and diverse. The current size of the Board (20 Members plus 3 Associate Members as a minimum) as set out in the Standing Orders should be reviewed.
- We support the proposal for a formal Vice Chair to Trusts. This has worked well in Health Boards and underpins good governance arrangements.
- We support the proposal for the Cabinet Secretary for Health, Well Being and Sport to have the authority to appoint additional Board Members. This should include both Executive and Independent Members.
- The current Associate Directors are not "citizen representatives" and Health Boards should have more discretion on who to appoint.
- We welcome the opportunity to review the role, purpose and terms of reference of the Health Professionals' Forum, Local Partnership Forum and Stakeholder Reference Group. Each of these has a critical role to play in delivering the Board Strategy but require review.
- Do we need to be prescriptive about the role of Independent Members in relation to specific expertise they will bring? In their recruitment we should be

able to look at opportunities to take the right members who have the correct expertise and experience required by the Board. General skills are the priority along with the flexibility to respond to need.

- Health Boards should have more discretion on the designated roles required for the Executive Directors as full Board Members. The Health Board believes that all Health Boards need to have the same core composition of Executive Directors.
- For the Board to make the change needed to make the transformation required in health care, clinical leadership of all the professions will be needed. The changes made in 2008 strengthened the Executive clinical leadership and moved away from "traditional" structures, recognising that healthcare had shifted to become multidisciplinary. It is therefore recommended that the model of Executive Directors for Clinical Services be maintained, whilst the Board is able to also have flexibility regarding the other Executive roles.
- The change of title of an Independent Member to “Public Member” is not supported as this could be misleading and not well understood.
- The Board supports the importance of the staff representative at Board level.
- Independent Members provide support well in excess of 4 days per month and this should be increased to 6 days per month.

2. Board Secretary

In order to deliver on the key principles outlined, the Welsh Government believes that the role of Board Secretary should be placed on a statutory basis and have statutory protection to allow the role to be independent with safeguards in place to challenge the Chief Executive of an NHS organisation or the Board more widely.

HEALTH BOARD REPSONSE

- This is a very important role and appropriate qualification and experience is required. The post needs a level of independence and statutory change could be considered.
- The proposal to give greater clarity to the role is welcomed, ensuring the role is perceived at an appropriately senior level to effectively challenge and advise Board Members.
- Some NHS organisations still used the title Board Secretary when other use the more appropriate title of Director of Corporate Governance.
- The role should directly be accountable to the Chair and report to the Chief Executive.

Duties to Promote Cultural Change

Duty of Quality for the Population of Wales

The Welsh Government believes that the duty of quality should be updated and enhanced to better reflect our integrated system. This duty should be sufficiently wide in scope to facilitate the needs of the population of Wales to facilitate and enable collaborative, regional and all-Wales solutions to service design and delivery.

NHS Bodies should also be placed under a reciprocal duty with local authorities to cooperate and work in partnership to improve the quality of services provided.

Welsh Government also believes that strengthening the existing planning duty will make sure health boards work together on the needs of the population of Wales in the planning and delivery of quality healthcare services.

HEALTH BOARD RESPONSE

- It is agreed that working across boundaries and budgets to meet the population needs will encourage innovation and partnership working to fully understand and address the population needs. To be transparent in the service design to meet the population needs in a quality driven manner that makes the most prudent use of the available resources.
- We do not support any further change to law to strengthen local collaboration in planning and meeting people's health and wellbeing needs close to home.
- The new legislation recently introduced - Social Services and Well Being Wales Act 2014 and Well Being of Future Generations (Wales) Act 2015 is sufficient to ensure closer collaborative working between Health and other public services.
- More time should be given to develop the recently introduced Regional Planning Forums to improve regional planning of service.

Duty of Candour

The Welsh Government believes that the development of a statutory duty of candour across health and social services in Wales would consolidate existing duties and be in the interests of a person centred system.

HEALTH BOARD RESPONSE

- The Board fully supports the introduction of a statutory duty of candour to strengthen the expectation for openness that currently exists.
- The Putting Things Right Regulations have embedded at their core a duty of candour. There would need to be joint investigation agreements across health and social care that would require legislative changes and review of reasonable timeframes. This would be a far more effective and equitable process for people who often have issues across multiple organisations. The Welsh proposal does not seem to include independent health providers as the Scottish model does. These should definitely be included.
- The principles of openness and candour could extend beyond the current requirements set out in Putting Things Right regulations while professional groups already have a duty of candour for patients and their families, this would be a strong message to extend this across NHS Wales.
- Introducing a legal requirement would enable inspection to take place and this commitment to be tested.

3 Person-Centred Health Care

The Welsh Government believes there should be a common set of high level standards applied to health and social care and that the standards should apply regardless of the location of care.

HEALTH BOARD RESPONSE

- The Health Board supports the concept of having in place consistent standards, which should be integrated with social care, the third sector and the independent sector.
- This common set of requirements should also be used as the framework for continuous improvement.
- Associated monitoring arrangements would need to be similarly joined up.
- Standards would need to be developed and defined in terms of providing person centred outcomes.

Joint Investigation of Health and Social Care Complaints

The Welsh Government believes that requiring different organisations to work together to investigate complaints will make it easier for people to complain when their complaint is about health and social services. We also believe it will encourage organisations to learn lessons to improve their services.

- Statutory guidance should set out a joint complaints process for service users who wish to complain about health and social care, where their package of care includes both. This would provide better transparency and communication systems.
- All opportunities to support and encourage organisations to learn lessons to improve their services would be embraced.
- The Health Board believes that a review of the Putting Things Right regulations would be timely and helpful, particularly in light of the suggestion to introduce a duty of candour.

4 Effective Citizen Voice, Co-production and Clear Inspection

Representing the Citizen in Health and Social Care

The Welsh Government believes that local health and social care organisations should be working with the public to co-design and co-create services and that the way they do this needs to be independently monitored.

We propose replacing the current statutory CHCs and their functions with a new national arrangement to represent the citizen voice in health and social care, to advise and provide independent assurance. The new body will work alongside Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales and have autonomy to decide how it will operate at local level.

HEALTH BOARD RESPONSE

- We have a very constructive and positive working relationship with our Community Health Council. We have also developed mechanisms for robust and systematic engagement which involves patients and carers in helping to co-design and co-create services to ensure they are more patient focused.
- The CHC function in providing an advocacy service for our patients is very much welcomed and valued. However, the Health Board believes it is timely for this approach to be reviewed and evolved. This could build upon the strength of the current system to maintain an independent voice for the patients whilst considering further developing an independent clinical scrutiny role as part of the national level arrangements in place.
- The independent inspection of the Health Board's service and premises has had its value but a new mechanism/approach which best meets the needs and requirements to represent patients and the public should be considered.

Co-producing Plans and Services with Citizens

The Welsh Government believes that introducing an independent mechanism to provide clinical advice on substantial service change decisions, with advice from the proposed new citizen voice body, will encourage continuous engagement and increase the pace of strategic change through enabling a more evidence-based, transparent process and a more directive and guiding role on the part of Welsh Government.

HEALTH BOARD RESPONSE:

- The proposal to introduce an independent mechanism to provide clinical advice on substantial service change is not supported. This would create additional stages in the planning process and could undermine the current engagement and consultation requirements.
- The Health Board does not support the proposal for more legislation to ensure Health Boards co-planning take place.
- Introducing this proposal would undermine the very constructive partnership working we already have with our Stakeholder Reference Group.

Inspection and Regulation and Single Body

The Welsh Government believes that ensuring a clearer underpinning legislative framework for HIW will help to foster closer integration and joint working with CCSIW and at the very least this should be taken forward.

HEALTH BOARD RESPONSE:

- The Health Board supports the proposal to have underpinning legislation for integrated inspection and integration.

- It was agreed that that there should be one inspectorate body but the view was that the role of the Ombudsman with their new powers also needed to be considered. The role and remit of the inspectorate body should be transparent with a proportionate approach to investigations. This should include independent providers, and consideration of how we provide the same standard for patients whose care is commissioned outside Wales, either by private providers or NHS Trusts.
- We would specifically like to see children and young people represented more robustly. We would welcome true participation by capturing and listening to the citizen's voice and using the many varied methods of doing this through technology and personal contact to have a truly representative view.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE – JULY 2017

The Welsh Health Specialised Services Committee held its latest public meeting on 25 July 2017. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what's happening in Welsh Health Specialised Services.

The papers for the meeting are available here

Action Log
Members noted the action log. Members received an update on:

- JC002 – The most recent Chairs' meeting had been cancelled but A Lloyd had written to Health Board Chairs to explain what was in and what was out of the 2017-20 ICP.
- JC006 – C Bell had provided input on engagement to the 2017-20 ICP.
- JC009, 011, 012 and 013 – Provision of Specialised Neurosciences in NHS Wales – The actions remained outstanding.

Chair's Report
Members noted the Chair's report.

It was noted that Professor Vivienne Harpwood has been appointed to succeed A Lloyd as Chair of WHSSC, whilst continuing as Chair of Powys Teaching Health Board, and that this would be AL's last meeting as Chair of WHSSC.

Acting Managing Director's Report
Members noted the Acting Managing Director's report and in particular:

- Genomics for Precision Medicine – The Welsh Government had launched its strategy in June. WHSSC's role in deployment of the strategy was noted. Whilst a £6.8m five year budget had been outlined within the strategy it was unclear what the implications were for non-recurrent and recurrent funding; WHSSC would be seeking clarification on this.
- Interventional Radiology – Since the report had been written, the first locum had resigned and left. A second locum would be joining the service shortly and a substantive consultant was expected to return to active duty shortly. The Walton Centre might be

approached to take emergency cases in addition to the ten elective cases it had already agreed to take.

- TAVI – WHSSC was awaiting further information from ABMUHB regarding the previously unreported TAVI list and mortality risk for patients on the list. ABMUHB had been reminded that all TAVIs are subject to prior approval in line with policy.
- Posture and Mobility – More information was awaited from CVUHB regarding its proposal for increased investment to replace obsolete wheelchairs. This is less of an issue for north Wales.
- Paediatric Rheumatology – Welsh Government had asked WHSSC to review the provision of paediatric rheumatology services for Wales. An initial scoping report was available for the meeting.
- Cardiac Ablation – Work has begun on developing the case for investment on economic grounds as a curative treatment for certain indications.

Perinatal Mental Health

Members received a paper, commissioned by Welsh Government, which set out the governance arrangements for the Tier 4 Specialised Perinatal Mental Health Task & Finish Group as a sub group of the All Wales Perinatal Mental Health Steering Group and presented a shortlist of three preferred options for the future configuration of tier 4 specialised perinatal mental health services in Wales. The three options were broadly (1) build upon IPFR process through a secured contract; (2) establish a single regional Mother & Baby Unit (MBU) for the whole of Wales; and (3) establish a regional MBU for south Wales and contract for an English provider for a north Wales service.

Various questions were raised around (1) Learning why the Cardiff MBU was de-commissioned. (2) How does a MBU fit with the recently expanded community based recovery model for mental health? (3) Is there any evidence of outcomes for mothers currently in the system? (4) How does a MBU proposal impact on value for money? (5) Will proximity of mothers' homes to the location of a MBU impact on its effectiveness and is there any evidence on this based on English experience where it is understood that some areas have MBUs and others don't? (6) What do English areas do that don't have local MBUs? (7) Can we approach the coding issue on an All Wales basis to generate meaningful data going forward?

It was agreed to provide this feedback to C Shillabeer, Chair of the Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group and lead Chief Executive for mental health, for further consideration and a clear recommendation on how to proceed.

Integrated Commissioning Plan 2017-20 – Risk Management Framework

Members received a paper that described the implementation of the ICP Risk Management Framework and recommended approval of the commissioning of (1) complex obesity surgery for paediatrics; (2) the use of Plerixafor for stem cell mobilisation; and (3) the use of Pasireotide for Cushings Disease, each of which would only apply to a small number of patients each year. It was explained that if this procedure and drugs were not commissioned it was highly likely that patients would proceed through the IPFR route; consequently the financial impact was neutral.

Members noted the progress made to date on the ICP Risk Management Framework and approved the commissioning of the procedure and drugs described above.

PET scans
Members were advised that a paper had been prepared for consideration by Management Group that set out a potential basis to mitigate the lack of agreed funding in the 2017-20 ICP for PET scans in respect of new indications. This was based on projections for lower demand than had been budgeted for PET scans on existing approved indications.

However, Chief Executives were reminded that the prioritisation process utilised in the ICP was evidence based, although new schemes were restricted by an overall lack of funding.

Value Based Commissioning - Progress Report
Members received an update on progress in the development of WHSSC's approach to value based commissioning as part of the 2017-20 ICP. This included work on identifying target areas in technical efficiency, allocative efficiency and patient value. A Right Value Commissioning Group had been formed that had already met several times and started looking at high cost low volume areas.

The content of the report was noted.

Inherited Bleeding Disorders (IBD)
Members received a paper which described a proposal outlining the management resource requirements and potential offsetting efficiency savings to facilitate the development of an all Wales commissioning strategy for IBD. It was noted that the estimated savings from repatriation of IBD services from Liverpool to BCUHB, through reduced administration charges alone, would more than cover the additional resource requirement in WHSSC but that the saving would not be achieved without pursuing this initiative. Members felt that the proposal to bring IBD under a single commissioner required further scrutiny.

Members noted the potential savings which would offset the resource required to increase WHSSC's commissioning capacity; supported the

outline proposal for repatriation of IBD services from Liverpool to BCUHB and referred the outline proposal to bring commissioner responsibility and funding under WHSSC as a single commissioner of IBD services across Wales to Management Group for further review.

Paediatric Rheumatology Services in South Wales
Members received a paper which described the current service provision and referral process for paediatric rheumatology in Wales, compared this to elsewhere in the UK and made recommendations to undertake a full review of the service to determine the population need, identify a service model to meet need, and quantify the resource requirements to deliver the service. It was noted that Welsh Government had asked WHSSC to review the service and make recommendations.

Members noted the position of the service in Wales and around the UK together with the recommendations of The British Society for Rheumatology and the National Rheumatoid Arthritis Society and agreed to refer the matter back to Welsh Government requesting its guidance on what was required next and noting that an improved service would require additional funding.

Integrated Commissioning Plan 2016-17 – Closure Report
Members received a report that set out the progress and outcomes against the delivery of the 2016-17 ICP schemes approved during 2016-17, highlighted where further action was required for schemes that had not been completed, and summarised the key lessons learned. 62 schemes had been delivered, 75 schemes were recorded as 'In progress' or 'Not commenced'. The full year financial effect of 2016-17 developments was £1.5m lower than the 2016-19 year 2 provision. Providers would be challenged as to whether they have spent the approved investment and on achieved outcomes.

Members noted the work completed in the 2016-17 ICP, the lessons learned and the closure of the 2016-17 ICP.

Annual Performance Report 2016-17
Members received the report for 2016-17, which provided a summary of the performance of providers throughout the year and details of the actions undertaken to address areas of non-compliance. Cardiac, Plastic, Paediatric, Neuro and Bariatric surgery failed to achieve 100% compliance with the 36 week RTT target and Thoracic surgery only achieved its 36 week RTT target once during the year. However Plastic, Paediatric and Bariatric surgery improved their performance during the course of the year. Lung cancer data previously provided by the Cancer Network ceased during Q4. It was noted that additional investment had been provided for Cardiac, Neuro and Thoracic surgery during the year and it

was therefore particularly disappointing that they had not achieved their targets.

Members noted the performance over 2016-17.

Financial Performance Report
Members received the finance report for Month 3 2017-18 noting a year to date over spend of £988k and a forecast under spend to year-end of £236k. The largest in year movement was a deterioration of £1.273m against NHS England contracts because of the previously disclosed HRG4+ PbR rates dispute, which were still in discussion but where DoFs were now making judgements and providing for the impact of the increased rates. It was noted that the main risk on HRG4+ was for BCUHB and PTHB because of their heavy reliance on English services.

Joint Sub Committees and Advisory Groups
Members noted the update report from the Child and Adolescent Mental Health Service and Eating Disorders Network Steering Group.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Minutes of the Welsh Health Specialised Services Committee
Meeting of the Joint Committee
held on 27 June 2017
at Health and Care Research, Castlebridge 4,
Cowbridge Road East, Cardiff

24.1

Members Present

Ann Lloyd	(AL)	Chair
Lyn Meadows	(LM)	Vice Chair
Marcus Longley	(ML)	Independent Member
Chris Turner	(CT)	Independent Member/ Audit Lead
Alexandra Howells	(AH)	Acting Chief Executive, Abertawe Bro Morgannwg UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Stuart Davies	(SD)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Sian Lewis	(SL)	Acting Medical Director, WHSSC
Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee
John Williams	(JW)	Chair of Welsh Renal Clinical Network

Apologies:

Tracey Cooper	(TC)	Tracey Cooper, Chief Executive, Public Health Wales
Gary Doherty	(GD)	Chief Executive for Betsi Cadwaladr UHB
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB

In Attendance

Ian Langfield	(IL)	Acting Director of Planning, WHSSC
Evan Moore	(EM)	Deputy Chief Executive, Betsi Cadwaladr UHB
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC
Ruth Treharne	RT	Director Of Planning and Performance/Deputy Chief Executive Cwm Taf UHB

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC

The Meeting opened at **12.50pm**

CONFIRMED

JC17/015 **Welcome, Introductions and Apologies**
The Chair formally opened the meeting and welcomed members and the public.

JC17/016 **Declarations of Interest**
There were no declarations to note.

JC17/017 **Patient Story (video)**
Members noted that the patient story was related to Perinatal Mental Health for which a paper was anticipated at the next meeting. Members agreed to defer the video to the next meeting.

JC17/018 **Accuracy of Minutes of the meetings held 30 May 2017**
Members reviewed and approved the minutes of the meeting held on 30 May 2017 as a true and accurate record.

JC17/019 **Action Log and Matters Arising**

Action Log
Members reviewed the action log and noted the updates provided.

JC007 – WHSSC Integrated Commissioning Plan 2017-20
It was noted that a written resolution for version 3.0 of the Plan had been circulated on 16 June 2017 in accordance with the agreement at the meeting held in May 2017. All voting members had signed the Written Resolution or confirmed their support in writing; the ICP was therefore approved. Therefore, work to produce a summary document for wider distribution could commence.

It was confirmed that the approval of the WHSSC Integrated Commissioning Plan (ICP) 2017-20 would enable the remaining open ICP related actions (JC001, JC004 and JC005) to be progressed.

JC009 – Provision of Specialised Neurosciences in NHS Wales
Members recalled the paper presented at the last meeting which highlighted the varying degrees of fragility with neurosciences and differences in the way services were provided. It was noted that a Neurosciences Strategy Group had been established and had held its first meeting at which it agreed a timeline and prioritised the consideration of sub speciality services; members requested sight of the proposed timeline. It was anticipated that an update paper would be presented to the Management Group in July 2017.

Action:

CONFIRMED

- **Timescales for work agreed by the Neurosciences Strategy Group to be circulated to member of the Joint Committee for information. (IL)**

Matters Arising
Community Health Councils (CHC)
Members received an update on the work being progressed around engagement. It was noted that, specifically in relation to the Thoracic Surgery Review, WHSSC officers continued to liaise with representatives of the joint Board of the CHCs and information had been shared with them but WHSSC had not yet received any feedback. Members recognised the difficulties faced and offered support in identifying opportunities and processes for engaging with the CHCs at a local level.

JC17/020 **Report from the Chair**
Members received the report from the Chair noting the following:

All Wales Chairs Meeting
An update of the meeting, which the Cabinet Secretary attended, was provided and key messages noted in relation to financial performance, transformation, quality of care and efficiency gains. Members noted that the Cabinet Secretary had reiterated that proposals to change services needed to be evidence based and approved promptly.

Chair's Action
Members noted the detail presented in the report relating to Chair's action taken following the WHSSC Joint Committee meeting held in May 2017 and the approval of the recommendations set out in the paper on the Specialised Neurosciences Review was ratified.

Members resolved to
- **Note** the content of the report, and
- **Ratify** Chair's action taken in relation the Specialised Neurosciences Review

JC17/021 **Report from the Acting Managing Director**
Members received the report which provided an update on key issues that had arisen since the last meeting. The following areas were highlighted.

Thoracic Surgery Review
Members noted that a revised timeline had been proposed due to a number of factors, including the engagement process noted earlier in the meeting. Members were informed that greater detail regarding this would be provided within the private session.

Performance Management

CONFIRMED

An enhanced performance management framework was being developed that would incorporate the WHSSC escalation process and be reported on through a revised version of the Performance Report. Members were advised that current performance issues would be considered under the Performance Management agenda item, and further detail made available during the private session.

All Wales Blood Service Programme
Members noted that the project completed in 2016 and the there was now an all Wales blood service, incorporating north Wales. The final report from the Project Board had recently been received by WHSSC. The report presented a positive outcome within timeline, generated cost savings and maintained a quality blood supply for the whole of Wales. It was anticipated that a paper on the closure report and proposed next steps would be presented at the next meeting of the Joint Committee.

Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales (WHSSC)
Members requested an update regarding the appointment of the Managing Director for WHSSC. It was noted that Sian Lewis' appointment as Managing Director of WHSSC had been confirmed and that she would commence in the role during September 2017.

Members resolved to

- **Note** the content of the report.

JC17/022 **Inherited Bleeding Disorders**

Members received the paper which highlighted the continued patient and commissioner risks in the Inherited Bleeding Disorders (IBD) service, made members aware that the WHSSC Team was not fully assured that the current arrangements would address these risks, and outlined options and a recommendation to address the risks.

Members noted that a paper had been considered by the Management Group in January 2017 to prioritise IBD within the Integrated Commissioning Plan to consolidate commissioning of the service to one commissioner as it was a specialised service; however, additional resources would be required to achieve this. It was noted that the addition resource could be delivered through the use of savings arising from other blood projects. The Management Group had considered the proposal, but a decision was deferred. The WHSSC Team had written to Health Board Chief Executives to advise them of the outcome and the continuing risks.

IL provided an overview of the concerns including, lack of resilience, inequity of access in south west Wales and provision of outreach clinics not achieved. The paper proposed three options to address the

CONFIRMED

commissioning arrangements as set out in section 3.5 and a recommendation was made to align commissioning responsibility and funding under WHSSC (option 3). Health Boards were asked to transfer their existing IBD resources to WHSSC in support of the proposal.

Members discussed the decision making process for this work and it was noted that it was within the remit of the Joint Committee as a joint committee of the seven Health Boards. It was also noted that the Management Group had not had an opportunity to consider the responses to the Chief Executive correspondence as it was felt more appropriate for the options proposed to be considered by the Joint Committee.

Members discussed the financial detail relating to the resource implications, sought further assurances in relation the level of savings from other blood services, the potential implication of future investments, and how to mitigate any ongoing risks.

The proposal was supported in principle, subject to a summary of the headline costs and savings on which the proposal was based.

Action:
Provide a summary of the headline costs and savings on which the IBD recommendation was based. (IL)

Members resolved to:

- **Note** the continued patient and commissioner risks in the IBD service;
- **Note** that current commissioning arrangements are suboptimal and make a single all Wales approach to strategic planning difficult to achieve; and
- **Support, in principle**, subject to a summary of the headline costs and savings on which the proposal was based.
    - the transfer of resources from Health Boards to WHSSC to align resources with commissioning responsibility;
    - the development of a proposal for an increase in commissioning capacity for this service on a spend to save basis; and
    - the development of a commissioning strategy for the whole of Wales for the IBD service.

JC17/023 **Performance Report**

Members received the report for March 2017, which provided a summary of the key issues arising and detailed the actions being undertaken to address areas of non-compliance.

Members noted that the focus of the paper had been narrowed to areas of high risk and escalation with Neuroradiology and Paediatric surgery

CONFIRMED

highlighted as areas for which further discussion was required 'in committee'.

Other key areas to note included:
Cardiac Surgery
The 36 weeks target was not being achieved. Members noted recent work being undertaken by the Delivery Unit around pathway start dates; the way in which these were being recorded varied. It was noted that an assessment of inter-hospital transfer rates was to be carried out.

Plastic Surgery
There had been some improvements in the service; however it was not believed that the target to reduce the number of 36 week breaches to 40 by year end would be achieved. It was noted that a service summit meeting had been scheduled at which this would be discussed.

24.1

Paediatric Surgery
It was noted that there had been a reduction in the number of 52 week breaches. Despite some progress the backlog was not expected to be cleared by the end of quarter 1 2017-18.

Neurosurgery
Performance continued to deteriorate due to issues around theatre capacity and length of stay reducing bed capacity.

Bariatric Surgery
Members noted good progress within this service; however WHSSC had written to the current service provider to confirm the intention to take forward a tender for future service provision for south Wales.

Thoracic Surgery
The outsourcing project for south west Wales had not commenced yet; the situation was being monitored but it may be necessary to identify a different provider.

It was further noted that WHSSC had contacted Chief Operating Officers as there had been difficulty obtaining data for lung resection data, previously sourced through the Cancer Network.

Posture and Mobility: Referral to Treatment Wheelchairs
The position for adult services had deteriorated due to staff vacancies across two of the three sites and was not likely to recover to achieve the national target in the near future. Members noted that comprehensive presentations were provided by each provider of the service at the All Wales Posture and Mobility Partnership Board, where future plans for recovery were clearly set out and assurance provided.

Children and Adolescent Mental Health Service

CONFIRMED

It was noted that work had commenced in north Wales around the balance of patients being managed locally and out of area. It was noted that there were staffing issues in terms of pay rates for staff working in the community being higher than rates for hospital staff and concerns around long term sustainability.

It was noted that work was being undertaken around outcomes and patient experience and it was anticipated that this would be included in future reports to better triangulate quality and performance information against the escalation framework.

A question was raised in relation to recovery plans for cardiac surgery and paediatric surgery waiting times and assurances sought that these would result in improved performance. It was noted that, for cardiac surgery, the breaches in north Wales were mostly attributed to minimitral valve surgery, whereby patients received a choice and had consented to the longer wait. It was noted that in Cardiff capacity was stable and positive progress was being made. There were some concerns around capacity in Swansea due to difficulties recruiting and retaining cardiac scrub nurses. In relation to paediatric surgery, members noted that there had been some improvement in volume of activity; however concerns still remained around the way in which patients were prioritised. Members noted that the WHSSC Team had sought further assurances around the impact on patients and management of risk by the provider.

Members discussed the impact of waiting times for cardiac surgery and noted that the Management Group would be undertaking a piece of work to understand the rationale for variance in acuity across Wales.

Members noted that an annual performance report 2016-17 was to be presented at the next meeting.

Members resolved to:

- **Note** current performance and the action being undertaken to address areas of non-compliance.

JC17/024 **Financial Performance Report**

Members received the report which provided the current financial position of WHSSC together with outturn forecasts for the financial year.

It was noted that the financial position reported at Month 2 was a projected underspend to year-end of £760k, based on Month 1 data. There were some concerns around the NHS England spend that was now based on HRG4+ Payment by results rates. The WHSSC Team was resisting this on the basis that it reflected a cost increase in specialised services for no extra activity. Members received an overview of HRG4+ pricing system used within the NHS in England.

CONFIRMED

Members resolved to:

- **Note** the current financial position and forecast year-end position.

JC17/025 **Reports from the Joint Sub-committees and Advisory Group Chairs'**

Members received the following reports from the Joint Sub-committees and Advisory Group chairs:

Sub Committees

All Wales Individual Patient Funding Request Panel

Members noted the update from the meeting held 31 May 2017 with the following areas highlighted to note:

24.1

Requests for positron emission tomography (PET) scans continued to rise; consideration was being given as to how these might be managed going forward.

Members noted that there had been a poor response from Health Board in relation to ensuring clinical representation at IPFR Panel meetings. It was noted that the lack of clinical representation lead to delays in the decision process and Health Board members were urged to feed this information back to their respective Boards and give greater consideration to nominations for clinical representatives.

Audit Committee

Members noted the update from the meeting held 31 May 2017 and were informed that the WHSSC Annual Accounts and Annual Governance Statement had been approved without comment.

Advisory Groups

All Wales Neonatal Network Steering Group

Members noted the update from the meeting held in June 2017 and the work being carried out in relation to a proposal for a 24 hour transport service in south Wales.

All Wales Gender Identity Partnership Group

Members noted the update from the meeting held on 16 May 2017, with the following areas highlighted:

At the last meeting of the Group there had been an agreement to change its name to better reflect its work. The Group received a closure report on the funding for the 2015 project, which indicated an under spend of £10,000 that Welsh Government had agreed could be released to support

CONFIRMED

the ongoing work of the Group.

Members were informed of the requirement to provide an interim solution for hormone prescribing due to associated issues arising. It was noted that work was progressing with this and it was anticipated that a proposed pathway would be shared with stakeholders in August 2017 with a report to the WHSSC Joint Committee in September 2017 for a decision. It was noted that Welsh Government had committed £500,000 to support this.

The Joint Committee received and approved the revised Terms of Reference for the Group.

The Chair and members extended their thanks to Tracy Myhill and Carole Bell for their hard work and commitment to the Partnership Board given the concerns and current difficulties within the service.

Child and Adolescent Mental Health Service and Eating Disorders Network Steering Group.
It was noted that the Group met on 22 June 2017 and that a formal report would be provided to the next meeting of the Joint Committee. Members noted that a paper had been presented on the work of the tier 4 task and finish group, mother and baby unit for perinatal mental health in south Wales. It was anticipated that a paper would be presented in July accompanied by a patient story.

JC17/026 **Date and Time of Next Meeting**
It was confirmed that the next meeting of the Joint Committee would be held on 25 July 2017.

The public meeting concluded at approximately **1.50pm**

Chair's Signature: .....

Date: .....

CONFIRMED

Item 2.1

CARDIFF AND VALE OF GLAMORGAN REGIONAL PARTNERSHIP BOARD
10.00 am – 12.30 pm, Tuesday 21 March 2017
Held in Community Room 1, STAR Hub, Muirton Road Cardiff CF24 2SJ

Minutes of the Meeting

Attendance

Cllr Susan Elsmore **(Chair)**	Cabinet Member, Health, Housing and Wellbeing, City of Cardiff Council
Abigail Harris	Director of Planning and Strategy, Cardiff and Vale University Health Board
Andrew Templeton	Chief Executive, YMCA Cardiff
James Livingstone	Carers' representative
Jeff Hawkins	Chief Executive, Age Connects Cardiff and Vice Chair Age Alliance Wales
Malcolm Perrett	Vice Chair, Care Forum Wales
Marcus Longley	Vice Chair, Cardiff and Vale University Health Board
Maria Battle	Chair, Cardiff and Vale University Health Board
Rachel Connor	Chief Executive Officer, Glamorgan Voluntary Services
Sheila Hendrickson-Brown	Chief Executive Officer, Cardiff Third Sector Council
Cllr Sue Lent	Cabinet Member, Early Years, Children and Families, City of Cardiff Council
Suzanne Clifton	Interim Head of Service, Social Services, Vale of Glamorgan Council (representing Phil Evans)
Suzanne Davies	Cluster Services Manager, Action for Children
Tony Young	Director of Social Services, City of Cardiff Council
Secretariat	
Rachel Jones	Assistant Director, Integrating Health and Social Care, Cardiff and Vale of Glamorgan Integrated Health & Social Care Partnership
Meredith Gardiner	Programme Manager, Health, Social Care and Well-being, Cardiff and Vale University Health Board
Rachel Armitage	Partnership Support Officer, Cardiff and Vale University Health Board

By invitation

Simone Joslyn	Engagement Lead, Cardiff and Vale University Health Board (for item 6)
Suzanne Wood	Consultant in Public Health (for item 10)
Claire Beynon	Specialist Registrar in Public Health (for item 10)

Apologies

Estelle Hitchon	Director of Partnerships and Engagement, Wales Ambulance Service Trust
Cllr Neil Moore	Leader, Vale of Glamorgan Council
Paul Orders	Chief Executive, City of Cardiff Council
Phil Evans	Director of Social Services, Vale of Glamorgan Council
Rob Thomas	Managing Director, Vale of Glamorgan Council
Sharon Hopkins	Interim Chief Executive, Cardiff and Vale University Health Board
Cllr Stuart Egan	Older Person's Champion, Vale of Glamorgan Council
Cllr Bronwen Brooks	Cabinet Member, Housing, Social Care and Health, Vale of Glamorgan Council

Item 2.1

Minute Number	Minute	Action/ Deadline
RPB 034	**1. WELCOME AND OPENING REMARKS** The Chair welcomed everyone to the final meeting of the first year of the RPB. She congratulated all members on the progress made, having developed a real community and partnership environment. Particular tribute was paid to Phil Evans for his contributions to the Partnership over a number of years and that the RPB wished him well in the future.	**Action**: Chair to send letter of thanks to Phil Evans on Behalf of RPB
RPB 035	**2. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING** The minutes were **APPROVED** as a correct and accurate record. <u>Action Log</u> All actions are complete and there were no matters arising. The Action Log status was **APPROVED**.	
RPB 036	**3. POPULATION NEEDS ANALYSIS** Rachel Jones confirmed that the Population Needs Analysis (PNA) has been approved by the City of Cardiff Cabinet and would be presented to the full Council on Thursday 23 March. It has been approved by the Vale of Glamorgan full Council and will be presented to the UHB Board on 30th March. Following these processes the PNA will be submitted to the Minister on 31st March. The summary of on page 4 was noted as highlighting cross-cutting themes which will inform future work. This will be done in collaboration with the Public Service Boards (PSBs), especially on issues which have not traditionally been considered health and social care responsibilities, such as transport. This work will in turn inform the Area Plan which will be developed in response to the PNA. An update will be provided to the RPB in June. The following points were discussed: • The need to be aware of the expectations and resource implications of the Area Plan, noting that resources will need to be appropriately realigned against the expectations set by the Plan • The need for clarity that not all issues raised in the PNA are the responsibility of the RPB • The interface with the Social Care for Wales 5 year strategic plan and the need for a strategic approach to funding. The RPB: • **NOTED** the update and **APPROVED** the PNA to be submitted to the Minister for Social Services and Public Health (subject to any comments by the UHB Board)	**Action:** PNA to be submitted to the Minister by 31st March.

24.2

RPB 037	**4. RPB ANNUAL REPORT AND WORK PROGRAMME** <u>Annual Report</u> Rachel Jones thanked all who had been involved in contributing to the annual report which celebrates the good work which has occurred during the past year. It includes outcome reports, in particular for ICF delivery, and highlights areas where further work is necessary. It was noted that the submission date of 31 March restricts the report to an incomplete year but further updates will be made following the year end. The following points were discussed: • The report is well presented. It was recommended that an Executive Summary be produced and added to the Partnership website. • The value of the outcome measures in the report in demonstrating the worth of integration. The RPB • **APPROVED** the Annual Report for submission to the Minister for Social Services and Public Health by 31st March 2017 <u>Work Programme</u> Rachel Jones summarised the updates of the 2016/17 work programme and suggested actions for the 2017/18 work programme. It was highlighted there was a need to focus on the issues highlighted by the PNA and the need to discuss with the PSBs how the responsibilities will be shared. An updated version of the work programme will be circulated before the next meeting of the RPB. It was highlighted that the work programme should include clear outcomes and measures where available. The RPB: • **NOTED** the work programme for 2016/17 and draft actions for 2017/18. <u>Communications – website and video</u> Susan Elsmore confirmed that the development of a Partnership website and introductory video has been completed, both of which evidence robust partnership working. In addition, there has been developed a Twitter and Facebook presence; all of these platforms will be regularly updated. All members were invited to submit case studies and reports to add to the website. The RPB: • **NOTED** the update.	**Action:** Executive Summary of Annual Report to be produced - Secretariat **Action:** Annual Report to be submitted to Minister **Action**: Circulate an updated work programme following discussion with the PSBs. **R Jones**.
RPB 038	**5. YOUNG CARERS** Andrew Templeton and James Livingstone provided a presentation on young carers, highlighting particularly that awareness of young carers' issues is generally quite low and that the key issue for young carers is social isolation, with particular challenges associated with the transition to adulthood and the cessation of funding for provision at 16 years old. It	

	was confirmed that YMCA funding mainly derives from Children in Need and Trust Funds. It was highlighted that the inability of young carers to be able to join in with social events due to caring commitment can often result in bullying and that it is difficult to identify exactly how many young carers exist especially as some young people do not recognise themselves as carers. The YMCA is currently researching this matter, noting that young carers' needs are wide ranging, with the only provider in Cardiff being the YMCA. Provision in the Vale of Glamorgan is funded from Families First. The greater recognition within the Social Services and Well-being (Wales) Act 2014 of young carers as a priority was welcomed, noting the reluctance of young people to engage with the statutory sector for fear that the family unit will be disbanded. Reference was made to the *Young Carers Speak Out* report noting that further consideration is required of the young carer's position when in contact with all health provision. Findings from the adverse childhood experiences (ACE) approach have highlighted the significant risk factors associated with the markers found in this group. The following points were discussed: • The need to improve services to young adults • The need for a closer strategic alliance between the YMCA and all third sector partners • The need for a safe place for young people with a one-stop approach to accessing respite and socialisation supported by specialised staff. It was noted that fixed locations for services are effective and that the YMCA offers over 250 respite activities every year, including 1:1 mentoring and skills acquisition programmes, with peer groups brought together as often as possible • The key relationship with professionals as the young person is usually referred at point of crisis • The lack of an overarching responsible body for young carers' services and the need to identify a lead and scope for a young carers' strategy • The time pressures and lack of continuity experienced by third sector providers of projects with finite funding • The role of technology especially in providing advice and assistance • The risk of regarding the group under discussion as homogeneous without recognition of diversity and the unique cultural mix in Cardiff. It was confirmed that the development of the Area Plan will interface with the locality and neighbourhood approach to ensure recognition of diversity • The need to encourage school governing bodies to have a role in identifying and providing for young carers • The need for a cohesive approach to the work • The importance of health services in enabling young carers to understand their parents' or siblings' conditions noting the additional risk • The need to identify how society manages the level of current need and to ensure that all needs for individuals are met while allowing them choice and control.	**Action**: Cllr Lent to raise with Cardiff Education Department

Item 2.1

	The RPB: • **AGREED** that the Strategic Leadership should discuss lead responsibilities in relation to progressing a Carers Strategy.	**Action**: SLG to consider responsibilities for development of Carer Strategy – next meeting of SLG is 2/5/17
RPB 039	**6. PERFECT LOCALITY** Simone Joslyn provided a presentation on the development of the perfect locality, noting that the specification remains in draft, allowing for additional comments and challenges. The specification has been developed in collaboration with many partner agencies and aims to be solution focused with an emphasis on the prevention agenda and keeping people well while recognising that health and social care is a complex system. The work facilitated identification of health literacy as an important factor when trying to engage citizens and users of the systems. A collaborative approach has been designed to help people gain information, improve self-care and reduce reliance on services, with an overall emphasis on well-being rather than ill health. There is also a focus on primary care and facilitation of technological solutions. The whole system approach model enabled the development of common terminology which has in turn facilitated discussions about locations for services and a change to a citizen-centred, partnership driven and more accessible service model. The following points were discussed: • The importance of relationships between individuals, communities and professionals • The model is non-medical, in response to citizens' views of what is important to them • The impact of the work on specifications for Well-being Hubs. • The full version of the specification would be shared with the RPB The RPB: • **NOTED** the presentation and discussion and agreed to forward any additional comments via the secretariat.	**Action**: Specification to be circulated and any comments to be forwarded via the Secretariat.
RPB 040	**7. JOINT COMMISSIONING AND POOLED BUDGETS** <u>Draft Statement of Intent – Older People</u> Rachel Jones introduced the Draft Statement of Intent for Older People which had been developed following work progressed by partners previously. The draft document which will enable development of a discussion document to form the basis of stakeholder events to be planned for 2017/18. <u>Update on Market Position Statement</u> Rachel Jones confirmed that work is ongoing to map all services and	

	finances across each level of the service model triangle to inform stakeholder discussions, with particular reference to the allocation of resource and support to improve early intervention and prevention. This work will provide the evidence necessary to inform future discussions. Pooled Budgets A summary was provided of the pooled budgets workshop held on 8th March. It was confirmed that a Project Manager has been appointed and will take up post in early April 2017 to help support this work. The following points were discussed: • The commissioning of different services for the population requires robust but flexible governance • The opportunities for innovation provided by the move to pooled budgets. The RPB: • **NOTED** the update.	
RPB 041	**8. INTERMEDIATE CARE FUND (ICF)** Abi Harris provided an update on the current financial position, noting the small underspend, for which there is a management process in place. It was confirmed that the ICF has been shown to have made a significant contribution to the winter plan and the metrics show that some of the ICF-funded projects will become embedded services. Ongoing recruitment challenges to some projects were noted. Proposed ICF Budget 2017/18 It was confirmed that the proposal currently includes both capital and revenue elements, noting the risk to revenue of the £200k over-commitment in 2017/18. Monthly budget monitoring will continue to ensure there is no overspend in the next financial year and oversight will continue to be held by the SLG and RPB. Regarding revenue, it was noted that Welsh Government has confirmed a further 3 years of funding, but that the amount was yet to be confirmed It was noted that the capital sum has been confirmed for 4 years; it was highlighted that there is now agreement that there are opportunities for brokering funding between Regional Partnership Boards to enable transformational work. Proposals for capital investment were still being developed and it was agreed that a meeting between leads will be taking to discuss options in April. Colleagues were invited to submit proposals and resulting recommendations would be circulated for RPB approval by email. The SLG: • **NOTED** and **ACCEPTED** the revenue overspend subject to robust budget monitoring being in place. The following points were discussed: • The improvement in position compared with 2015/16 with increased ability to capture the impact of the funding, noting that the confirmed	**ACTION**: Capital recommendations to be circulated via email. **R Jones**

	additional funding arrangement will make recruitment easier • The need for a strategic capital plan to be in place and agreed by the end of April 2017. The RPB: • **NOTED** the update.	
RPB 042	**9. PATIENT FLOW** Meredith Gardiner provided an update on the Delayed Transfers of Care position, noting the significant improvement compared with previous years. The following points were discussed: • The service redesign and consolidation of Mental Health Services for Older People has prevented many admissions although the delayed transfer position remains static • The need in future reports to indicate the rate as well as absolute numbers and the completion of axes to assist clarity of understanding • The Head of Integrated Care has introduced a targeted approach to Mental Health as well as non-Mental Health areas • The Day of Care Audit demonstrated that 43% of UHL and 23% of UHW patients did not meet the criteria for secondary care: the BIG 1 goal is to cohort patients appropriately. It was recommended that reporting of this work should be combined with the DToC report • The need to also build ICF funded work into this reporting. The RPB: • **NOTED** the update	**ACTION**: Include the rate and complete the axes in future reporting. **J Hill** **ACTION**: Include the BIG1 goal and ICF funded work in future reporting. **J Hill**
RPB 043	**10. DEMENTIA STRATEGY** Suzanne Wood and Claire Beynon summarised the process undertaken to develop the strategy, noting that additional themes suggested as part of the consultation process had focused mainly on progression of the disease. It was highlighted that 9 themes had been identified, including isolation and loneliness, kindness and compassion, co-ordination of services, what to do in a crisis, moving support to primary care, inequalities in access to services particularly the differential between living in urban or rural areas and the associated costs, end of life care, and prevention. It was confirmed that an action plan was under development divided by theme and matched with statutory obligations, which will be supported by a new structure to lead the work. Further comments were welcomed. The following points were discussed: • The need to mention safeguarding, the built environment and public awareness, including what children understand about dementia	

24.2

	• The need to reference mental capacity and making decisions as a family • The need to ensure a backlog does not develop following the use of non-recurrent ICF funding • The importance of transport, support for carers and having a single point of access to services • The anticipated impact of the new communities being built in the region and the need for different types of accommodation to mix different social groups to ensure support • The need to use current and projected future costs of dementia care to support the strategy and inform work on pooled budgets and strategic planning • The need to improve the competency of primary care as part of the strategy • The need to embed the strategy into the Area Plan. The RPB: • **NOTED** the update • **AGREED to** provide any comments on the draft response to the WG Dementia Strategy – Together for a dementia Friendly Wales prior to submission on 3rd April. • **AGREED** that the RPB would send a formal letter of thanks to Dame Deirdre Hine for her support of this work and role as Chair of the Task Force.	**Action:** comments on consultation response by 27/03/17 to be sent to Suzanne Wood - ALL **Action**: Write letter to Dame Deirdre Hine - Cllr Elsmore
RPB 044	**11. RESPONSE TO LONELINESS ENQUIRY** The RPB noted the response for information. Thanks were extended to contributors and Public Health Wales for collating the results. The interface with the PNA and Dementia items above was noted.	
RPB 045	**12. ANY OTHER BUSINESS** • Parliamentary Review into Health and Care Services: Rachel Jones invited colleagues' comments to influence the response noting that the Review will be a key influence on future work. Cllr Elsmore confirmed that she will give oral evidence to the Review on behalf of the Welsh Local Government Association. It was recommended that the draft response should be cross-referenced with the NHS collective response to the NHS Confederation. • Social Enterprise Event 22 March: the event was intended to be an opportunity to develop work with social enterprises to respond to some of the challenges identified in the PNA and dementia work. It was confirmed that Cardiff Third Sector Council is collaborating with Cardiff University on social enterprise issues.	**Action:** Comments to be sent to R Jones by 12/04/17 for inclusion in response
RPB 046	**CHAIR'S CLOSING REMARKS**	

Item 2.1

	The Chair highlighted that this meeting could be the last of the existing RPB membership owing to the forthcoming elections. She thanked all members for their contributions and commitment to the work of this Board. The work had been rewarded by demonstrable progress in a short time frame.	
RPB 047	**DATES OF FUTURE MEETINGS** **RPB Meetings** • **Friday 9 June 2017** 9.30 am – 12.00 pm (Vale of Glamorgan) • **Tuesday 10 October 2017** 2.00 pm – 4.30 pm (Cardiff) • **Thursday 18 January 2018** 2.00 pm – 4.30 pm (Vale of Glamorgan) • **Tuesday 20 March 2018** 2.00 pm – 4.30pm (Cardiff) Venues to be confirmed Dates for workshops will be set in due course.	

24.2

Item 2.1

CARDIFF AND VALE OF GLAMORGAN REGIONAL PARTNERSHIP BOARD
10.00 am – 12.30 pm, Friday 9th June 2017
Held in Conference Room, Potter's House, Hebron Hall,
Dinas Powys, CF64 4YB

DRAFT Minutes of the Meeting

Attendance

Sam Austin	Deputy Chief Executive and Director of Operational Services, Llamau
Maria Battle	Chair, Cardiff and Vale University Health Board
Suzanne Clifton	Head of Service, Social Services, Vale of Glamorgan Council (representing Lance Carver)
Rachel Connor	Chief Executive Officer, Glamorgan Voluntary Services
Cllr Susan Elsmore **(Chair)**	Cabinet Member, Social Care and Health, City of Cardiff Council
Jeff Hawkins	Chief Executive, Age Connects Cardiff and Vice Chair Age Alliance Wales
Sheila Hendrickson-Brown	Chief Executive Officer, Cardiff Third Sector Council
Cllr Graham Hinchey	Cabinet Member for Children and Families, City of Cardiff Council
Estelle Hitchon	Director of Partnerships and Engagement, Wales Ambulance Service Trust
Sharon Hopkins	Interim Chief Executive, Cardiff and Vale University Health Board
Cllr Gordon Kemp	Cabinet Member for Social Care, Health and Leisure, Vale of Glamorgan Council
Marcus Longley	Vice Chair, Cardiff and Vale University Health Board
Cllr Andrew Parker	Cabinet Member for Housing and Building Services, Vale of Glamorgan Council
Malcolm Perrett	Vice Chair, Care Forum Wales
Rob Thomas	Managing Director, Vale of Glamorgan Council
Tony Young	Director of Social Services, City of Cardiff Council
Secretariat	
Rachel Armitage	Partnership Support Officer, Cardiff and Vale of Glamorgan Integrated Health & Social Care Partnership
Meredith Gardiner	Programme Manager, Health, Social Care and Well-being, Cardiff and Vale of Glamorgan Integrated Health & Social Care Partnership
Rachel Jones	Assistant Director, Integrating Health and Social Care, Cardiff and Vale of Glamorgan Integrated Health & Social Care Partnership

By invitation

Judith Hill	Head of Integrated Care, Cardiff and Vale University Health Board
Jane Thomas	Assistant Director, Housing and Communities, City of Cardiff Council
Pam Toms	Housing Solutions & Supporting People Team Leader, Housing Services, Vale of Glamorgan Council

Apologies

Lance Carver	Director of Social Services, Vale of Glamorgan Council
Abigail Harris	Director of Planning and Strategy, Cardiff and Vale University Health Board
James Livingstone	Carer representative

Item 2.1

Paul Orders	Chief Executive, City of Cardiff Council
Andrew Templeton	Chief Executive, YMCA Cardiff
Cllr John Thomas	Leader of Vale of Glamorgan Council

Minute Number	Minute	Action/ Deadline
RPB 048	**1. WELCOME AND OPENING REMARKS** The Chair welcomed new members to the RPB, highlighting the importance of work to integrate health and social care, continuing the achievements made since April 2016, including responding to the Population Needs Assessment.	
RPB 049	**2. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING** The minutes of 21st March 2017 were **APPROVED** as a correct and accurate record **SUBJECT TO** the following minor amendment: Action allocated to Suzanne Clifton to raise the matter of young carers with Education colleagues in the Vale of Glamorgan Council. S Clifton confirmed that there is continual dialogue with Education colleagues, including on the subject of young carers. <u>Action Log</u> RPB 038: Cllr Lent to raise the matter of young carers with the City of Cardiff Council Education Department – matter to be followed up by Cllr Graham Hinchey following a change in Cabinet responsibilities. It was agreed that an update on young carers would be discussed by the Strategic Leadership Group (SLG) at its meeting on 6 July. All other actions are complete or on the agenda for this meeting and there were no further matters arising. The Action Log status was **APPROVED** subject to the minor amendment highlighted above. **Actions:** ➢ Amend the minutes and action plan regarding links with education. ➢ Raise the matter of young carers with Cllr Graham Hinchey to follow up with Cardiff Council's Education Department. ➢ Progress arrangements for the discussion of young carers at SLG on 6th July 2017.	

	The following points were discussed: • Make arrangements to invite Cllr Lynda Thorne, Cabinet Member for Housing and Communities, Cardiff Council to future meetings to enable housing to be represented following changes in portfolio responsibilities within Cabinet. • The relationship between the RPB and Strategic Leadership Group (SLG) and the need to ensure that the RPB has full awareness of the work undertaken by the SLG • The challenge of meeting all the requirements of the Act within four RPB meetings a year and support for additional 'informal' workshops. • The need for time to develop innovations in response to data and evidence • The need for RPB members to understand how the workshops inform the RPB work plan and associated discussions at SLG • The need to enable RPB members to access materials and discussions without attending additional meetings, noting that the work plan sets out the RPB priorities The RPB: • **APPROVED** the revised Terms of Reference **SUBJECT TO** the inclusion of the Cabinet Member for Housing and Communities at City of Cardiff Council within the membership. • **AGREED** to consider the management of the relationship between the RPB and SLG at a future RPB workshop session. **Action:** ➢ Confirm Cllr John Thomas is content to be Vice Chair of the RPB ➢ Make arrangements for Cllr Thorne to be invited to future meetings; ➢ Include the establishment of links between the RPB and SLG as a topic for consideration at a future RPB workshop session.	Secretariat Secretariat Secretariat.
RPB 051	**4. RPB WORK PROGRAMME** Cllr Elsmore highlighted that the work programme acts as a framework for quarterly updates to the RPB. Rachel Jones confirmed that the work plan aims to capture all the work under way across the Partnership, is updated quarterly and informs the RPB agenda and the Annual Report. It is a dynamic document to which other emerging priorities can be added. The following points were discussed: • The need for appropriate levels of focus on the strategic collective workforce challenge, noting the need to ensure that the right people are available to provide the right services in the right way. • It was confirmed that the Directors of Social Services hold responsibility for all social care workforce development. Tony Young was currently the Chair of the Regional Workforce Partnership, a presentation on which had been given to the last meeting of the SLG. • The significant issues which are outside RPB control, including WG approach to zero hours contracts and current commissioning processes in the context of the Regulation and Inspection of Social Care (Wales) Act. • The need for a clear collective regional strategy for workforce including understanding the interlinking challenges for partners across the region • The importance of ensuring best use of assets including people, vehicles,	

	buildings and technology • It was agreed that workforce issues should be a topic for a RPB workshop with the aim of establishing an overarching strategy for workforce across the region. • Other areas for workshop sessions should include prevention, community engagement, and housing. The RPB: • **APPROVED** the work programme for 2017/18 **SUBJECT TO** increased emphasis on workforce issues. **Action:** ➢ The work plan should be updated to include an increased emphasis upon workforce. ➢ The topic of Workforce to be included as the focus of an RPB development session in the coming year.	Secretariat Secretariat
RPB 052	**5. DEVELOPMENT SESSIONS** Cllr Elsmore confirmed that workshop dates have been identified for which diary markers will be distributed in due course. Members were invited to discuss priorities for workshop consideration. The following points were discussed: • The need to develop a strategy to manage the commissioning arrangements for learning disabilities services • The benefits possible from defining and improving citizen engagement • Collaborative work across all services on optimising use of assets and sites, noting the impact on patient flow of accommodation challenges and the role of housing associations as key providers • Preventative services. The RPB: • **AGREED** that the workshops should consider workforce, learning disabilities, housing and accommodation, citizen engagement, assets, and preventative services. **Action:** ➢ Workshops to be arranged in accordance with the topics agreed above.	Secretariat
RPB 053	**6. OLDER PERSONS' SERVICES JOINT COMMISSIONING AND POOLED BUDGETS UPDATE** <u>Update and Current Position</u> Rachel Jones provided an update on the joint commissioning activity undertaken since the RPB met in March, noting that the key priority was for older peoples' services. It was confirmed that work had been undertaken to establish a baseline for older peoples' services and map provision and costs of services. Data gathered have shown that the total spend in the region is in excess of approximately £220 million per annum, demonstrating the need to realign services and amend delivery models. <u>Draft Statement of Intent – Older People</u>	

DRAFT

24.2

	Rachel Jones introduced the draft Statement of Intent, confirming the objective to develop a common approach across the statutory partners, aligned with the "Shaping Our Future Well-being" strategy, and aiming to develop a model of prevention to reduce escalation of need. It was highlighted that the draft document will be discussed at a focused workshop on 5 July 2017. <u>Draft Market Position Statement</u> Rachel Jones confirmed that work continues on the development of the Market Position Statement which is intended to enable stakeholders and providers to supply against identified gaps in the market. It was highlighted that a number of key measures, population projections and demographics are being developed for each neighbourhood/GP cluster area across the health board footprint, which will be used to inform priorities and capital developments. Local assets are also being mapped against the data to identify gaps in provision and inform future developments, commissioning and market provision. This will act as a template for analysis against other priority population groups as part of the Area Plan development to inform future delivery plans. The following points were discussed: • The support for a focus on neighbourhood/locality evidence base to inform future prioritisation • The need to rethink how we realign our core funding to support different ways of working – instead of the disproportionate focus on ICF • The importance of engaging provides in developing the final document • The need to ensure the Third Sector contribution is recognised within the Market Position Statement. <u>Pooled budgets</u> Rachel Jones confirmed that discussions are ongoing on the requirement to develop a pooled budget for care accommodation by April 2018. The Project Board, comprising statutory partners, has made good progress on agreements in principle which will be presented to formal Cabinets and the UHB Board over coming months. Based on advice given by WG and the National Commissioning Board, work to date has focussed on care accommodation for older people and the initial consensus that there are 2 pooled budgets, the UHB with the City of Cardiff Council and the UHB with the Vale of Glamorgan Council. This proposed approach was based on the recognition of the differences in maturity of arrangements and approaches to fee structures. Work will continue to develop a common approach to fee setting, contracting and commissioning arrangements on the identified in-scope services. Since the work has been progressed a letter from the Minister had been received setting out an expectation that there should be a single pooled budget across the region. It was confirmed that there are continuing discussions at both Ministerial and officials level and across the other regions to clarify the extent of the expectations expressed in the recent Minister's letter. The following points were discussed:	

	• The responsibilities of sovereign bodies to make decisions which ensure that services are safe and within expenditure limits. • The need for individual regions to be able to control the pace at which work is done appropriately to their needs and context. • The need for clarity on how regions will be penalised if the requirement is not met. • The need for awareness of the all Wales position to share learning. • The need to maintain the current pace and continue proportionately to achieve improvement. • The need for appropriate caution and mutual review of every stage. • The need to be clear that the work is under way to improve service models and provision for service users and to improve people's lives. • The need to continue sharing information, trust and understanding, to enable moving jointly towards integration. • The All Wales view that one pooled budget across all services is not achievable in the time frame outlined. • Discussions are under way to devise a collective response to the Minister's letter; RPBs will be invited to respond to state their need for ownership of the work. The RPB: • **NOTED** the updates and • **SUPPORTED** the approach. • It was **AGREED** that the outcome of Wales-wide dialogue in response to the Minister's letter would be sought before seeking to change the current focus of the pooled budget work. **Action:** ➢ Ensure Third Sector involvement in the development of the Market Position Statement. ➢ Maintain a 'watching brief' on current national dialogue re. the Ministerial letter on pooled budgets and inform the work of the project board as required.	Rachel Jones Rachel Jones
RPB 054	**7. OLDER PEOPLE HOUSING STRATEGY** Jane Thomas and Pam Toms undertook a joint presentation on Older Persons' Housing in Cardiff and the Vale of Glamorgan, highlighting the context of the growing older population as well as the health and financial benefits of specific older persons' housing. Data were provided on the need for accessible affordable accommodation in both Cardiff and the Vale of Glamorgan matched against the available designated elderly and sheltered accommodation and residential and nursing homes across the region, with associated costs. There was discussion on the opportunities for increasing supply and the range of services and adaptations available to enable independent living. Future plans for both local authorities were outlined and suggestions made for additional partnership working. The following points were discussed: • The differing demographics across the region • Both authorities are researching whether there is a need for increased extra care provision , noting the associated high capital and revenue costs, or whether sheltered accommodation could be used more flexibly	

	• The need for strategic decision making, noting the impact on strategic decisions of the identified model of need and of subsidy available from WG • Some accommodation costs are met by housing benefits, with social and health care funded separately • The need to more closely analyse the data to identify what is required to meet demand • Work is under way to ensure that service users are located appropriately • The provision within ICF for 2017/18 of £50,000 to support a feasibility study on the types of accommodation required • The use of capital investment to generate revenue savings • The need to acquire or dispose of land at below market value in order to stimulate further capital provision • The importance of data integrity and robust governance in ensuring how that data is presented. • The need to use the data to inform the development of appropriate fixed assets • The need to develop a dialogue with people to enable entry to services in a planned and manageable way, rather than at a point of crisis • The importance of this work to the Cardiff and Vale population and the need to mandate the associated data collection. The RPB: • **NOTED** the update. **Action:** ➢ Link with colleagues in housing and commissioning re data presentation. ➢ Consider the possibility of visiting some of the accommodation as part of the RPB workshop plan.	Suzanne Clifton Secretariat
RPB 055	**8. INTEGRATED CARE FUND (ICF)** Cllr Elsmore highlighted that further guidance received from WG had reduced the regional allocation, for which work has been undertaken to meet the revised budget. Meredith Gardiner summarised the updated position and plans for 2017/18, highlighting that the name of the fund has been amended from "intermediate" to "integrated", and that priorities have been set for the next 3 years, namely older people, learning disabilities, children with complex needs, autism and the Welsh Community Care Information Solution. It was noted that most revenue projects had performed in excess of targets and full expenditure was achieved across the programme at end of March 2017. Formal thanks were extended to all members of the ICF Programme Board for their collaborative work in response to the requirement for a revised revenue budget which had been incorporated into the Written Agreement following the reduced allocation from Welsh Government. The Written Agreement was attached for ratification by the Regional Partnership Board. Members also considered the ICF capital proposals which were under development in readiness for submission to Welsh Government by the end of June 2017. This included support for work to inform a more strategic development plan for the use of ICF capital monies over subsequent years. Rachel Jones highlighted that Welsh Government has indicated that additional	

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24.2

	capital will be provided specifically for housing with integrated care, namely £5m across Wales in year 1, £15m in year 2 and further years £20m. The RPB: • **NOTED** the end of year ICF Report for 2016-17; • **NOTED** the end of year Financial Position for 2016-17. • **NOTED the final ICF allocation for 2017-18;** • **RATIFIED** the Written Agreement and Revenue Investment Plan for 2017-18. • **NOTED and APPROVED** the capital proposals which are under development for 2017-18 ICF funding. **Action:** ➢ Finalise ICF capital proposals for submission to Welsh Government by end June 2017. ➢ Take forward the performance management of ICF revenue funded projects for 2017-18.	Secretariat Meredith Gardiner
RPB 056	**9. PATIENT FLOW** Judith Hill provided an update on the current position, noting that the main rate limiting factors are care home capacity and the lack of availability for beds for older people with mental health challenges, the latter of which is having an adverse effect on the number of bed days lost. It was confirmed that partners are working collaboratively to manage this issue and that a significant amount of multidisciplinary working is under way. Training for ward based staff remains a particular priority, focusing on early identification of discharge need, adopting the principle of home first, and ensuring that no long term care assessment should be undertaken in an acute environment, but should occur in a more appropriate or community based setting. It was confirmed that significant work was under way on admission avoidance. It was highlighted that there is weekly review of the needs of 200 patients who need safe and appropriate discharge destinations. In addition, the "End of Pyjama Paralysis" campaign has been launched, aiming to prevent deconditioning of patients in hospital and improve their potential to return home. It was noted that the data presented in the update reports represents a single day census and is validated with colleagues from health and social services. Members were also asked to note that the 'rate' figures used for regional comparison are informed by the total number of delayed transfers and not people over the age of 75. This may be of particular importance when considering the specialist and tertiary services offered by the Cardiff and Vale region and the consequent difference in scope and scale of services in comparison with other regions. The following points were discussed: • The need to ensure that work to improve Delayed Transfers of Care did not plateau – constant focus was needed to review and energise reduction plans; • Improvement in relationships has enabled a robust partnership approach; • The need to retain housing options as a regional priority to enable more assessments to be done in appropriate environments;	

Item 2.1

	• The need for continued support for Discharge to Assess (D2A) and workforce integration; • The impact on delayed transfers by the lack of available domiciliary care provision; • The requirement for community based models to enable ongoing assessment of need - the residential Discharge to Assess work has shown significant reduction in long term need as a result of this approach; • Data revealing that 47% patients in University Hospital for Wales and 23% patients in University Hospital of Llandough do not meet criteria for requiring hospital care. This supported the emphasis on the priorities identified in this meeting as having the greatest impact on people's health and well-being; • The Unscheduled Care Transformation Board will review the above and work to ensure a reduction in average length of stay in conjunction with an improved discharge process, noting that the individuals behind the data have complex needs and personal circumstances. The RPB: • **NOTED** the update. **Actions:** ➢ Ensure that Housing Options are retained as a priority for ongoing focus by the Regional Partnership Board; ➢ Ensure that workforce requirements are included as part of the Home First agenda; ➢ Ensure an ongoing link with the work of the Unscheduled Care Transformation Board to ensure an ongoing, comprehensive plan to continue reducing delayed transfers of care.	Secretariat Secretariat Judith Hill
RPB 057	**10. SOCIAL VALUES** Rachel Jones confirmed that the Social Services and Well-being (Wales) Act 2014 requires the establishment of a Social Values Forum to develop a shared approach to supporting social values based providers. It was highlighted that a workshop held in May 2017 had informed the development of draft Terms of Reference, noting that this workstream links closely with the RPB priorities. The following points were discussed: • The need to articulate what is not part of the social value perspective and for clarity on what product is expected from the forum • The need to maximise engagement to ensure there is added value • The need to prioritise the elements that will make a real difference to citizens • The interface with social enterprise work and commissioning. The RPB: • **NOTED** and **APPROVED** the Terms of Reference for the Social Value Forum **Action:** ➢ To receive a further update on work re. the Social Values Forum in October 2017.	Secretariat

Item 2.1

RPB 058	**11. ITEMS FOR INFORMATION** The RPB **NOTED** • The Cardiff and Vale of Glamorgan Dementia Strategy Consultation – RPB members were invited to submit comments as part of the consultation • Area Plan Toolkit • Partnership Summary Leaflet – this is also available on the website if people require copies.	
RPB 059	**12. ANY OTHER BUSINESS** There were no items to discuss.	
RPB 060	**DATES OF FUTURE MEETINGS** **RPB Meetings** • **Monday 13 November 2017** 2.00 pm – 4.30 pm, Committee Room 3, County Hall, Cardiff, CF10 4UW • **Thursday 18 January 2018** 2.00 pm – 4.30 pm (Vale of Glamorgan – venue to be confirmed) • **Tuesday 20 March 2018** 2.00 pm – 4.30pm, Community Room 1, STAR Hub, Muirton Road, Tremorfa, Cardiff CF24 2SJ **RPB Development Sessions/Workshops** • **Friday 15th September** 9.30 am – 12.30 pm (Venue to be confirmed) • **Monday 27th November** 9.30 am – 12.30 pm (Venue to be confirmed) • **Thursday 15th February 2018** 9.30 am – 12.30 pm (Venue to be confirmed).	

24.2

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CONFIRMED MINUTES OF A MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9am ON 20 JUNE 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Maria Battle	Chair
Akmal Hanuk	Independent Member – Community
Ivar Grey	Independent Member /Chair of Audit Committee
Margaret McLaughlin	Independent Member – Third Sector
Martyn Waygood	Independent Member – Legal

In Attendance:

Abigail Harris (part)	Director of Planning
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Observer (Health and Safety Representative)
Daniel Price (part)	Deputy Chief Officer CHC
Fiona Jenkins (part)	Director of Therapies and Health Sciences
Fiona Salter (part)	Staff Representative
Dr Graham Shortland (part)	Medical Director
Helen Donovan (part)	Senior Nurse, PCIC
Jonathan Webb (part)	Observer, Legal and Risk
Kay Jeynes (part)	Director of Nursing, PCIC
Peter Welsh (part)	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Sue Morgan (part)	Director of Operations, PCIC
Steve Curry	Interim Chief Operating Officer
Stuart Egan	Staff Representative
Urvisha Perez	Observer – Performance Auditor, WAO

Apologies:

Cllr Susan Elsmore	Independent Member – Local Authority
Angela Hughes	Acting Assistant Director Patient Experience
Dr Sharon Hopkins	Director of Public Health Medicine
Stephen Allen	Chief Officer CHC

Secretariat: Julia Harper

QSE 17/080 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular, Urvisha Perez from Wales Audit Office who was attending the meeting as an observer, as part of Wales Audit Office Structured Assessment work.

QSE 17/081 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/082 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

QSE 17/083 MINUTES OF THE COMMITTEE HELD ON 18th APRIL 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.**

QSE 17/084 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. These would be removed. The action log was updated as follows:

QSE 17/048 Ward Bathroom Refurbishment – The analysis of comparative data of 10 refurbished bathrooms did not demonstrate any significant decrease in the number of falls. However, one ward had seen a significant reduction, C1, and further work would be undertaken to identify the reason for this. The Chair asked for an analysis of the impact of colour to be undertaken at the same time. In addition, investigation into the use of transportable toilet bags (as per Manchester) would also be considered.
Action – Mrs Carol Evans

QSE 17/051 Mental Health QSE Sub Committee – In the absence of an update on identified action, the Chair asked that the individuals be invited to attend the next meeting.
Action – Mrs Julia Harper

QSE 16/192, 17/023, 17/048, Care of the Deteriorating Patient – There were systems in place, but this was not a single system. A report would be provided for the September meeting.
Action – Dr Graham Shortland

QSE 17/063 Healthy Restaurant and Retail Policy – In the absence of the Director of Planning, the Chair asked when healthy eating would be advertised in the UHB catering facilities.
Action – Mrs Abigail Harris

QSE 17/085 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken in between meetings.

QSE 17/086 PATIENT STORY – PRIMARY, COMMUNITY & INTERMEDIATE CARE – SALLY'S STORY

Ms Helen Donovan, Interim Senior Nurse, Vale Locality, PCIC Clinical Board, presented Sally's story. Sally was 26 years old and severely disabled. Due to an eating disorder, and due to her poor physical health, she could not be actively treated when she was diagnosed with MS. This led to an extended period of rehabilitation at Rookwood Hospital, completely dependent on others to meet her daily living and care needs. Sally also had challenging behaviour, OCD, anxiety and depression.

On discharge, Sally remained at home for almost 3 years with a comprehensive package of care. This package broke down when she became non compliant with her treatment which resulted in her BMI falling to an unacceptable level and she developed a non healing pressure ulcer. As a result, Sally was admitted to UHL.

Although Sally requested a quick discharge home, there was a difference of opinion as to whether she had capacity to make a safe decision. The community staff felt unable to support her discharge at that point, involved the full MDT and agreed a specialist care home placement should be made in her best interest.

Sally continued to ask to go home and the DoLs team and an independent advocate were brought in to support her. Sally's physical and mental health improved as she continued to put weight on. As her capacity returned, and she understood the consequences of non compliance with treatment, a package of care was put in place for Sally to return home. Sally said "I am happier and in control of my life. I feel more confident and independent".

The Chair invited comments and questions:

- The cost of a specialist nursing home was £107k and the care package at home was £50k. More importantly, Sally was happier and where she wanted to be. It was noted that a saving was not always the case, and normally it was more expensive to provide a comprehensive care package at home.
- Sally's insight improved as she managed to put weight on and her physical health improved.
- Decisions on capacity were complex as acute consultants disagreed initially with the community team who were better acquainted with Sally. In addition, there was a lack of family support.
- The community team went above and beyond to meet Sally's wishes as soon as they thought she was safe to return home.
- Around 80 patients currently had home care packages at a cost of £4m.

The Chair thanked Ms Donovan for presenting. The Committee **NOTED** the excellent example of advocacy in this patient story.

QSE 17/087 PRIMARY COMMUNITY & INTERMEDIATE CARE CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

Mrs Kay Jeynes advised that the Reviews undertaken in Prison Services and Asylum Seekers had been omitted from the report in error.

The Chair invited comments and questions on the report:

- Triangulation was not going well with commissioned services as the framework was outdated and awaiting Welsh Government review. UHB services were diverse but one theme was accessibility and waiting times for drop-in services. The Committee could expect to see reference to this in the Sub Committee Minutes.
- It was confirmed that sensory loss was included in engagement work.
- Guidance was awaited from Welsh Government on the uptake of GP enhanced service for adults with learning disability. In the meantime, this was being picked up by the contract monitoring team.
- Recruitment had improved. Workforce planning was being undertaken to map the need for staff over the next 5 years. There were currently 10 vacancies, a significant number for the Clinical Board. Efforts were being made to make jobs flexible and attractive and to retain staff. Exit feedback was being gathered in order to make improvements. However, recruitment was taking some time particularly when novice starters were appointed – this was the first time such staff were appointed. 40% of nursing staff were aged over 50 years.
- Specialist Nursing staff were key to supporting patients and reducing the need for clinic follow up appointments eg Diabetes reduced by 30%. This could be expanded to other specialties but required careful thought and modelling. It was agreed that the new Committee would be asked to consider this developmental work and connectivity with University syllabus.
  Action – Mr Peter Welsh
- It was agreed that the new Committees would be asked to scrutinise PCIC's top priorities and the impact of the Local Delivery Plan.
  Action – Mr Peter Welsh

ASSURANCE was provided by:

- The Internal Audit Department provided substantial assurance on the processes in place for quality, safety and experience within the Primary, Community & Intermediate Care (PCIC) Clinical Board (2016).

The Quality Safety and Experience Committee:

- **APPROVED** the contents of the brief report of the PCIC Clinical Board QSE Sub Committee
- **NOTED** the areas for further action:
  1) Increase the PPI activity across the breadth of the Clinical Board's provider and commissioned services

2) Ongoing work required to ensure that a comprehensive and responsive interface system of incident reporting was in place
3) The work required to treat and mitigate the Clinical Board's top 5 risks
4) The ongoing safeguarding work and monitoring of commissioned placements that was being undertaken across the commissioned nursing homes through the Locality Teams.

QSE 17/088 COMMUNITY HEALTH COUNCIL (CHC) REPORT

Mr Daniel Price, Deputy Chief Officer of the CHC corrected the dates in the report summary and highlighted commencement of follow up visits.

In terms of recommendations, the information requested on hand hygiene was available in the Infection Prevention and Control report. Repatriation information was not normally supplied to the CHC but the CHC had representation on other UHB Committees and Groups where this was discussed. Repatriation was discussed regularly and every Monday all Chief Executives considered such issues. This was another area that would benefit from system rules. It was noted that the Medical Director was discussing the production of a repatriation policy with a professor from Bristol in advance of the setting up of the Trauma network. Enforcement may require the introduction of charges for non compliance. The Committee requested that the CHC instigated a national debate on repatriation.
Action – Mr Daniel Price

It was agreed that, in addition to feedback to wards and departments, the CHC would, in future, provide feedback to the Equality Manager.
Action – Mr Daniel Price

The report was **RECEIVED** and **NOTED.**

QSE 17/089 CHARGES FOR LOST HEARING AIDS POLICY AND PROCEDURE

The Director of Therapies and Health Sciences, Ms Fiona Jenkins confirmed that patients would be supplied with a new hearing aid but that they would be followed up for payment if they did not meet the exemption criteria.

ASSURANCE was provided by:

- Compliance with all Wales Policy
- An independent Appeals process was available so exceptional circumstances could be taken into account

The Quality, Safety and Experience Committee:

- **APPROVED** the Charges for Replacement of Lost Hearing Aids Policy

- **APPROVED** the full publication of the Policy in accordance with the UHB Publication Scheme.
  Action – Mrs Julia Harper

QSE 17/090 EXTERNAL REGULATORY AND ACCREDITATION VISITS TO CLINICAL DIAGNOSTICS AND THERAPEUTICS SERVICES

The Executive Nurse Director, Mrs Ruth Walker commented that the report was positive, demonstrated robust governance and showed lessons had been learned. The Chair agreed to write a letter of thanks and support to the Clinical Board.
Action – Ms Maria Battle

ASSURANCE was provided by:

- The findings of the inspection visits, and completion and closure of action plans.
- Accreditation awards

The Quality Safety and Experience Committee:

- **NOTED** the report made by the Clinical Diagnostics and Therapeutics Clinical Board to date and its planned actions
- **APPROVED** the approach taken by the Clinical Diagnostics and Therapeutics Clinical Board.

QSE 17/091 ANNUAL QUALITY STATEMENT (AQS)

The Executive Nurse Director thanked Mrs Carol Evans, Assistant Director of Patient Safety and Quality and her Team for the depth and breadth of the work throughout the year that culminated in the production of the AQS. The timetable for production had been brought forward this year, but more engagement work had been undertaken. Mr Price confirmed the CHC section would be provided immediately.

The Chair invited comments and questions on the report:

- A sentence would be added linking the work to the Intermediate Medium Term Plan (page 94).
- Consideration would be given to making reference to improvements in the Emergency Unit and the current situation with Paediatric Surgery, although the dates were possibly not appropriate for inclusion until next year.
- In terms of engaging with young carers, details could be found in the Carer's Report.
- The author was asked to check pages 85, 125 to include behaviour and 128 to specify which disability awards this referred to. In addition,

the use of charitable funds to enhance patient experience would be included.
- It was noted that the template for the AQS had been set by Welsh Government as it was considered that this was easier for public digestion. Therefore, it may not be possible to reference benchmarking in the AQS.
- It was agreed to insert the traffic lights for clinical audit on page 106. **Action – Dr Graham Shortland**

ASSURANCE was provided by:
- The provision of the draft Annual Quality Statement 2016/2017.

The Quality, Safety and Experience Committee:

- **APPROVED** the Annual Quality Statement for 2016/2017 in draft; prior to full design work being undertaken in readiness for endorsement at the public Board meeting in July 2017.
- **AGREED** to include, where possible, comments made at the meeting. **Action – Mrs Carol Evans**

QSE 17/092 HEALTH AND CARE STANDARDS SELF ASSESSMENT 2016/17

The Executive Nurse Director, Mrs Ruth Walker, presented the annual assessment that was undertaken either by Clinical Boards or Committees. Links were available for Members to see the detail of each assessment. The final version for each assessment was signed off by an Executive Director and an Independent Member. The whole process had been given Reasonable Assurance by Internal Audit.

Concern was expressed about the verification process for the self assessments. It was noted that there was a tool for this and there would be a move away from self assessment in future years in favour of constant monitoring by Committees - progress would be clear in the QSE Sub Committees' minutes. The annual report would contain more detail on progress against key pieces of work so that areas of non-delivery would be identifiable.

ASSURANCE was provided by:
- The comprehensive assessments of each standard.
- Corporate validation of Self Assessments

The Quality, Safety and Experience Committee:

- **CONSIDERED** the outcomes of the Health and Care Standards Assessment for 2016/2017.

QSE 17/093 SAFEGUARDING REPORT UPDATE

The report was presented by the Executive Nurse Director, Mrs Ruth Walker. The agenda was growing in significance in terms of the work undertaken and the number of cases. This was challenging operationally and strategically with no resource increase to the Safeguarding Team.

One item raised was the deep distress caused to the local Somali community by the UHB's reporting of female genital mutilation (FGM). This was a Welsh Government requirement and the figures were significant. Whilst the UHB wanted to be respectful of this community's beliefs and culture, the message was unequivocal – FGM was a criminal offence and supporters of this practice could be charged with aiding and abetting. It was not clear whether the practice was taking place locally or abroad and this was being explored. Mr Hanuk commented that the Yemeni and Somali communities were some of the oldest in Wales and were now 4th/5th generation. It would be worth engaging with them and opening the debate. It was agreed to provide the Committee with details of the number of cases and the action being taken in response.
Action – Mrs Ruth Walker

Concern was expressed about safeguarding financial support to the Sexual Assault Referral Centre (SARC) as one Police force was not contributing. A joint meeting was about to be held. The UHB was clear that the model was working well and referrals were increasing.

The capacity of the Safeguarding Team was noted. An increase in resources would require a business case, although different ways of working, such as MASH, were proving supportive. In addition, it would be helpful to reference the Iris project and the bereavement work undertaken with charities.

Domestic homicide was an emerging agenda. Meetings had been held with Local Authorities to ensure a robust governance framework was in place.

ASSURANCE was provided by:

- The provision of a detailed Safeguarding report
- Safeguarding training and raising awareness across the Health Board encompassing all safeguarding themes
- The number of appropriate safeguarding referrals made
- Consistent approach across the Health Board
- Good working partnerships with statutory agencies

The Quality, Safety and Experience Committee:

- **NOTED** this report.

QSE 17/094 INFECTION PREVENTION AND CONTROL EXCEPTION REPORT

The Executive Nurse Director had nothing to add to the report. It was noted that half a ward was currently being refurbished but this did not include the provision of single rooms. Isolation rooms required specific criteria. With regard to the provision of single rooms, this required increased investment as well as a loss of capacity that depended on Welsh Government support. None of this work could be achieved without identification of a decant ward. It was also noted that UHW wards did not lend themselves easily to a new configuration. Given this, the UHB currently had no plans to create single rooms as no empty ward was available for decant purposes. The hospital was full and was in a catch-22 situation. However, one ward had flexed down to 19 beds and this would be used to refresh as many areas as possible over the summer months.

It was noted that significant capacity had been lost last year following outbreaks of D&V. Ideally, two wards needed to be identified – one for decant to enable a rolling programme of refurbishment and one to re-provide a ward of single rooms. To achieve this, demand had to be reduced. The Chair requested that this plan be brought to the July Board.
Action – Mrs Abigail Harris

The resource available in the IPC Team was raised frequently and also featured in the Neonatal Unit external report. If investment in this area provided payback financially, it was worth reconsidering. It was therefore agreed to revisit the resource risk assessment.
Action – Mrs Ruth Walker
The UHB was carrying a risk at senior nurse level but it was not clear if investment in this area would bring savings elsewhere. Additional staff may not result in reduced levels of infection because many of the issues were linked to the fabric of the estate and antimicrobial prescribing.

LIMITED ASSURANCE

The Quality, Safety and Experience Committee:

- **APPROVED** and **NOTED** the content of the paper.

QSE 17/095 CLEANING STANDARDS

The Director of Planning, Mrs Abigail Harris commented that this had been discussed at the Health Systems Management Board. Resources did not benchmark well in low risk areas and some of the public areas were not prioritised and were looking shabby. An internal audit would be carried out in the near future.

Reference was made to findings in the external report on the Neonatal Unit. This cited the use of the correct cleaning solution, but the wrong process (not

being left long enough before washing off) and the fact that the special cleaning machine could not be used when the operator was on holiday. This was a training issue which the department was addressing, along with attempts to stabilise the high turnover and vacancy rates.

It was hoped that the good practice of each ward having its own housekeeper managed by the ward Sister or Charge Nurse would be strengthened, avoiding the need to move staff around.

LIMITED ASSURANCE was provided by:

- KPI scores on Very High and High Risk areas were meeting targets.
- Progress was reported through the Clinical Boards Quality, Safety and Experience meetings.
- Progress with Action Plan reported through the UHB Quality, Safety and Experience Committee.
- Verbal feedback from Health Inspectorate Wales.

The Committee:

- **AGREED** the implementation of the Credits for Cleaning and Welsh Government Standards were being embedded and scores had improved to meet targets (or were being managed for immediate improvement) in the high priority areas (Very High and High Risk) given the current resource profile.
- **AGREED** that the Health and Safety Committee would receive a further report on clutter and cleaning at fire exits.
  Action – Mrs Abigail Harris

QSE 17/096 INDEPENDENT REVIEW OF THE MANAGEMENT AND RESPONSE TO ACINETOBACTER OUTBREAKS IN 2015

The report was presented by the Executive Nurse Director, Mrs Ruth Walker. It was noted that there was always an element of infection within hospitals, but where patients were placed affected its spread. On occasions, the UHB had reached the point where there was no physical space for this client group and admissions had been halted. However, a new environment was identified and made available very quickly.

The lesson was that the UHB knew it had a high risk (as identified in the CRAF), but failed to act. Fortunately no deaths had resulted from the infections. This had been a difficult agenda to balance, given the inertia whilst waiting for the outcome of the South Wales Plan that would have addressed the shortcomings.

Concern was expressed about the findings on hand hygiene. This was free and was within the UHB's control. The Policy was clear and had been

recently reiterated at the Health Systems Management Board and was also being reiterated at Clinical Board Performance Reviews.

ASSURANCE was provided by:

- Findings of the Independent review
- The development of a robust improvement plan to address the recommendations

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the report
- **APPROVED** the improvement plan
- **AGREED** to receive 6 monthly progress updates on improvements (December and June)
  Action – Mrs Ruth Walker

24.3

QSE 17/097 POINT OF CARE TESTING

The Medical Director, Dr Graham Shortland, gave a verbal update on the governance issues associated with POCT (point of care testing). It was important to have robust governance and accountability arrangements to ensure patients were not harmed. This was difficult without a national policy although the Committee would be asked to approve a local policy in September where POCT results would be sent directly to the clinical portal, providing a better audit trail.

The Committee **NOTED** the update.

QSE 17/098 CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh reminded Committee of the complete review of risk management that was being undertaken.

ASSURANCE was provided by:

- Mitigation of risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF required strengthening.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the CRAF Update Report and the high risks assigned to the Committee.
- **AGREED** to give further consideration to whether the risk descriptors and controls identified were adequate to provide assurance to the Committee. Comments would be provided to the Director of Corporate Governance by 20th July.
  Action – All Members and Attendees

QSE 17/099 CARE OF THE DETERIORATING PATIENT

The Chair had requested that the Committee debate this item as it had remained unresolved for a number of years and the previous Chair of the Committee had expressed her concern that no way forward had been agreed. This item had already been raised as part of the Action Log and it was agreed that a report with clear timelines would be presented in September.
Action – Dr Graham Shortland

QSE 17/100 PATIENT WRISTBANDS

The Executive Nurse Director, Mrs Ruth Walker, gave a verbal update to the Committee as the UHB was being criticised for not implementing the Safety Notice. The Board had previously placed this Safety Notice on hold as it was not considered a top priority. A business case for a solution would be presented in July to the BCAG and it was also agreed to include IT requirements in the IM&T Outline Plan.
Action – Mrs Ruth Walker

QSE 17/101 CANCER PEER REVIEWS - BRAIN

The Medical Director, Dr Graham Shortland, reminded Committee that peer review was a good process and as the second cycle was entered, comparison would be possible. The process was moving into specialty areas but the teams needed support across the cancer pathway and this would be highlighted to the cancer network.
Action – Dr Graham Shortland

Concern was expressed that WHSSC had not prioritised several areas that had been brought to their attention and the UHB Board was not cited on the detail of the decision making.

There was some confusion with the structure of the network. For example, doctors were locally accountable and not accountable to the network. It was agreed that the Medical Director would brief the Chair in order for her to raise all the issues with the Chair of the WHSSC QSE Committee.
Action – Dr Graham Shortland and Miss Maria Battle

Mr Curry reported that he had met with the commissioning team where he had discussed the risk impact on the UHB priority areas that were currently not being supported and flows from other Health Boards. All issues came back to the lack of system rules and how Health Boards collaborated generally. It was agreed to undertake work on rules in order to challenge WHSSC and the cancer network.
Action – Dr Graham Shortland

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Healthcare Inspectorate Wales Cancer Peer Review assessment and Peer Review reporting process. Any concerns identified were addressed via an action plan and were regularly reported within the required process; at the Clinical Board performance reviews and by Welsh Government and the South Wales Cancer Network.

The Quality, Safety and Experience Committee:

- **NOTED** the report and
- **DID NOT AGREE** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern. A report on "system rules" and collaboration would therefore be received at the September meeting. **Action – Dr Graham Shortland**

24.3

QSE 17/102 MORTALITY DATA AND MORTALITY REVIEW

The Medical Director, Dr Graham Shortland, presented the 6 monthly trend report and made specific reference to the number of patient deaths at weekends. Fortunately, this demonstrated there was no significant difference. Further observation and work demonstrated that the allegations of higher incidence of deaths at weekends had been overstated in the media, probably by the use of inappropriate data. It was noted, however, that a different population of patient was admitted at weekends which did impact the likelihood of death. Mortality would continue to be monitored and the UHB still had the lowest crude mortality in Wales.

ASSURANCE was provided by:

- Monitoring of Mortality measures reviews
- Mortality Data

The Quality, Safety and Experience Committee:

- **AGREED** the ongoing proposed plans for mortality reviews.
- **NOTED** the planned introduction of the Medical Examiner Role.
- **NOTED** the discussion about weekend mortality.

QSE 17/103 UPDATE ON HEALTH INSPECTORATE WALES ACTIVITY

The Executive Nurse Director, Mrs Ruth Walker gave an overview of the very positive report. There were still some areas that required further work, in particular engagement with Mental Health staff.

The Chair requested that a progress report on the plans for a single point of entry for Paediatric Emergencies be brought to the next meeting in September.
Action – Mr Steve Curry

ASSURANCE was provided by:

- The development, implementation and monitoring of improvement plans to address recommendations.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the inspections that have been undertaken
- **AGREED** that the appropriate processes were in place to address the recommendations
- **AGREED** that a future report, outlining progress should be presented at the October 2017 Committee.

QSE 17/104 CARERS INFORMATION AND CONSULTATION STRATEGY

ASSURANCE was provided/demonstrated by:

- The progress and actions highlighted within the report.

The Quality, Safety and Experience Committee:

- **NOTED** and **APPROVED** the contents of the annual report

QSE 17/105 MANAGEMENT OF OUTPATIENT FOLLOW UPS AND ENDOSCOPY SURVEILLANCE

Ms Caroline Bird attended the meeting to comment on the strategy for outpatient follow ups and its impact on the number of patients waiting and the improvement in the waiting times for endoscopy.

The Chair invited comments and questions:

- Asked why the UHB had the highest DNA rates in Wales, it was noted that the number varied by specialty and was part of the Transformation work. It was suspected that the figures may, in part, be due to data quality issues and “cashing up” at the end of clinic.
- Assurance was provided that there had been an 80% reduction in the number of highest risk patients waiting.
- It was noted that work was ongoing and that there was no quick fix option available.

ASSURANCE was provided by:

- Progress made against the UHB’s Outpatient Follow Up Improvement Strategy and the re-focus of actions to increase the pace of improvement

- Outpatient Transformation was one of the Health Board's priorities for 2017/18 and was a key element of the National Planned Care Programme
- Reduced volume of patients waiting greater than 8 weeks and an improved risk profile for endoscopy surveillance patients.

The Quality, Safety and Experience Committee:

- **NOTED** the current position and work ongoing in relation to the management of outpatient follow up care and endoscopy surveillance.
- **AGREED** to receive a further report in February 2018.
  Action – Mr Steve Curry

QSE 17/106 TRAUMA AND ORTHOPAEDIC JOINT REVISION RATES

The Medical Director, Dr Graham Shortland advised Committee that he had brought this report at the request of the Audit Committee where concern was expressed about the high number of joint revisions undertaken at the UHB. He confirmed that the reason for this was the UHB's use of an implant that was identified, by the manufacturer, as being substandard. All costs associated with the increased work had been reimbursed by the manufacturer. The Committee regretted the impact of this on patients.

ASSURANCE was provided by:

- A National UK Programme of monitoring hip replacement products had been introduced to better predict failure rates and reduce the likelihood of a further large scale product failure.
- Strict choice of local implants to produce better outcomes
- Established programme of audit and clinical review, including NJR
- Results over the last five years (NJR) confirmed revision ratios within normal outcome limits.

The Quality, Safety and Experience Committee:

- **APPROVED** the ongoing programme of audit and product selection to ensure improved patient outcomes.

QSE 17/107 SINGLE ROOMS, DECANT FACILITIES AND ISOLATION ROOMS AT UHW

Given the earlier discussion, it was agreed that no further comment was required on this report and it would be referred to Health Systems Management Board.
Action – Mrs Abigail Harris

LIMITED ASSURANCE was provided by:

- NWSSP – Specialist Estate Services Isolation Room Ventilation Inspection Report March 2017
- Capital Investment agreed to improve the existing ward environment on B6.

The Committee:

- **NOTED** the position in relation to the identification of a decant ward area that would enable a rolling proactive ward refurbishment programme to be implemented.
- **NOTED** the plans for an estates strategic plan which would set out the programme for development of the estate – both hospital and community facilities in order to deliver the strategy and ensure facilities were fit for purpose and sustainable.

QSE 17/108 COMMUNITY MENTAL HEALTH TEAM (CMHT) ACCOMMODATION – UPDATE ON PLANS

The Director of Planning, Mrs Abigail Harris advised Committee of current thinking around the critical mass needed for larger community mental health teams. This would mean that 3 teams would need accommodation in the new Hubs.

The Chair requested a timescale for the delivery of BIG 2. This would be discussed with the Director of Corporate Governance as to where and when this should be received.
Action – Mrs Abigail Harris

LIMITED ASSURANCE was provided by:

- Long term solution identified as part of Shaping Our Future Wellbeing in the Community Programme.
- Short term solution being considered at joint meetings with Local Authorities from Cardiff and the Vale.

The QSE Committee:

- **NOTED** the situation in relation to the current CMHT accommodation.
- **NOTED** the potential outcome of the review of CMHTs and the implications for accommodation.

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

QSE 17/109 HM CORONER REGULATION 28 PREVENTION OF FUTURE DEATHS

ASSURANCE was provided by:

- The actions undertaken following conclusion of the internal investigation in conjunction with the response provided to Her Majesty's Coroner.

The Quality, Safety and Experience Committee:

- **RECEIVED** the overview of the recommendations made by Her Majesty's Coroner.
- **NOTED** the actions undertaken in response to the internal investigation and Coroner's recommendations.

24.3

UHB 17/110 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – APRIL**
2. **MENTAL HEALTH – MARCH AND LESSONS LEARNED – MAY**
3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - MARCH**
4. **SPECIALIST SERVICES – NO REPORT SINCE FEBRUARY**
5. **MEDICINE (AND ACUTE AND EMERGENCY WAITS) – APRIL**
6. **SURGERY – MARCH AND APRIL**
7. **CHILDREN AND WOMEN – FEBRUARY AND MARCH**
8. **DENTAL – MARCH**

QSE 17/111 AGENDA FOR THE PRIVATE QSE

The private agenda was published as part of the culture on openness..

QSE 17/112 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

Report to July Board on plans for decant facilities, single and isolation rooms.

QSE 17/113 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 17/114 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 12th September 2017.

UNCONFIRMED MINUTES OF A MEETING OF THE STRATEGY AND ENGAGEMENT COMMITTEE
HELD ON 25 JULY 2017 – 9.00AM
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

John Antoniazzi	Independent Member – Capital Management, Chair
Ivar Grey	Independent Member - Finance
Margaret McLaughlin	Independent Member – Third Sector

In Attendance:

Fiona Jenkins	Director of Therapies
Marie Davies	Deputy Director of Planning
Peter Welsh	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Steve Curry	Interim Chief Operating Officer

Apologies:

Eileen Brandreth	Information Communication and Technology
Abigail Harris	Director of Planning
Sharon Hopkins	Director of Public Health
Bob Chadwick	Director of Finance
Julie Cassley	Interim Director Workforce and Organisational Development

Secretariat: Glynis Mulford

24.4

SE: 17/001 WELCOME AND INTRODUCTIONS

The Chair introduced himself explaining his background and welcomed everyone to the inaugural meeting of Strategy and Engagement Committee.

SE: 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

SE: 17/002 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

SE: 17/003 MINUTES OF THE PEOPLE, PLANNING AND PERFORMANCE COMMITTEE MEETING HELD ON 16 MAY 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 16 May 2017.

SE: 17/004 ACTION LOG FROM MEETING PEOPLE, PLANNING AND PERFORMANCE MEETING HELD ON 16 MAY 2017

The Committee **RECEIVED** the Action Log from the meeting of 16 May 2017 and **NOTED** the following:

It was **AGREED** for the appropriate actions to be distributed to the relevant Committee.

QSE 17/063: Healthy Restaurant and Retail Policy – As this item did not fall in the remit of the Strategy and Engagement Committee it would be removed from the action log.

SE: 17/005 TERMS OF REFERENCE

The Committee was informed that the Terms of Reference was still a work in progress. It would be kept on the agenda for future meetings and reviewed in six months' time. The committee identified a number of matters and changes to be made as follows:

- The Welsh Digital Strategy was not mentioned in the document or linked with the Legacy Statement. It was suggested this should have a separate section called 'IT Strategy' where this can be discussed.

ACTION: P Welsh to work with F Jenkins in terms of wording

- ***Section B – Collaboration:*** For the Third Sector Framework to be included under this heading.
- ***Section C (bullet point 6) - Integrated Medium Term Plan:*** It was highlighted that the Strategic Equality Plan (SEP) had been allocated to the Resource and Delivery Committee but noted that the item was on the Strategic and Engagement workplan. It was stated that there was a need for one Committee to take ownership of the SEP as it tied into the overall strategy and **AGREED** for the bullet point to be reworded.
- ***Section D – Engagement:*** For the wording 'Health Foundations' to be removed and for the section to be more explicit in regard to public sector equality. In regard to volunteers it was clarified this would be in relation to aligning them to the strategic plan of the organization.

- ***Section E – Capital:*** For medical equipment and discretionary capital to be included in this section. The Committee would also monitor the car parking specification for new contract services.
- ***Section F – Commercial Development:*** Concerns were raised over the expertise and knowledge of the Members. In response it was clarified that the Committees remit was to be provided with assurance and to have oversight on the strategic direction of the commercial programme and development of the UHB. It was explained once these were in place the Audit Committees' remit would be to ensure they were operating with the appropriate procedures, policies and governance arrangements.

ACTION: For a paper to be brought to September meeting on Car Parking Contracts / Specification

24.4

It was emphasized that the remit of the Committee was to be provided with assurance and to have oversight on the strategic direction and engagement of the overall plan and for this tone to be adopted through each section of the Terms of Reference. In regard to the size of the Committees agenda, it was recognized that a sub-committee may be required.

- ***3.6 - Authority:*** To replace 'committee' with wording 'commission'.

- ***3.8 - Sub Committees:*** The Committee was considered to be a useful reporting point for the Capital Management Group and Clinical Change Group, who review and monitor regional clinical service change plans and programmes. There was also opportunity to look at strategic and service planning governance arrangements within the organisation.

- As there were a number of other groups and committees discussed it was suggested that in order to improve governance arrangements, there was a need to look at all the other elements that had an effect on the strategic plan and it was recommended that a group be formed to map out the process.

ACTION: M Davies to form working group mapping out process of how other Committees and groups have an effect on the strategy plan. To be brought to September meeting

- Membership and attendance of the Committee was discussed and confirmed the Equality and Diversity Manager would also be in attendance. The change of title was noted to be replaced with 'Executive Nurse Director'.

- ***5.2 - Frequency of Meetings:*** For wording to include 'Meetings should **'normally'** be held quarterly'. This will be in terms of the planning cycle for things to be signed off.

ACTION: Terms of Reference to be revised with track changes and circulated to Members

The Committee:
CONSIDERED and **NOTED** the Terms of Reference **SUBJECT** to amendments

SE: 17/006 LEGACY STATEMENT

The Legacy Statement was discussed in detail with the Terms of Reference and the key issues will be reviewed alongside the action log. It was recommended that the components of the legacy and Welsh language be placed in the work plan. The Legacy Statement will be reviewed at the end of the year to ensure all the elements from the People, Planning and Performance Committee have been transferred.

ACTION: To review Legacy Statement at end of financial year

The Committee:

- **NOTED** the Legacy Statement

SE: 17/007 BROAD ISSUES FOR WORKPLAN TO BE DEVELOPED

The draft workplan was discussed and described in depth stating that the Standing Items would come to the Committee for noting. The following was also highlighted:

- The Digital Strategic Outline Plan is a working document to inform the IMTP Programme. As this is a business case it will be kept under review by the Committee.
- The role and function of the Regional Planning Committee was being established. The draft Terms of Reference and minutes will be brought to a future meeting.
- Shaping Our Future Wellbeing was a large and complex programme and will be featured in the Wales Audit Office structured assessment.
- Will look at the UHBs response to the TCS business case that Velindre were producing for the Cancer Services Centre. A joint Board meeting will be established between both organisations on this issue. Members were informed that we have been asked to look at cancer services planning within this organization and to consider how the Cancer Strategy Group feeds into our planning arrangements.
- Board Development will focus on the IMTP at end of August looking at deliverables to sign up for over the next three year plan. This will be worked up into formal paper and recommended for approval to the Board. It was emphasized that Welsh Government will focus on the financial

balance and there were a range of performance deliverables that need to be executed which require assurance that plans are robust. Other elements needed were in relation to our plans to clarify and review our position and aspirations and what the pathway to getting there is. In addition, based on what had been done over the past three years, there was a need to understand how this becomes sustainable in terms of affordability and being cost effective.

It was stated the Organisation did not have a three year plan that was balanced therefore the Welsh Government could not approve the one year plan. The basis on how the IMTP was being prepared was explained and discussed.

The Chair asked to receive assurance of key milestones that are clear and appropriate and a view on pace in terms of timescales as the Committee needed to see how the IMTP is approached so it can be challenged and supported with some knowledge and asked for a diagrammatic flow chart to demonstrate its position.

Members were informed a plan will be presented to the next Board meeting that was more articulated than it had been previously with improved assurance. The key steps show how we are providing the top down guidance to the organization and appropriate plans with clinical and service boards.

The Committee:

- **NOTED** the report

SE: 17/008 KEY ISSUES TO BE RAISED

There were no issues of note to be raised.

SE: 17/009 ANY OTHER BUSINESS

There was no other business.

SE: 17/010 REVIEW OF THE MEETING

There was nothing of note to report.

SE: 17/011 DATE OF NEXT MEETING

The next Strategy and Engagement Committee meeting is scheduled to take place at 9.00am on **Tuesday, 5 September 2017** in the Corporate Meeting Room, Headquarters, UHW

UNCONFIRMED MINUTES OF A MEETING OF THE RESOURCE AND DELIVERY COMMITTEE
HELD ON 8 AUGUST 2017 – 9.00AM
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Margaret McLaughlin	Independent Member – Third Sector, Chair
Stuart Egan	Independent Member – Trade Union

In Attendance:

Fiona Jenkins	Director of Therapies, Health Science and IT
Julie Cassley	Interim Director of Workforce and Organisational Development
Peter Welsh	Director of Corporate Governance
Sharon Hopkins	Director of Public Health
Steve Curry	Chief Operating Officer

Apologies:

Ruth Walker	Executive Nurse Director
Akmal Hanuk	Independent Member – Local Community

Secretariat: Glynis Mulford

24.5

RD: 17/001 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the inaugural meeting of the Resource and Delivery Committee.

RD: 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

RD: 17/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

RD: 17/004 MINUTES OF THE PEOPLE, PLANNING AND PERFORMANCE COMMITTEE MEETING HELD ON 16 MAY 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 16 May 2017.

RD: 17/005 ACTION LOG FROM MEETING PEOPLE, PLANNING AND PERFORMANCE MEETING HELD ON 16 MAY 2017

The Committee **RECEIVED** the Action Log from the meeting of 16 May 2017 and **NOTED** the following:

PPP 17/006 – Year End Referral To Treatment Time Update: The year-end position will be captured in the performance report. **COMPLETE**

PPP 17/018 – WAO Review of Operating Theatres & UHB Management Response and Theatre Improvement Project: It was explained that the Audit Committee maintains a Tracking Report of all reports received from the Wales Audit Office, these are allocated to relevant Committees for monitoring and receipt of assurance purposes. **COMPLETE**

Management Executive Meeting – Employee Relation Case: This has been dealt with through Management Executive meeting. **COMPLETE**

The Committee:

- **NOTED** the Action Log

RD: 17/006 TERMS OF REFERENCE

The Director of Corporate Governance informed Members that the Terms of Reference were still a work in progress and will be on the agenda for the next few meetings. Comments had been received, which will be reflected in the next draft. It was stated that the new arrangements will be reviewed in six months' time.

The Committee was informed that revisions were being made to the Strategy and Engagement Committee Terms of Reference. These will also be distributed to Resource and Delivery Committee Members since there is a need to have clear mechanisms in place for reporting to and from the Board.

There was wider discussion on needing a clearer definition and understanding on the meaning of 'Resource and Delivery' and further queries were raised and suggestions shared.

The Committee identified a number of matters that need to be addressed as follows:

- There was a need for greater clarity on the purpose of the Committee.
- A number of the current items were operational and therefore considered inappropriate for Committee level. It was acknowledged that the IMTP will feature as part of the Resource and Delivery Committee's work (although it had been identified as key to the work of the Strategy and Engagement Committee in its inaugural meeting).

- In relation to IT, it already sat in the Strategy and Engagement Committee. However, it was relevant to the Resource and Delivery Committee and it was unclear how it would fit in with it.
- It was necessary to strike a balance between monitoring performance and receiving assurance
- It was important that work should not be repeated by Committees.
- A stronger steer was needed to ensure clear alignment with other Committees. There was a need for this Committee to be distinct and lead on issues and when needed, cross-reference to other Committees.

The Chair asked for further comments on each section:

- ***1.3:*** Paragraph to be reworded as unclear and needing clarity as it references clinical performance and workforce. It was stated that the Committee, in its Delivery capacity, was also about trends and whether the Health Board met Welsh Government targets. In this case they would need to talk about performance.
- ***2. Purpose:*** The purpose of the Committee will need further discussion.
- ***3.1*** – For paragraph to be removed.
- ***A Performance:*** Section to be reworded.
- ***C Workforce and Organisational Development:*** This section was considered to be too operational.
- ***Membership:*** It should be made clearer how many Independent Members needed to attend for the meeting to be quorate. It was highlighted that there should be two trade union representatives on the Committee.
- **Equality:** As there would be no Equality, Diversity and Human Rights sub-Committee in future, concerns were raised about where its sub-groups would now feed into, such as the Welsh Language Steering Group. It was suggested that all Sub-Committees Terms of Reference would need to be reviewed to ensure that they were feeding in appropriately to Board Committees. It was confirmed that the equality programme sat within the Workforce and Organisational Development portfolio.

24.5

The Director of Corporate Governance agreed to revise the Resource and Delivery Committee's Terms of Reference and circulate them to members. It was suggested that once the Terms of Reference had been redrafted, a meeting would be arranged with the UHB Chair, Chair of Committees and Lead Executives for further discussion.

ACTION: Terms of Reference to be revised with track changes and circulated to Committee Members – P Welsh

ACTION: To arrange meeting with Chair once the Terms of Reference had been redrafted for further discussion – P Welsh

ACTION: To review the relationship of working groups to sub-Committees and Committees and ensure the most appropriate reporting relationships are in place.

The Committee:

- **CONSIDERED** and **NOTED** subject to revisions, the Terms of Reference

RD: 17/007 LEGACY STATEMENT

It was stated that once there was clarity on the Terms of Reference, the Legacy Statement would be revised with more detail on what would be considered at the Committee. A greater sense of the remit, strengths and weaknesses of the Planning, People and Performance Committee in relation to resources and delivery should be provided.

The Committee:

- **NOTED** the Legacy Statement subject to revision

RD: 17/008 BROAD ISSUES FOR WORKPLAN TO BE DEVELOPED

In light of discussion on the Terms of Reference and Legacy Statement, the workplan would need to be reviewed. It was stated that the Committee would require oversight of the IMTP and to make use of its structure and measures to inform the agenda. Members were advised that the Welsh Delivery Framework was changing and should be sighted by the Committee.

The Committee:

- **NOTED** the report

RD: 17/009 KEY ISSUES TO BE RAISED

- To review Terms of Reference and the name of the Committee

RD: 17/010 ANY OTHER BUSINESS

There was no other business to report.

RD: 16/011 DATE OF NEXT MEETING

The next Resource and Delivery Committee meeting is scheduled to take place at 9.00am on **Tuesday, 7 November 2017** in the Corporate Meeting Room, Headquarters, UHW

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 29TH JUNE 2017

UHW HQ

Present:

Len Richards	Chief Executive
Sharon Hopkins	Deputy Chief Executive
Maria Battle	Chair
Marcus Longley	Vice Chair
Ruth Walker	Executive Director of Nursing
Bob Chadwick	Executive Director of Finance
Chris Lewis	Deputy Director of Finance
Julie Cassley	Executive Director of Workforce
Steve Curry	Director of Operations
Ivar Grey	Independent Member
Andrew Gough	Assistant Director of Finance (Transformation & Planning)
John Antoniazzi	Independent Member

Secretariat:

Cath David	Finance Manager

FC – 18/067 Welcome and Purpose of the Committee

The Vice Chair welcomed everyone to the meeting.

FC – 18/068 Apologies for Absence

Apologies were received from Graham Shortland, Margaret McLaughlin, Peter Welsh and Abigail Harris

FC – 18/069 Declarations of Interest

The Vice Chair invited members to declare any interests in proceedings on the Agenda. None were declared.

FC – 18/070 Minutes of the Finance Committee Held on 31st May 2017

The Committee RECEIVED and APPROVED minutes of the meeting held on 31st May 2017.

FC - 18/071 Action log following the last meeting

Deputy Director of Finance confirmed the action point raised on adverse variance reported against accommodation and catering income was covered within the Financial Position update.

All other outstanding actions were picked up on the agenda.

FC - 18/072 Financial Position Month 2

The Deputy Director of Finance presented the UHB's financial performance to month 2.

Two corrections required to the finance report tabled were highlighted.

1) Page 1 'Financial Impact' bullet point 3:

- £5.168m planned deficit (2/12th of £30.900m)

2) Page 3 'Month 2 Cumulative Financial Position' bullet point 3:

The UHB recorded a £5.168m deficit at the end of month 2 based on a planned year end deficit of £30.900m. The deficit was made up as follows:

- £0.028m adverse variance against the UHB's savings target
- £(0.010m) favourable budget management variance
- £5.150m planned deficit (2/12th of £30.900m)

Income position reported to month 2 was an adverse variance of £0.444m. Key issues driving this adverse income variance were highlighted:

Reduced funding received for Research and Development from Welsh Government linked to Commercial income. The Vice Chair questioned whether the Health Board had a grip on Research and Development as this has been an ongoing issue. The Deputy Chief Executive confirmed work is required to ensure we maximise access to available funding by focussing on recognisable Research and Development. This will be picked up outside this meeting at the Executive time out meeting on 14th July 2017 to give an opportunity to agree timelines.

Action: Deputy Chief Executive to provide update on Research and Development timelines

Under performance against the Neonatal Intensive Care Unit cot day contract which is partly offset by underspends against pay and non-pay.

NHS patient related income mainly relates to underperformance against the Health Board's contract with English providers and is not expected to continue.

Accommodation and Catering income over performance against target in month offset the cumulative adverse variance noted at month 1.

Pay position reported to month 2 was favourable with an underspend of £0.347m in month. Nursing staff expenditure is creating a pressure with a year to date adverse variance on registered/unregistered nursing staff of £0.306m. The rate of Nursing overspend reduced from month 1. The Finance Committee noted a high level of vacancies which was driving the need to utilise more high cost temporary staff. The Executive Director of Nursing confirmed that newly qualified staff had been recruited and were due to start over the summer which would improve the vacancy position by September. There is also work ongoing through the Nursing Productivity Group to move Health Care Support Worker staff employed by Agencies onto the Health Board's internal bank.

Non Pay position reported to month 2 was an adverse variance of £0.161m. An increase in expenditure on drugs within Children's Services, ICU, Haematology. This is being reviewed by the Medicines Management group. Within Clinical Diagnostic and Therapeutic Clinical Board high cost stent usage within the first 2 months of 2017-18 is at the same level as the full year 2016-17. It is not anticipated this will continue.

Most Clinical Boards with exception of 3 are within budget plan. Clinical Diagnostics and Therapeutics Clinical Board overspend due to non-pay pressures; Children and Women Clinical Board overspend due to Neonatal Intensive Care Unit underperformance against contract; Medicine overspend due to Clinical Board nursing pressures.

The Vice Chair questioned whether the 2016-17 budgetary pressures were reflected in the financial position reported in months 1-2. The Deputy Finance Director advised that the grip and control processes put in place at the end of 2016-17 were working with majority of the Clinical Boards managing within their revised budget plans.

Each Clinical Board is to undertake a full year forecast after the Month 3 position is finalised. This will include actions to recover forecast overspends to year end. The key risks were highlighted as delivering the original £20.028m CRP programme plus the £14.973m stretch target. The Chair asked which was causing most concern. The Executive Director of Finance confirmed it was the £14.973m stretch target. A comprehensive risk register has been completed and included within the Finance Committee papers. It was noted that good progress has been made on the CRP programme to date.

The Vice Chair noted that the additional £14.973m Stretch cost saving target has been phased in from month 7. The Deputy Finance Director confirmed this was to give managers space in order to put actions into place. Although phasing is from

month 7 this is not a detailed plan and this savings target will be re-phased as and when savings are identified.

The Chief Executive highlighted that enabling transformation to take place and release savings will take time and it will be necessary to take tactical decisions and opportunities until transformation savings begin to be released.

There is a forecast shortage against cash based on the projected deficit. Funding will need to be drawn down against the Health Board's resource limit as and when needed. Welsh Government has historically provided a cash only resource assistance. If Welsh Government were not able to provide cash this could be managed internally through management of transactions.

FC - 18/073 Financial Plan Update

The Executive Director of Finance provided a verbal update.

Following submission of the Financial Plan detailing a revised £30.9m gap there was a further meeting held with Welsh Government. The Welsh Government have requested to see the detail of the plan including run rates with which to monitor performance against. These have been completed and were shared with the Finance Committee.

Welsh Government have requested a plan as to how the Health Board will deliver the additional £14.973m target to reduce the planned deficit to £30.9m.

The committee discussed who currently owned the £14.973m stretch target. The Executive Director of Finance confirmed it was the whole organisation. The Clinical Board's primary objective was to meet their existing delegated target but will be expected to contribute to transformation work being led by Executives. The allocation and management of the £15m will be discussed further at the next Executives time out on 14th July. There is good governance around existing savings schemes. Now need to accelerate schemes, strengthen grip and control and take opportunities as they arise to meet targets in the shorter term.

The committee discussed how cash releasing savings can be made in the short term with majority of costs relating to payroll with only 8% variable pay costs. Skill mix changes take time and rely on turnover. The Health Board is not considering redundancy as this is seen to be costly and ineffective. There will be a big focus on reducing Bank and Agency expenditure and capitalising on turnover. The Executive Director of Nursing confirmed that use of premium nursing agencies has stopped.

The Finance Committee was asked by Independent Members if the Health Board has a Transformation Director in place. The Chief Executive confirmed that this post will be going to advert shortly. The Deputy Chief Executive confirmed the Health

Board has put internal structures in place to support transformation. Clinical appointments have been made. Getting the internal structures and governance right up front will ensure the Health Board can start work now with the right balance of priorities. Other Health Boards who have already appointed a Transformation Director are not as far forward in terms of putting internal structures in place.

The Chief Executive confirmed that the organisation would further scrutinise the savings plans and will feedback to the Finance Committee following the Executive time out session on 14th July.

Action: Chief Executive to update Finance Committee following further scrutiny of savings plans

24.6

FC - 18/074 Cost Reduction Programme

The Assistant Director of Finance for Transformation and Planning highlighted the Cost Reduction Report key points:

The Report identifies the delegated target of £17.333m. It does not include the transformation or stretch target. At the end of last week £17.430m savings had been identified against this target. Confirmed that plans are in place to deliver this initial savings target.

The impact of full year effect of savings schemes identified this year was discussed by the Committee. The delegated target this year is 2% of which 1.5% must be delivered recurrently to avoid the Health Board carrying forward an unmanageable level of new savings to be found next year. There is continued focus on the balance between recurrent and non-recurrent savings.

The paper also highlights progress against cross cutting schemes. Currently £4.764m has been identified against the indicative £7.5m target. These savings contribute to the overall delegated savings target.

The efficiency framework has been submitted to Welsh Government to enable them to compare Health Board performance across Wales. This framework needs to be updated to reflect latest progress with a greater level of detail. The RAG rating was explained. Green – scheme will be achieved; Amber – should deliver 80%; Red – pipeline schemes where new schemes and ideas added can migrate across into Green and Amber.

FC - 18/075 Risk Register

The Executive Director of Finance asked the Finance Committee to review the risk register and to feedback if there is any risk not covered.

Action: Finance Committee Members to review risk register

This register is updated daily. The Chair confirmed that she found the register reassuring and gave added confidence to the plan. It was noted that R&D was unscored. This has been included in mitigating actions 10.9. The Health Board is anticipating opportunities to offset this risk.

FC - 8/076 Items to bring to the attention of the Board/Other Committees

The Vice Chair asked if the Health Board had heard anything back from the Deloitte review. It was confirmed that this has not been received yet. A report is expected by the end of this week. This will be presented at the Board meeting before going to Committee.

No other items to bring to the main board.

The Chief Executive thanked the Executive Director of Finance for the focussed work undertaken on the CRP tracker as this has made a big difference within the Health Board.

FC - 18/077 Date and time of next meeting

Wednesday 26th July; 9.00am; HQ Board Room, UHW

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 26TH JULY 2017

UHW HQ

Present:

Len Richards	Chief Executive
Maria Battle	Chair
Marcus Longley	Vice Chair
Bob Chadwick	Executive Director of Finance
Chris Lewis	Deputy Director of Finance
Julie Cassley	Executive Director of Workforce
Steve Curry	Director of Operations
Margaret McLaughlin	Independent Member
Ivar Grey	Independent Member
Andrew Gough	Assistant Director of Finance (Transformation & Planning)
John Antoniazzi	Independent Member

Secretariat:

Paul Emmerson	Finance Manager

FC – 18/078 Welcome and Purpose of the Committee

The Vice Chair welcomed everyone to the meeting.

FC – 18/079 Apologies for Absence

Apologies were received from Graham Shortland, Sharon Hopkins, Chris Lewis and Abigail Harris, Ruth Walker, Peter Welsh

FC – 18/080 Declarations of Interest

The Vice Chair invited members to declare any interests in proceedings on the Agenda. None were declared.

FC – 18/081 Minutes of the Finance Committee Held on 29th June 2017

The Committee RECEIVED and APPROVED minutes of the meeting held on 29th June 2017 subject to the addition of Margaret McLaughlin to apologies for absence.

FC - 18/082 Action log following the last meeting

The Medical Director is taking forward the UHB's Research and Development Strategy within agreed Timelines.
All other outstanding actions were picked up on the agenda.

FC - 18/083 Financial Position Month 3

The Assistant Director of Finance (Transformation & Planning) presented the UHB's financial performance to month 3.

The UHB recorded a £7.695m deficit at the end of month 3 based on a planned year end deficit of £30.900m. The deficit was broadly in line with the plan being made up as follows:

- £0.041m adverse variance against the UHB's savings target
- £(0.071m) favourable budget management variance
- £7.725m planned deficit (3/12th of £30.900m)

Performance against income targets improved by £0.507m in month leading to a cumulative over recovery against targets of £0.063m. In month performance against R & D income improved due to the collection of commercial R & D income. Income from the Compensations Recovery Unit remains ahead of plan for the year to date due to the rise in the notified number of new claims. An analysis of previous years suggests that actual income reported is subject to significant monthly variation. Accommodation and catering income for the year to date is now marginally ahead of plan. The surplus against NHS patient related income relates to the recovery of costs from English NHS commissioning bodies where a bad debt provision had previously been provided.

The pay position reported to month 3 was favourable with an underspend of £0.157m in month in line with trend. All pay groups were underspent with the exception of registered/unregistered nursing where the in year pressure continued with a year to date adverse variance of £0.628m.

The overspend reported against Non Pay deteriorated by £0.616m in month to £0.777m. Commissioned Services reported an in month overspend due to recognition of the additional cost of the Velindre LTA. Drugs and prescribing reported an overspend primarily due to a shortage in the supply quetiapine and olanzapine where the cost to the UHB of the NCSO ('No Cheaper Stock Obtainable') price concession is estimated at £0.188m per month. The number of high cost haematology tests has increased in year and in this context the UHB is in the process of implementing a Lab Medicines Trading Framework to manage the demand for all laboratory tests. The number of new Continuing Healthcare packages approved in month was significantly greater than the number of packages coming to an end.

Most Clinical Boards broadly balanced month 3 expenditure within existing resources and budgets. The key exceptions were the Medicine Clinical Board which was overspent on its nursing budgets and Children and Women where there was underperformance in NICU alongside premium costs of medical cover. Clinical Board year end forecasts were being reviewed and those Clinical Boards with a forecast year end overspend will be escalated and requested to produce recovery plans in order to achieve a balanced year end outturn with the expectation that all Clinical Boards will deliver the lower of their forecast position or a break even position.

It was noted that the Surgery Clinical Board had undertaken a review of internal governance to strengthen the Boards decision making process in line with the transformation agenda. Common themes had been shared across Clinical Boards through Clinical Board's Heads of Finance.

24.6

For the first 3 months, £5.071m of the savings target are profiled into the position, against which the UHB has delivered £5.030m. The resultant shortfall of £0.041m is expected to be recovered as the year progresses. Good progress to identify new schemes had been made in month and at the end of June the UHB had identified £22.6m of savings schemes against the stretched target of £35m leaving a gap of £12.4m.

The12.4m gap is a risk to the overall achievement of the UHB's plan and any gap remaining at the end of September would be phased into the reported position from month 7 onwards. A revised risk share agreement for WHSSC with a potential £0.5m cost was also highlighted to the Committee as a risk.

Following a question from one of the Committee's Independent Members the Executive Director of Finance confirmed that no additional resource for Birthrate Plus was included in the 2017/18 plan. The Children and Women's Clinical Board was in the process of completing a business case so that the UHB could consider implementation of Birthrate Plus in 2018/19. The Director of Operations informed the committee that excellent patient outcomes are already achieved in the Children and Women's Board. The Committee noted that future investments decisions will be tested against the principle of supporting finance but not to the detriment of patient safety.

The Chair indicated that the majority of the nursing agency overspend fell against qualified nursing and that the majority of overspend on bank staff related to non-qualified nursing. It was suggested that qualified nurses were paid a significant premium above substantive and bank rates when fulfilling agency shifts. The committee discussed and noted that the future UHB approach to the use of nursing agencies would be informed by work currently being progressed at an all Wales level.

The Vice Chair noted that overspends particularly in the Medicine and Children and Women's Clinical Boards were currently broadly balanced by underspends in other Clinical Boards. The Committee acknowledged this point but also stressed that all

Clinical Boards should continue to manage performance, safety and finance for all services within agreed criteria. It was noted that this approach required the continuing development of a culture that managed risks without recourse to additional finance where services are already safe and sustainable.

Following on from this, the Vice Chair indicated that the £12.4 gap in savings plans was the greatest risk to the delivery of the UHB's 2017/18 plan. The Chief Executive confirmed that reports to both the Board and Welsh Government had consistently highlighted the risk around the gap in savings schemes. The Executive Director of Finance reported that this risk would crystallise in months 7 to 12 if plans to bridge the gap were not in place.

The Executive Director of Finance added that in the absence of larger schemes to bring the UHB into balance on a recurrent basis that the UHB would need to continue to chip away at the remaining savings gap through the pursuit of non-recurrent opportunities and smaller schemes. The Chief Executive confirmed that the transformation agenda was still in its infancy and that further work across the organization and with all stakeholders was required to quantify the larger scale opportunities accessible to the UHB.

FC - 18/084 Cost Reduction Programme

The Executive Director of Finance highlighted the following key points from the Cost Reduction Report:

The report identifies the delegated target of £17.333m. It does not include the transformation or stretch target. As at 3rd July 2017, £18.424m savings had been identified against this target. It was noted that the table at appendix A indicated that not all Clinical Boards had yet reached the target of 80% Green and 20% Amber schemes. The importance of reaching the milestone of 100% Green Schemes by the 1st October was stressed

Cross Cutting Themes were established to support the delivery of the £17.333m delegated CRP target. Further urgent work is required to progress detailed plans to so that cross cutting schemes feed into Clinical Board trackers. At the time of reporting, three of the cost cutting schemes were RAG rated as RED as follows:

- Medical Productivity – Job planning and the management/use of locums has been escalated through the Medical Directors Office
- Nursing Productivity – Progress is dependent on the reduction in the use of agency nursing
- Workforce Productivity – arrangements are in place to restrict the carry forward of annual leave.

Currently £5.188m of cross cutting themes had been identified against the indicative £7.5m target. These savings contribute to the overall delegated savings target.

The All Wales efficiency framework is now led by the UHB's Executive Director of Finance. Work to quantify share the areas of greatest gain across Wales is ongoing. This framework is expected to be updated after month 4.

FC - 18/085 Risk Register

The Executive Director of Finance asked the Finance Committee to review the risk register and to feedback if there is any risk not covered.

The Committee noted that the majority of risks continued to be managed.

The largest risk continued to be the identification of £15.0m additional stretch plan actions to achieve £30.9m deficit position.

Action: Finance Committee Members to review risk register

FC - 18/086 Items to bring to the attention of the Board/Other Committees

No other items to bring to the main board.

FC - 18/087 Date and time of next meeting

Wednesday 30th August; 16.30pm; Large Meeting Room, Corporate HQ

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am ON 18 JULY 2017 IN SEMINAR ROOM 1, COCHRANE BUILDING, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Martyn Waygood	**Independent Member – Legal (Chair)**
Stuart Egan	Independent Member – Trade Union/Health and Safety Staff Lead (1st part of meeting)

In attendance:

Charles Dalton	Head of Health and Safety
Fiona Jenkins	Director of Therapies and Health Sciences (2nd part of meeting)
Fiona Kinghorn	Deputy Director of Public Health
Catherine Salter	Staff Representative (RCN)
Peter Welsh	Director of Corporate Governance
Lee Wyatt	Head of Facilities

Apologies:

Carol Evans	Assistant Director of Patient Safety and Quality
Geoff Walsh	Director of Capital, Estates and Facilities

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 17/054 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting. Mr Waygood informed the Committee as Mr Egan would not be able to stay for the full meeting those items on the agenda requiring action would be taken first.

HSC: 17/055 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.

HSC: 17/056 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 25 April 2017 were **APPROVED** and **ACCEPTED** as a true record.

HSC: 17/057 UPDATED ACTION LOG

The Committee **RECEIVED** the Updated Action Log from the previous meeting. The following updates were provided:

- HSC: 17/032 – the Head of Health and Safety informed the Committee that whilst no formal meeting had taken place to progress the overall strategy for pedestrian safety, the Director of Capital, Estates and Facilities had been progressing pedestrian safety within the tunnels.

  The Deputy Director of Public Health stressed the need for pedestrian safety to be a key design component when planning future projects.

  An update on progress was requested for the next meeting.

  ACTION – Mr G Walsh/Mr C Dalton

  The Independent Member – Trade Union advised of concerns relating to the mini roundabout outside the Emergency Unit whereby there was not enough turning room so vehicles had to mount the pavement. The Head of Facilities stated he would investigate this further.

  ACTION – Mr L Wyatt

  The Director of Corporate Governance thanked the Capital and Estates Teams for significant improvements made at University Hospital Llandough (UHL) in respect of road safety.

- 17/036 – the Head of Health and Safety advised the one page guidance in respect of wedging fire doors open had been discussed at the Fire Safety Group and would be produced by the Senior Fire Safety Adviser.

  ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/058 CORPORATE RISK ASSURANCE FRAMEWORK DOCUMENT (CRAF)

The Director of Corporate Governance informed the Committee there continued to be 9 significant risks on the CRAF and their scoring remained static whilst minor changes had been made to 2 of the risks.

Mr Welsh advised following the Development Day on the 27th April 2017, there was now a review of the way the Health Board addressed and prevented risks and more emphasis would be placed on the impact of risks. Mr Welsh advised that Committee Members had a role to play in addressing their risks and requested any comments on how risks should be managed were to be forwarded to himself and Sian Rowlands, Head of Corporate Governance by the end of August 2017. An update would then be provided to the October meeting of the Audit Committee.

The Head of Health and Safety informed the Committee there was documentation behind the risks on the CRAF which demonstrated key milestones taken to reduce the risks. The Head of Facilities supported this by adding the risk register was being reviewed by the Capital and Estates Team.

The Staff Representative (RCN) queried the status of the e-datix risk management module, it was **AGREED** that a timeline would be obtained from the Assistant Director of Patient Safety and Quality.

ACTION – Miss R Daniel/Mrs C Evans

24.7

The Corporate Risk Assurance Framework Document was **RECEIVED** and **CONSIDERED** by the Committee.

ASSURANCE was provided by:

- The mitigation of Health Board risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF required strengthening.

HSC: 17/057 LETTER TO CEO's FROM WELSH GOVERNMENT (WG) RE HEALTH AND SAFETY ASSURANCE

The Director of Corporate Governance informed the Committee the letter from Welsh Government had been sent to all Health Boards and was to be received by this Committee so that assurances could be given to the Board that health and safety was being sufficiently managed and given appropriate priority. Mr Welsh added he was comfortable that the Health Board had the necessary arrangements in place to manage health and safety risks. The Chair concurred with this stating the Health Board had a designated Lead Director for health and safety and this Committee was a formal Committee of the Board. Mr Waygood added it was justified that the Health Board should have a Health and Safety Committee in its own right and not form part of a Quality and Safety Committee where health and safety risks may not be given the attention that was merited.

The Independent Member – Trade Union stated there were good processes in place and the Health Board was very good at addressing those issues it has the knowledge of, however the unknown was a concern. The Deputy Director of Public Health added there was a clear system in place and progress was being made, however it was essential that any risks were owned by the organisation.

The Head of Health and Safety stated the Priority Action Plan was a useful mechanism for providing assurance to the Board.

The Staff Representative (RCN) said there was monetary implications for some risks which required investment if they were to be resolved.

The letter from Welsh Government was **RECEIVED** and **NOTED** by the Committee.

HSC: 17/058 HEALTH AND SAFETY ANNUAL REPORT

The Head of Health and Safety presented the key issues in the annual report:

- Incident data collated from the Datix system showed a high level of close out and management involvement.
- RIDDOR events have remained constant but there had been a continued increase in the number of patient behavioural incidents which had doubled over the last 2 years and up 28% on the previous year.
- The Health Board received its second Health and Safety Executive (HSE) enforcement action since 2001 relating to Legionella requirements.
- The HSE were also active in visiting the Health Board and applying "Fees for Intervention"
- A change in the way fines were applied highlighted the significant potential risk of a fine being in the order of £1-2 million.
- The number of Prosecutions and other Police interventions were significantly lower than previous years, however the Health Board was working closely with the Police, Crown Prosecution Service and Shared Services Legal to improve the Memorandum of Understanding between all parties.
- Training compliance for both manual handling and violence and aggression had improved, although this mostly related to e-learning Module A and not tutor led training.
- Training improved although it was still not at the target level of compliance and some Clinical Boards were demonstrating low compliance or poor progress in improving the percentage of their staff trained. This is being pursued by the Mandatory Training Steering Group.
- Tutor led training continued to show a very high level of failure to attend on the day and this was being considered by the Health and Safety Operational Group.
- With the appointment of a new Staff Safety Representative Chair and Deputy the workplace inspection regime had been reviewed and enhanced local representative's involvement.
- Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period.
- Dirty medical sharps injuries were 37% lower since the introduction of safer sharps in 2012/13.
- Dirty needle stick injuries were 17% lower than the previous year.

The annual report also demonstrated the improvement in the management of health and safety aspects through the priority action plan and the control of policy schedule, keys areas of progress included:

(1) Acquiring approval from Welsh Government for £420k to be allocated for the renewal of patient hoists for implementation in early 2017/18.
(2) Implemented improved re-usable glide sheets reducing injury risks which also resulted in a saving.
(3) Introduced new lone worker devices and improved usage from 20% - 74%.
(4) Revised all health and safety policies within their required review period.
(5) Needle stick and sharp incidents were again lower than the previous period justifying the safer sharps devices introduction.

24.7

The Chair thanked Mr Dalton for his presentation. Mr Waygood stated compliance to training and particularly the failure to attend rate needed to be reported to the Board. The Deputy Director of Public Health agreed and added it also needed to be reported to the Clinical Board's Performance Meetings.

Mr Dalton referred to Table 39 - benchmarking data and suggested this be used as the format in which Clinical Boards reported to the Committee in order for assurances to be obtained. The Director of Corporate Governance also suggested this be shared with Management Executive.

ACTION – Mr P Welsh

Mr Waygood stated the Medicine Clinical Board should be first to attend the Committee to explain their position and provide assurance as they were clearly experiencing some difficulties. The Director of Therapies and Health Sciences advised she would raise the matter at their Performance Review. Mrs Jenkins also added this data needed to be shared with the Clinical Boards as a priority.

ACTION – Mrs F Jenkins

The Staff Representative (RCN) referred to Table 15 and the number of 'workplace stressor demands' incidents and queried where the Health and Wellbeing Group reported to, Mr Welsh advised he would raise with the Assistant Director of Organisational Development.

Action – Mr P Welsh

Mrs Salter referred to page 51 and queried whether any additional funding would be made available to purchase additional glide sheets. Mrs Jenkins stated there was no corporate budget and the resourcing should come from the Clinical Boards. Mrs Kinghorn advised the positive aspects of the glide sheets needed to be shared with the Clinical Boards.

ACTION – Mr C Dalton

The Health and Safety Annual Report was **RECEIVED** and **NOTED** by the Committee.

ASSURANCE was provided by:

- Health and Safety aspects being monitored and progressed as appropriate.

HSC: 17/059 LETTER TO CEO's FROM WELSH GOVERNMENT (WG) RE FIRE SAFETY GRENFELL TOWER

The Director of Corporate Governance informed the Committee the letter had been sent to all Health Boards and the Director of Planning was taking the lead in providing a response to Welsh Government (WG). Mr Welsh added a report had also been presented to Management Executive the previous day.

The Staff Representative (RCN) informed the Committee staff had raised concerns with herself in respect of whether any of the Health Board buildings had cladding which posed a fire risk and requested that a brief message of assurance be issued through 'CAV Have You Heard', this was **AGREED.**

Action – Mr L Wyatt

Mr Welsh requested the formal report be brought to the next Committee meeting.

ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/060 FIRE SAFETY ANNUAL REPORT

The Head of Facilities highlighted the key issues in the annual report:

- Enforcement notice for Whitchurch Hospital would remain until the hospital was unoccupied.
- 28 fires reported during the period.
- 510 unwanted fire signals reported during the period.
- Compliance to fire safety training required vast improvement.

The Staff Representative (RCN) expressed her disappointment at the quality of the Fire Safety Annual Report. Mr Wyatt advised there was a lot of ongoing work behind the report and the Director of Corporate Governance added the Fire Safety Group provided continual assurance to this Committee.

The Chair queried whether the report gave sufficient understanding on the position of compliance to fire training and evacuation. Mr Waygood added he did not consider section 9.0 to be an action plan but comments and would like to see more detail in relation to the effectiveness of training, compliance to evacuation procedures and compliance with fire risk assessments.

The Director of Therapies and Health Sciences concurred that the report was not robust enough and did not provide assurance to the Committee, it also needed to cover the correct financial year and required a detailed and specific action plan with targets.

The Fire Safety Annual Report was **RECEIVED** by the Committee but did not provide the necessary assurances and a more detailed report was **REQUIRED** for the next meeting.

ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/061 FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT

24.7

The Head of Facilities advised the Committee Whitchurch Hospital was vacated by the 7th July 2017 and the enforcement notice would now be reviewed by South Wales Fire Service. Mr Wyatt also advised the second enforcement notice was in relation to a patient smoking in their bedroom at Hafan y Coed, University Hospital Llandough (UHL) and the Fire Service considered the Health Board had failed to control smoking.

In relation to Whitchurch Hospital the Director of Corporate Governance informed the Committee whilst there were no staff in the hospital there was still a significant amount of medical records and equipment stored there which had been reported to Management Executive as the Health Board had a period of time to remove the records.

In respect of the enforcement notice at Hafan y Coed the Chair queried whether the Health Board was content that assurances made to South Wales Fire Service were sufficient for the enforcement notice to be lifted. The Head of Health and Safety confirmed a 12 point action had been developed which was being led by the Mental Health Clinical Board and had been shared with South Wales Fire Service. The Deputy Director of Public Health added a trial was being undertaken in relation to the purchase and use of e-cigarettes to see if smoking could be reduced with this client group but added it was a very challenging area. Mr Waygood requested an update for the next meeting.

ACTION – Mrs F Kinghorn

The report was **CONSIDERED** by the Committee in relation to the on-going work to meet the requirements of fire enforcement compliance.

ASSURANCE was provided:

- That identified fire enforcement compliance and safety were being appropriately managed.

HSC: 17/062 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

The Head of Facilities informed the Committee NHS Wales Shared Services Partnership – Specialist Estates Services carried out an in-depth fire safety audit at University Hospital Llandough (UHL) during November 2016 and an action plan had been developed to address those issues raised in the audit. Mr Wyatt informed the Committee some of actions required updating but the action plan was being monitored by the Fire Safety Group.

The Director of Corporate Governance advised he would share the action plan with the membership of the Managers' Forum at UHL.

ACTION – Mr P Welsh

The Health and Safety Adviser suggested the Leads identified on the action plan should be job title and not initials and also an extra column be added for progress made, this was **AGREED**.

Action - Mr L Wyatt/Mr G Walsh

It was **AGREED** this would remain an agenda item until the Committee was **ASSURED** that all actions had been completed.

ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/063 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee in respect of the Contractor fall incident the Health and Safety Executive were still interviewing staff and therefore no outcome at present was known.

The report was **RECEIVED** and the Committee **AGREED** that appropriate actions were being pursued to address the issues raised.

ASSURANCE was provided by:

- The continued investigations, actions and monitoring referred to within the report.

HSC: 17/064 TREND ANALYSIS OF CONTRACTOR CONTROL SAFETY BREACHES

The Head of Facilities informed the Committee a lot work had been undertaken to reduce the number of contractor control safety breaches and this was predominately achieved through Contractor Monitoring across all Health Board sites. Mr Wyatt advised the Contractor Monitoring consisted of challenging contractors present on site and auditing them on their paperwork, risk assessments, working procedures and induction status.

Mr Wyatt explained the process was maturing and they were still finding issues but there were fewer breaches and these were improving on a monthly basis.

The Chair stated the report provided significant assurance to the Committee.

The report was **RECEIVED** and the Committee **AGREED** the on-going contractor control measures.

ASSURANCE was provided by:

- The on-going monitoring and challenging of contractors on site.
- Monthly analysis of contractor control.

HSC: 17/065 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN EXCEPTION REPORT

The Head of Health and Safety informed the Committee there were six red areas on the plan, these were in relation to:

- Risk Assessments
- Health and Safety Management Training
- Bariatric Patient Care
- Firecode/Fire Training
- Backlog Maintenance
- Legionella Survey and Risk Assessments

The Staff Representative (RCN) queried given the number of incidents reported in the annual report for workplace stressor demands whether this should be included on the action plan. The Head of Health and Safety confirmed following the publication of the annual report the action plan would undergo a full review.

The exception report was **RECEIVED** and **CONSIDERED** by the Committee.

REASONABLE ASSURANCE was provided by:

- The demonstration of progress against each strategic area and highlighting further actions required within set timescales.

HSC: 17/066 INCIDENT REPORTING POLICY

The Head of Health and Safety informed the Committee the Policy had previously been approved by the Quality, Safety and Experience Committee and this was a review of the current Policy to which minor changes had been made. Mr Dalton added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

Mr Dalton also informed the Committee the Procedure under pinning the Policy required amendment but did not affect the Policy content.

The Staff Representative (RCN) queried whether staff could still complete paper copies and whether e-datix was available in Welsh. The Health and Safety Adviser stated paper copies were no longer available and only e-datix was to be used to report incidents, if staff had difficulties in completing e-datix they should report this to their line manager who could then complete on their behalf. In respect of e-datix being available in Welsh Miss Daniel did not think it was as it was a national system but would verify with the Clinical Governance Department.

ACTION – Miss R Daniel

The Policy was **APPROVED** by the Committee

HSC: 17/067 SHARPS MANAGEMENT POLICY

The Health and Safety Adviser informed the Committee this was a review of a current Policy to which minor changes had been made. Miss Daniel advised the Policy originally had a two review period due to it being a new Policy but was now embedded within the Health Board so would revert to a three year review period. Miss Daniel added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

The Policy was **APPROVED** by the Committee.

HSC: 17/068 1ST AID POLICY

The Head of Health and Safety informed the Committee this was the 3rd review of the Policy which followed Health and Safety Executive (HSE) Guidance and minor changes had been made. Mr Dalton added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

The Staff Representative (RCN) referred to section 4.5 and queried whether these should actually be responsibilities of the Health and Safety Department as opposed to LED. Mr Dalton concurred 4.5.1 should remain with LED but 4.5.2 and 4.5.3 transfer to Health and Safety.

Mrs Salter referred to section 5.2.2 and queried whether this now included Mental Health Nurses, Mr Dalton confirmed that it did. Mrs Salter requested communication be sent out to outline this change, prior to this the Director of Therapies and Health Sciences requested that this be re-checked.

ACTION – Mr C Dalton

The Chair referred to section 4.9 and queried whether it was a Health Board requirement or a regulatory requirement, Mr Dalton confirmed regulatory. Mr Waygood stated therefore it should read in compliance with regulations.
ACTION – Mr C Dalton

The Policy was **APPROVED** by the Committee

PART 2

HSC: 17/069 COMMITTEE WORK PROGRAMME FOR 2017/18

The Work Programme was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/070 REGULATORY REVIEW AND TRACKING REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/071 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN (DETAILED)

The full Priority Action Plan was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/072 WASTE MANAGEMENT COMPLIANCE REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/073 LONE WORKER DEVICES REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/074 ENVIRONMENTAL HEALTH REPORT OF BARRY HOSPITAL OF WALES ON 21ST FEBRUARY 2017

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 5 had been achieved.

HSC: 17/075 ENVIRONMENTAL HEALTH REPORT OF AROMA COFFEE OUTLET, UNIVERSITY HOSPITAL LLANDOUGH ON 20TH JUNE 2017

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 5 had been achieved.

HSC: 17/076 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF MARCH 2017

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/077 FIRE SAFETY GROUP MINUTES OF FEBRUARY 2017

The Director of Therapies and Health Sciences noted the poor attendance from Clinical Boards and stressed attendance at this meeting must be prioritised by Clinical Boards due to the increased emphasis being placed on fire safety.

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/078 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF FEBRUARY 20167

The Staff Representative (RCN) requested minute 2.2 be reworded to reflect whilst violence and aggression training was not part of the mandatory training core modules, the training is based off risk assessment and is over and above the requirements of mandatory training.

ACTION – Mr C Dalton

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/079 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The Heath and Safety Adviser informed the Committee communication had been received from the Assistant Director of Organisational Development who advised there were a number of Health and Wellbeing policies due for review and was proposing a slightly different arrangement for them. The Health and Wellbeing at Work Strategy was the key document and instead of having a number of other related policies, there would be a series of 'statements' that fall under this overarching document, one of which would be Stress and Mental Health Wellbeing.

Miss Daniel also noted the Asbestos Policy was due for review but had not come forward to the Committee, the Head of Facilities stated he would take this back to the Department.

ACTION – Mr L Wyatt

The schedule was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 17/080 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

It was **AGREED** the following should be brought to the attending of the Board:

- Compliance to training and the failure to attend rate.

Mr Welsh highlighted to the Committee this was Mr Waygood's last meeting and wanted to formally record his thanks and appreciation for the way in

which he had led the Committee for the last 8 years, this was fully endorsed and supported by all members.

Mr Waygood thanked Mr Welsh for his kind words. Mr Waygood thanked everyone for bringing their vibrancy and commitment to the meeting and stressed how pleased he was that this Committee retained its status as being a formal Committee of the Board.

Mr Waygood thanked Miss Daniel and Mr Dalton for their support during his Chairmanship of the Committee and thanked Mr Welsh for his leadership since taking over as Executive Lead for Health and Safety.

HSC: 17/081 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 24th October 2017 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

CONFIRMED MINUTES OF THE CHARITABLE FUNDS COMMITTEE MEETING HELD AT 09.00AM TUESDAY 21 MARCH 2017 CORPORATE MEETING ROOM, UNIVERSITY HOSPITAL OF WALES

Martyn Waygood	**Chair**
Margaret McLaughlin	Independent Member – Third Sector
Akmal Hanuk	Independent Member - Community
Christopher Lewis	Deputy Director of Finance
Fiona Jenkins	Director of Therapies and Health Science

In Attendance:

Peter Welsh	Director of Corporate Governance
Katie Mallam	Fundraising and Communications Manager
Alun Williams	Head of Financial Services
Angela Hughes	Acting Assistant Director of Patient Experience
Joanne Brandon	Director of Communication and Engagement
Joanne Wilson	Directorate Manager, Mental Health Services for Older People

Apologies:

Robert Chadwick	Director of Finance

Secretariat:
Glynis Mulford

CFC: 16/74 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting.

CFC: 16/75 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

CFC: 16/76 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

CFC: 16/77 UNCONFIRMED MINUTES OF THE MEETING HELD ON 20 DECEMBER 2016

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 20 December 2016 subject to the following:

To correct spelling of Ben Hope-Gill.

CFC: 16/078 ACTION LOG FROM MEETING OF 20 DECEMBER 2016

The Committee **RECEIVED** the Action Log from the meeting of 20 December 2016 and **NOTED** the following:

CFC: 16/079 MATTERS ARISING

CFC 16/060: Investment – Update from Schroders: New password sent to Alex Bailey. **COMPLETE**. Gains on investment converted to cash through Chairs Action **COMPLETE**

CFC 16/067: Foodsense Wales - Since the last meeting further discussions had been helpful with regard to governance arrangements and the recommendation was to go ahead with the proposal clearly outlining responsibilities. A meeting had been arranged with Public Health Wales in relation to the liability issue in terms of the member of staff and flow of monies. The member of staff will be employed by Public Health Wales (PHW) and the liability sits with PHW. It was envisaged that placing this within the Charity would increase the income streams from other organizations.

There was a need to ensure that there was no cross cutting with UHB fundraising and that the Fundraising Manager should be informed of pending fundraising and grant applications. It was **CONFIRMED** this will be included in the written agreement with PHW. Members **AGREED** with the terms of agreement.

ACTION: Mr Martyn Waygood to take Chair's Action

AC: 16/080 ROOKWOOD HOSPITAL – UPDATE

Mr Christopher Lewis, Deputy Finance Director presented an update on Rookwood Hospital stating that the UHB had met with the Solicitor.

For the purpose of a new Independent Member joining the Committee, it was explained that as part of the Charity, Rookwood Hospital was no longer fit for purpose and the facilities did not match the high quality care provided by the staff. The Health Board had put a business case together which had been approved by WG, for a new facility on the Llandough site and the move was expected in the first quarter of 2019/20. The asset of the charity will no longer be needed for the

purpose initially donated and was therefore going through a change of purpose of the legacy.

The Charity Commission had written to the Health Board and the need to change the objectives was agreed. Eversheds Solicitors, who are acting on behalf of the Health Board, was formalizing these changes. The solicitors suggested a timeline of 6-9 months to draft the scheme and this was progressing.

The Committee:
NOTED the update

AC: 16/081 STAFF LOYALTY/BENEFITS CARD - UPDATE

Peter Welsh, Board Secretary gave an update on the Staff Loyalty/Benefits Card, stating that since the last meeting the Staff Benefits Group had met again with more information provided about the loyalty card. It was envisaged that delivery of cards would be by the end of April beginning of May and will be dispatched to staff personal addresses. Alternatives of distribution had been looked at but this was deemed the best process.

The background and use of the cards was explained. The card, which is specifically branded to the Health Board, will be dispatched with literature explaining usage and will also highlight the Charity and how staff can get involved. This will be monitored through the Staff Benefits Group and give assurance through reporting to the Local Partnership Board.

In terms of recruitment, it was stated this was one of the key benefits and demonstrates the value the card brings to staff.

The Committee:
NOTED the update oral report

AC: 16/082 COMMUNITY HEALTH COUNCIL REPORT ON BOREDOM AND LONELINESS IN HOSPITALS

The Chair presented the national report received from the Community Health Council stating it had gone before Quality, Safety and Experience Committee. The minute from Committee was read out: *"It was agreed and suggested that the Charitable Funds Committee consider that the Boredom and Loneliness Scheme be used to help determine the allocation of Charitable Funds".*

It was noted and discussed:

- To allocate funding as reflected in the paper to avoid boredom and loneliness was an effective way of encouraging departments and wards to apply for funding.
- It was stated that the Charity had contributed to a number of departments but there was a need for promotion as there were a number of events that had transpired but had not been publicized. There was a need to talk to

staff about the smaller things that can be done to make a difference to patient experience using small amounts of money.
- There was a need to point people to a source of funding and raise awareness.
- It was within the gift of wards to use monies for smaller projects but for bigger needs they could apply to the Bids Panel for consideration.
- To ensure that communication goes back to the Clinical Boards highlighting there are ward based funds to use to their QSE Committees.
- It was stated while preparing funds for public scrutiny they could include the names of funds on the website so that people can choose who and what to donate to. This was currently only available to wards in UHW and UHL.
- There was a need to revisit the names of some of the funds.
- It was suggested that a menu be produced of what can be bought by wards where a cost can be attached to the items enabling wards to make a choice of what can be purchased. This could be linked back to the report.
- To ensure there was a governance process for those who do not have funding.
- It was emphasised that each of the expenditure requests had to be counter signed by the Clinical Board Head of Operations and Delivery and that communication should go out to these people in their areas.
- In response to whether there was a link for feedback from patients asking for their experience and need, it was stated that a number of surveys are sent out each month. Feedback was received from both patients and volunteers with useful information about where the target was needed and whether these were being met.
- The focus currently was on patients with dementia but there was a need to meet needs of the wider community within the Health Board.
- It was suggested to review this on patient walk rounds and added to questionnaires.

24.8

ACTION:
- **K Mallam to liaise with J Brandon and A Hughes to write to Clinical Board Directors of Operations**
- **Attach a suggested menu for wards' use, and for this to be disseminated throughout the relevant wards**

The Committee:
RECEIVED the report issued by the Community Health Council
NOTED the progress made to provide engagement and activities for patients
NOTED the challenges identified in providing engaging activities for patients

CFC: 16/083 6 MONTH MARKETING REPORT

Ms Joanne Brandon, Director of Communications gave a verbal update on the 6 Month Marketing Report. An overview was given of the Away Day about developing a marketing plan, there was discussion on the overall mission and

vision of the charity, what the opportunities were and how these could be exploited more looking at key areas. It was stated that intelligence gathering was still ongoing.

There had been discussion on how to find gaps in the market and further discussion on becoming commercially focused, whether this was the right direction and how to improve patient and staff experience as part of an overall plan. It was recognized that while it was an important piece of work, there was difficulty in allocating time to the project. It was suggested there was a need to appoint someone for a period of time to work on this aspect.

The Chair raised the issue of delay with the marketing strategy and suggested there was a need for someone to be brought in do to specialist work due to the processes involved. It was stated this could only be achieved quickly if approved by the Committee.

It was highlighted that the recent changes in the HMRC process had to be adhered to. It was therefore suggested this go through the procurement department.

ACTION:

- **L Barrett to liaise with M Waygood, M McLaughlin, K Mallam, J Brandon, P Welsh to arrange meeting date to revisit draft strategy**
- **Process for appointment to go through procurement**

The Committee:

- **SUPPORTED** the proposal for a marketing specialist to be brought in and
- **NOTED** the update

CFC: 16/084 CHARITABLE FUNDS TIME OUT – BRIEF NOTES

The Chair asked for the Time Out notes to be rolled out to members.

ACTION: P Welsh to bring progress report against actions to next meeting

AC: 16/085 DRAFT COMMITTEE WORKPLAN 2017/18

The Committee **NOTED** the draft Committee Workplan.

AC: 16/087 FINANCIAL PLANNING REPORT PAPER 2017/18

Mr Christopher Lewis, Deputy Director of Finance set out the Financial Planning Report for the forthcoming year. Based upon historic trends there was nothing of concern for the Charity to note. The Committee was informed that the Charity had a successful year. This was largely driven by the investment portfolio and the net

value of the Charity had increased considerably. The charity was now in a position to make additional funds available to support the Bids Panel.

Mr Alun Williams explained the funding source and how the income was generated for the Charity Funds Bids Panel; this was linked to the staff lottery.

In response to the availability of funds to the third sector, it was stated that in July the Panel will be reviewing bids at an Away Day and will bring all the feedback from the last third sector bids and have a discussion to consider these.

It was queried whether the Charity had explored the corporate sector in relation to the larger donors' Corporate Social Responsibility (CSR) and whether there was an opportunity to approach this area as the Health Board had demonstrated they had a good track record of generating their own funds.

There was robust discussion on this and it was agreed that more could be done externally to get to a different platform and be more visible. It was suggested once the website was up and running the corporate sector could be approached with the prospectus and could be incorporated into the marketing strategy.

The Committee:

- **NOTED** the Financial Plan

CFC: 16/088 RECRUITMENT – UPDATE AND FUNDRAISING REPORT

Miss Katie Mallam, Fundraising and Communications Manager, gave an update on recruitment stating the additional post was for a Fundraising Officer who would have good links with community fundraising.

In relation to the Fundraising Report, there was a request that the Committee agree the Staff Lottery Summer Super Prize Draw proposal, following the success the £10k January mega draw. The Committee was informed that in January the position for membership numbered 4,070.

Other elements of the report were highlighted, such as the Easter run on 9 April, the official launch of Our Orchard on 7 April, the half marathon on 2 April, which raised a considerable sum, and will shortly be promoting 'In For a Penny'.

There was awareness that membership would plateau at some point and between corporate induction and night shift walkabouts the fundraising team were trying to increase numbers.

The Committee:

- **Noted** and **APPROVED** the progress and activities outlined
- **AGREED** the Staff Lottery Summer Super Draw Prize proposal

AC: 16/089 IN FOR A PENNY PROPOSAL

Miss Katie Mallam, Fundraising and Communications Manager, presented the proposal stating this was a project to take on within the team's current scope of activity.

It was noted and discussed:

- The paper made reference that we have been using Pennies from Heaven to support two local charities and proposed that it supports one external charity, Wales for Africa.
- Under the re-launch more funding will be available.
- There was a need to have an external view.
- Funding was being made available for specific projects for third sector grant schemes.
- Opting in and out had been discussed with staff side and explained how they came to a decision of the proposal to opt in and those already in the scheme would be asked if they wanted to opt out.
- Staff side was positive but did require a name change.
- If staff are signing up to 'In for a Penny' there was a need to work out a system where they did not feel compelled.

The Committee:

- **AGREED** the 'In For A Penny' roll out **SUBJECT** to including Wales for Africa

CFC: 16/090 WIFI EXTENSION - UPDATE

Dr Fiona Jenkins, Executive Director of Therapies and Health Sciences gave a verbal update on the WiFi extension.

The Committee was informed that St David's and Barry Hospitals did not have any WiFi and there were also particular hotspots around the Health Board.

It was stated that they had identified year end capital slippage money in the sum of £250k, which had been utilized by Capital Estates, Medical Equipment and IT. This was used to wire up St David's and Barry Hospitals and the weak areas on UHW. WiFi is now available on all sites.

Members were informed that the Digital Strategic Outline Plan (SOP) submitted to Welsh Government, was a 10 year plan and the Health Board put forward an initial 3 year plan. Currently there had been no feedback from Welsh Government on the SOP. Looking forward to 2017/18, the IT team's budget remained standard and there was no extra funding at present.

Miss Mallam informed the Committee that the registration page went live today (21 March). The design was modeled from the Charity website and gave a seamless set of branding illustrating the Wifi User Experience. The landing page was also described and will be launched on Friday, 31 March.

It was discussed and noted:

- In response for accessibility for people with visual impairment, it was stated that the tablet will recognize settings and if using a screen reader or using very large type it will recognize and automatically shuffle around.
- To look at the accessibility link for those who are visually impaired.
- The landing page will be reviewed in four weeks' time to look at performance.
- Work will commence on Welsh translation.
- Wifi will be improved in areas. The speed of downloading should be improved. If specific areas are not working properly to go back to the IT department.
- The Committee was reassured that security was in place.
- It was stated that this should have a link with boredom and loneliness as previously discussed.

The Committee:
NOTED the Wifi extension Update

CFC: 16/091 EXPENDITURE > £25K MURPHY LEGACY

Joanne Wilson, Directorate Manager presented the report on the Murphy Legacy.

An amendment was made to the lease cost stating that the sum of £3,642 was an annual cost and not monthly as in the paper. This legacy was donated several years ago to the unit specifically for the social aspect of patients. A few options regarding vehicles had been looked at in the past and noted that day services had changed significantly since the donation.

The Unit had looked at purchasing two vehicles to be used by three sites across the Health Board's day services where the use of vehicles was explained. The carers group would also benefit from the use of the cars and were considering vehicles that were not stigmatized.

It was discussed and noted:

- It was commented that this would make a big difference to the community
- Concerns were raised over parking arrangements and the committee were informed that they were currently talking with the Head of Transport.
- Both options of buying and leasing had been looked at but concluded that leasing was a better option as this gave flexibility stating the service may change in the near future.
- The Unit had not looked at other companies as deadlines were tight.

- It was suggested to contact ALAS who had specialist knowledge in equipping vehicles and seek their advice.
- There was a need to ensure that staff was covered by the Health Board insurance to drive the vehicles.
- To explore looking at the difference of two year or three year contracts. Members were informed there was no upfront payment but they had a strict cancellation clause.
- It was suggested to look at volunteer drivers.

ACTION: J Wilson to explore with ALAS if they consider the vehicles suitable and whether a cheaper contract can be procured

24.8

The Committee:
APPROVED the expenditure outlined in the application

AC: 16/092 FINANCE MONITORING REPORT

Mr Christopher Lewis, Deputy Director of Finance stated the report showed the financial position to December 2016. It was reported that the investment portfolio had risen over the last financial year and the expectation was that this would increase again at end of financial year. The Committee was informed that the Legacy income was also substantially higher for the period to December and period to February.

The Chair thanked the Fundraising team for the effort and work they have put in in raising funds for the Charity and commented that this was the first time the global assets had exceeded £10m.

The Committee:
- **NOTED** the financial position of the charity

AC: 16/093 ITEMS TO BRING TO THE ATTENTION OF THE BOARD / OTHER COMMITTEES

- The extension of WiFi and launch of website and landing page and
- 'In for a Penny' and continued funding of Wales for Africa

AC: 16/094 DATE OF NEXT MEETING

The next Charitable Funds Committee meeting is scheduled to take place on **Tuesday, 13 June 2017, at 9.30am** in the Corporate Meeting Room, Headquarters, UHW.

CONFIRMED MINUTES OF THE SPECIAL CHARITABLE FUNDS COMMITTEE MEETING

HELD ON TUESDAY 30 MARCH 2017, 9.00AM CORPORATE MEETING ROOM, UNIVERSITY HOSPITAL OF WALES

Present:

Martyn Waygood	Chair
Maria Battle	Chair of Cardiff and Vale UHB
Margaret McLaughlin	Independent Member – Third Sector
Stuart Egan	Independent Member – Trade Union
Mr Akmal Hanuk	Independent Member - Community
Christopher Lewis	Deputy Director of Finance
Fiona Jenkins	Director of Therapies and Health Science

In Attendance:

Peter Welsh	Director of Corporate Governance

Secretariat:
Glynis Mulford

CFC 16/095 WELCOME AND INTRODUCTIONS

Martyn Waygood, Chair, welcomed everyone to the meeting.

CFC 16/096 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

CFC 16/097 DECLARATIONS OF INTEREST

The Chair, invited Members to declare any interest in the proceedings on the agenda – none were given.

CFC 16/098 PROVISION OF SUPPORT WORKERS FROM MENTAL HEALTH MATTERS TO PROVIDE THERAPEUTIC ACTIVITIES FOR COGNITIVELY IMPAIRED INPATIENTS ON C7N, UHW

The Chair of the Health Board presented the paper. It was explained that BIG 1 was one of the main improvement goals and a day care audit conducted last March identified that 46% of patients in UHL and 23% in UHW did not meet the criteria for secondary care.

The Executive Programme Director of Unscheduled Care sent out an email asking for support and for volunteers for the programme to help those patients who no longer

needed secondary care. The pilot commenced in January 2017 through the Integrated Care Fund slippage but this was for only half a ward. There were plans to expand the service by moving onto another site, such as St David's or Barry Hospital. Feedback and comments had been received via letters and website from patients and family stating how valuable a service this had been and the difference it had made.

It was recognised that the service needed to grow but due to the financial constraints of the Health Board, there was a need to look at alternative funding streams whilst keeping the service going. Support was requested for the programme for one year.

It was discussed and noted:

24.8

- Concerns were initially raised of a commitment of £73k and what would happen at the end of 2018 when this funding ran out.
- The programme was doing valuable work with the services provided which made a difference to lives and had to consider the impact it would have on the service users.
- It was clarified that there was a partial exit strategy as there has not been time to recruit volunteers.
- Whilst not yet possible to predict, the Charity should see if there was any ICF slippage in 17/18 that could be used to meet these costs (and reimburse the charity).
- The pilot demonstrated the skills required therapeutically. There was a need to consider the model on the ward as the service will be rolled out to other wards.
- There was a need to use learning and work out what best fits for the site, to maintain the care and dignity of patients and to ensure there was a right skill mix.
- It was highlighted that the Union would argue the point of not allowing volunteers to do work of paid staff.
- It was emphasised this was short term support for a long term strategy.
- There was an onus on local government of picking up some of the funding and a need for discussions around this.
- There was a need to look at the marketing strategy and how this was being showcased and uploaded onto the charity website.
- It was suggested that this should be encouraged to go forward for an award where it could promote and illustrate the positive contributions made to service users.
- Members of the Committee were happy to support taking into account the points raised.
- It was **AGREED** that the Charity would fund the initiative for 12 months with the potential of recovering back from slippage.

ACTION: **For a report to be submitted in six months stating what added value the funding brought to the initiative and another report in nine months stating how the service would be funded in future.**

CFC 16/099 DATE, TIME, VENUE OF THE NEXT MEETING

Tuesday, 13 June 2017, 9.30am – 1.00pm, Corporate Meeting Room, University Hospital of Wales

Pre-Meeting: 8.30 – 9.30am

UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 09.00 AM ON TUESDAY 9th MAY 2017
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

24.9

Present:

Prof Marcus Longley	**MHCLC Chair and Vice Chair, Cardiff and Vale UHB**
Martyn Waygood	Independent Member and MHCLC Vice Chair
Margaret McLaughlin	Independent Member – Third Sector

In attendance:

Sue Bailey	Clinical Director for Quality, Safety and Patient Experience
Maria Jones	Nurse Representative
Dr Graham Shortland	Medical Director
Ian Wile	Director of Operations, Mental Health
Sunni Webb	Mental Health Act Manager
Dr Jenny Hunt	Clinical Psychologist
Julia Barrell	Mental Capacity Act Manager
Kay Jeynes	Director of Nursing, PCIC
Steve Curry	Acting Chief Operating Officer
Lucy Phelps	Service User Representative
Amanda Morgan	Service User Representative
Jeff Champney-Smith	Vice-Chair, Hospital Managers Power of Discharge Sub-Committee

Apologies

Alice Casey	Chief Operating Officer (Lead Executive)
Dr Annie Proctor(DNA)	Clinical Board Director, Mental Health
Jayne Tottle	Clinical Board Nurse
Peter Welsh	Director of Corporate Governance
Dr Richard Evans(DNA)	Clinical Board Director, Medicine
Andy Cole	Operational Manager, Mental Health, Vale of Glamorgan Social Services
Eileen Brandreth	Independent Member – Information, Communication and Technology
Steve Lewis (DNA)	Director, Advocacy Support Cymru
Jane Hancock (DNA)	Service User Representative

Secretariat: Helen Bricknell

MHCLC 16/080 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 16/081 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 16/082 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

MHCLC 16/083 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 29TH NOVEMBER 2016

The minutes were RECEIVED and CONFIRMED as a true and accurate record following the amendment to minute MHCLC 16/068:

The monthly Quality and Safety meetings report on all usage of the MCA, no audit has been undertaken from the Community Child Health Directorate. An audit will be undertaken during 2017 with the Audit Clinical Lead, however no clinical incidents in Child Health had been reported.

MHCLC 16/084 ACTION LOG REVIEW

The Committee **RECEIVED** and **NOTED** the Action Log

MHCLC 16/085 ANY OTHER URGENT BUSINESS

There was no other urgent business.

MHCLC 16/086 PATIENT STORY – MENTAL CAPACITY ACT

There was no Patient Story.

MHCLC 16/087 MENTAL CAPACITY ACT CLINICAL BOARD PRESENTATIONS

1. **Clinical Diagnostics and Therapeutics**

The Clinical Director for CD&T, Sue Bailey presented the position in Clinical Diagnostics and Therapy. It was advised that ongoing Mental Capacity Act

training was provided to all staff as it is now an element of Mandatory training from April 2017 and Personal Appraisal Development Reviews (PADR). Compliance figures were unavailable from LED at the current time.

The Clinical Board dementia action plan and Dementia Champions across the patch all provide a helpful service within the clinical board. A baseline audit was undertaken and the following was highlighted:

- No clinical incidents relating to capacity
- From April 2016 to March 2017, 49 incidents of violence and aggression behavior were reported, 5 of these lacked capacity, 19 deemed to have capacity and the remainder not known. Phlebotomy and Occupational Therapy were the main areas.
- There is a mis-understanding of “capacity”, and what constitutes capacity within these areas. Mainly verbal consent is gained within the Clinical Boards. At point of referral it has been assumed that capacity has been recorded and this is not always the case.
- The Medical Director has agreed with the report presented and with the Mental Capacity Act being part of the Mandatory Training element, it has improved the compliance recording and the impact it has received within the services.
- The Interim Chief Operating Officer has clarified the importance of the different types of consent given and how it is recorded, given the vast multiplex of procedures that are undertaken by the Clinical Boards.
- Vice Chair asks how well the PADR works with the staff and the training levels, it has been agreed that it is a good mechanism for staff to complete and is taken seriously and it is important in identifying training needs and setting objectives.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations when all Clinical Boards had been heard.

2. Mental Health

The Director of Operations, Mental Health, Ian Wile gave a presentation on the 3 directorates within Mental Health, Working Adults, Older People Services and Psychology/Therapies. The report/audit compiled is an amalgamation of the 3 directorates.

Clinical Directors are responsible for their areas but felt that all staff have a responsibility to have an understanding of the Mental Capacity Act. The Mental Health Clinical Board have a quality and safety meeting and the Mental Capacity Act and Deprivation of Liberty Safeguards are standing agenda items with no outstanding items to report within.

Mental Health is a high reporting topic that is dealt with promptly throughout the Clinical Boards. Governance issues that have been reported in Psychology/ Counselling. Concerns have been raised with senior clinicians relating to informal admissions and consent to admission. But no capacity to such admission has been obtained and documentation completed on patients files to reflect this.

Healthcare Inspectorate Wales have visited older people services recently and compliance with DoLS and MCA has been questioned relating to staff training and awareness.

Training data feedback has not been made readily available, but mandatory training can be recorded and monitored.

- No evidence of audit through the Mental Health Clinical Board. Professor Robert Kidd has outlined an audit which is due to be rolled out this summer.
- Clinical incidents and assaults on staff by patients have been identified through the Sentinels' group. Assessments are to be undertaken prior to staff prosecuting.
- Comment from the older people's directorate that training is needed.
- Older People's Service not aware of any incidents regarding the Mental Capacity Act.
- Issues raised by IMCA services have been disseminated to Clinical Boards.
- Lack of awareness around the Adult services and DoLS regulations.

Comment was made on the compliance figure of 80% around Mental Capacity Act awareness/compliance and how it has been achieved throughout the Clinical Board, more training and awareness over the next 18-24 months to improve the outcome on Mental Capacity Act awareness.

- The feedback from the IMCA services is a valuable tool, raising awareness across the Health Board.
- The issue for the Mental Health Clinical Board is the difference between the MHA Act to the MCA, it has been highlighted that the DoLS training could be more beneficial**.**
- Within patient files especially in older people services written documentation surrounding the MCA can be improved upon.
- Being able to demonstrate that using the least restrictive measures have been considered and documented are more apparent than being threaded through patients' notes.
- Code of practice states that if someone needs to be detained then it is appropriate to do so, but there is a need to ensure that it is

documented thoroughly within the notes/care and treatment plan and which avenues are explored.
- Community areas have more practical avenues and ways of gaining consent but more detail needed around area of capacity.

- Moving forward the data of Mental Capacity Act training can be captured on ESR training.
- Centrality of training is highlighted throughout the Clinical Boards

Maria Jones and Sue Bailey leave the Committee meeting.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations.

24.9

MHCLC 16/088 UPDATED DoLS MONITORING REPORT

The Committee received and noted the report from the Operations Manager. The Chair opened up to questions and discussion. There are currently urgent assessments outstanding for Cardiff and Vale due to the nature of hospital referrals.

- The statistic table does not meet100% on the last page of the report due to a typo.
- Debate has been around the costings of the assessments and budgets being met.
- Apologies around lateness of dissemination of the report.
- Discussion is needed on how to take forward the regular reporting of the Clinical Boards.
- Having all clinical boards attend and present at the committee has focused more on the awareness of MCA.
- Auditing can identify the key issues needing more training.
- Issues raised in IMCA's reports need to be raised, a strategy plan is in place to ensure all components can be discussed and carried forward with best governance practices and Data Protection Act being adhered to.
- Do Not Attempt Cardio Pulmonary Resussitication (DNA CPR), issues raised around this and the root cause analysis.
- Training and how to report into performance reviews
- Audits can be carried out in sections and feedback reviewed over the next 12 months.

Committee to receive reports 3 times a year without clinical board presentations.

Chair summarizes and a report to be brought forward to next committee.
ACTION – Medical Director

MHCLC 16/089 MENTAL HEALTH ACT ACTIVITY REPORT

The Director of Operations, Mental Health, Mr. Ian Wile presented the report and advised there were no exceptions to the report. Explanations of the breaches to the Mental Health Act were reported, why and what steps were followed to rectify the breaches. The Mental Health Clinical Board was reporting a high standard of non-compliance due to mis-communication and incorrect paperwork breaches occurred. The 4 occasions of unlawful detentions have not been taken further.

The number of 136 assessments in custody have remained low.

The Chair of the Committee leaves the meeting 10.32am, Mr. Martyn Waygood continued to Chair as Vice Chair of the Committee.

The Committee **NOTED** the report.

MHCLC 16/090 SECTION 117 COMPLIANCE

The Director of Operations, Mental Health, Mr Ian Wile gave an oral update on Section 117, stating it would no longer come to Committee as a standing item. A serious incident had been reported where a service user fell out of contact from the services and 117 aftercare was not maintained.
A centralized list of 117 aftercare and monitoring of compliance has been compiled and is best practice throughout Wales. Cardiff and Vale University Health Board have gone through in excess of 21,000 files to ensure the sector is covered with patients that move out of area or who are no longer under the care of Section 117. Up to date lists are audited every 2/3 months.

The Vice Chair **NOTED** the report, the committee **AGREED** that it will no longer be a standing item on the Agenda.

The Committee **NOTED** the report.

MHCLC 16/091 a) SECTION 136 PARTNERSHIP ARRANGEMENTS

The Director of Operations, Mr Ian Wile gave an oral report, this piece of work was in conjunction with the police. The amount of mental health well-being and social care issues have increased across all of the services, and are aiming to be targeted more effectively.

Partnership working is taking place to provide better services with a "sanctuary" for those not in need of the acute/crisis setting.

b) CONCORDANT DELIVERY PLAN

The Director of Operations had nothing further to add to the report, but outlined the following:

- Training front line officers
- Place of refuge for those in need of well-being support, short stay
- Mental Health Learning Disability being taken forward by Caswell Clinic
- Representation by all health boards and Cardiff and Vale are coming forward with nominations.
- Call centre triage, mental health practitioners – 24/7 support.
- Not to implement another layer and for it to be addressed initially within the current infrastructure.

Medical director leaves the committee 10.47hrs

The Committee **NOTED** the report

MHCLC 16/092 HEALTH INSPECTORATE WALES - MENTAL HEALTH ACT ANNUAL REPORT

The Chair **NOTED** that there is no current report available.

MHCLC 16/093 HEALTH INSPECTORATE WALES – INSPECTION REPORTS

The Chair **NOTED** that there is no current report available.

MHCLC 16/094 REVIEW OF SMOKING EXEMPTION

The Committee **NOTED** there is no written report and Ian Wile gave an oral update

Project group put together in Mental Health service, including the caring staff, patients and Ethics Committee on the general overview that a proposal of no smoking within Mental Health services. A draft plan to be taken back to the project group and for it to be piloted in the summer with a period of 3 months initially.

The Chair opened up to discussion, NO COMMENTS made.

MHCLC 16/095 HOSPITAL MANAGERS POWER OF DISCHARGE SUBCOMMITTEE MINUTES

The Vice Chair of the Power of Discharge group had nothing further to add to the report.

The Vice Chair opened up to comments:

- It was noted how well the appraisal system for the Power of Discharge members has been working effectively in their development process.

The Committee had no further questions or comments and the report was **NOTED.**

MHCLC 16/096 MENTAL HEALTH ACT BENCHMARKING REPORT

The Director of Operations, Mental Health, Ian Wile gave an overview of the report produced. It was documented that the definitions around invalid detentions are to be investigated .

Due to the sensitivity of information shared anonimised data was given from 4 other health boards which was included in the report. It was discussed that the noting of rectifiable errors is of importance for training standards within the directorate and work is taking place on reducing them. The report will be refined and completed bi-annually for submitting at committee. Mr Ian Wile to attend the Mental Health Act Managers' meeting and encourage the other Health Boards in Wales to share information and complete their reports.
The work completed from Cardiff and Vale Health Board surrounding the current status of invalid detentions and the measures in reducing these will enable the All Wales group to reduce these figures dramatically.

The Vice Chair opened up to comments :
The Interim Chief Operating Officer commented that it was only when seeing the data in front of you it impacts on how it has been functioning within the Clinical Board to date.

The committee **NOTED** the report

The Vice Chair mentioned that "All Wales Benchmarking" will be brought back in 2017 for further discussion.

MHCLC 16/097 MENTAL HEALTH MEASURE MONITORING REPORT

The Director of Operations, Mental Health, Mr. Ian Wile delivered an oral update. The Manager of the service, Mr. Julian Willett has given some predictions over the yearly quarters of 2017/18; currently there has been high profile from the media with regard to the royal family, (Prince Harry) and the discussions around Mental Health services. Over 1200 referrals were received over the last 12 months putting high pressures within the team. The recruitment process is nearly complete for the assessing roles to enable the vast quantity to flow more productively and meet the 28 day target.

- Good progress on the CAMHS service**.**
- Single point of referrals for GP's into part 1 services.
- No long term sickness has been reported

Report tabled from CAMHS, the target was achieved for under 16's, breach was made for not reaching target of 56 days for assessment within the services due to a member of staff leaving the post.

The Committee **NOTED** the report

MHCLC 16/098 COMMITTEE WORK PLAN

The Committee **RECEIVED** and **NOTED** the work plan

MHCLC 16/099 HOSPITAL MANAGERS' POWER OF DISCHARGE SUB COMMITTEE MINUTES

The Committee **RECEIVED** and **NOTED** the report

MHCLC 16/100 REVIEW OF THE MEETING

The Chair reviewed the meeting and no comments were brought forward.

MHCLC 16/101 DETAILS OF NEXT MEETING

The next meeting will be held on Tuesday 3rd October 2017, Boardroom, Headquarters, UHW

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP HELD ON WEDNESDAY 26 JULY 2017, HAFAN Y COED, UNIVERSITY HOSPITAL LLANDOUGH

Present:

Paula Martyn	Care Forum Wales (Chair)
Sarah Capstick	Cardiff Third Sector Council
Alison Kibblewhite	South Wales Fire and Rescue
Liz Fussell	Cardiff and Vale UHB Volunteer
Richard Thomas	Care and Repair Cardiff and the Vale

In Attendance:

Marie Davies	Deputy Director of Strategy & Planning, Cardiff and Vale UHB
John Hughes	One Voice Wales
Melanie Wilkey	Head of Outcome Based Commissioning, Cardiff and Vale UHB (item 17/31 only)
Emma Wilkins	Assistant Director of Strategic Development and Transformation, Cardiff and Vale UHB
Suzanne Wood	Consultant in Public Health Medicine (items 17/24-17/25 only)

Apologies:

Posy Akande	Carer
Ben Gray	Vale of Glamorgan Council
Riah-Jayne Jones	Cardiff University
Darren Panniers	Welsh Ambulance Service NHS Trust
Stuart Parfitt	South Wales Police
Linda Pritchard	Glamorgan Voluntary Services
Geoffery Simpson	One Voice Wales

Secretariat: Gareth Lloyd

SRG 17/24 WELCOME AND INTRODUCTIONS

The Chair welcomed colleagues to the meeting. The SRG was informed that following local elections, new members to replace Councillor Pamela Drake and Councillor Lewis Owen had been nominated to join the SRG. The new nomination from Vale of Glamorgan Council was Councillor Ben Gray and the new nomination from One Voice Wales was Councillor Geoffery Simpson. The Chair and Abigail Harris had sent joint letters of thanks to Councillors Drake and Lewis, thanking them for their valued contribution to the SRG.

SRG 17/25 CARDIFF AND VALE DRAFT DEMENTIA STRATEGY 2017-2027

The SRG **RECEIVED** and **NOTED** the Cardiff and Vale Draft Dementia Strategy 2017-2027 and received a presentation on the Strategy from Dr Suzanne Wood, Consultant in Public Health Medicine.

Suzanne Wood explained that

- There are several types of dementia including Alzheimer's Disease.
- Dementia is a progressive and largely irreversible clinical syndrome although treatment is available to help the symptoms.
- Dementia prevalence increases exponentially with age and shares many risk factors with heart disease
- Dementia is the top cause of mortality amongst women and the second amongst men behind heart disease.
- 42% of dementia cases are undiagnosed.
- Dementia can be prevented by keeping the brain active and a healthy lifestyle e.g. not smoking and only having a moderate alcohol intake.
- A lower proportion of people with dementia die at home.

The SRG was informed that the Dementia Needs Assessment had identified nine key themes:

- Isolation and loneliness
- Kindness and compassion
- Co-ordination of services - discontinuity of care is a frequent problem
- Caring for carers – carers are often exhausted and more likely to suffer from anxiety and depression
- What to do in a crisis – there is frequently a lack of clarity
- Moving support to primary care
- Inequality in access to services
- Dementia is everyone's business – the 'Dementia Friendly' ethos is a good example of how this could be promoted.
- Prevention is essential.

The SRG was then asked how to best ensure that:

- by 2027 the whole population of Cardiff and the Vale of Glamorgan will be dementia aware and will reduce their risk of dementia; and
- carers will feel supported and empowered.

The SRG made several observations.

- Education is important and should be aimed at all groups including those of school age.
- Messages must be easily understood and consistent
- All forms of media should be used to publicise dementia e.g. free press, television and social media.

- Consideration should be given to using high profile celebrities to front campaigns.
- Education/publicity campaigns should be ongoing rather than one off
- Young children are generally tolerant of those with dementia and it is often their peers who are the most intolerant
- Consideration could be given to having regular public health sessions in schools.
- Dementia may be significantly under-reported in the southern arc of Cardiff as dementia is considered a taboo subject amongst Black and Ethnic Minority (BME) communities.
- There should be a duty on public bodies to undertake dementia awareness sessions.
- Increasing awareness and understanding of dementia will increase tolerance.
- Cardiff is aiming to be a Dementia Friendly city by March 2018
- It is important to highlight that dementia is preventable and people should be encouraged to participate in preventative activities.
- A greater number of adult education opportunities should be aimed at keeping the brain active rather than attaining qualifications.
- Primary care could lead dementia services e.g. have experts based within GP practices.
- The ethos that there is 'life after dementia' should be emphasised/promoted.
- Respite services for carers must be reliable.
- Carer require emotional as well as practical support
- There is potentially a greater role for volunteers.
- Greater use could be made of assistive technologies dementia care

The SRG then completed a prioritisation exercise which identified the priorities as:

- The need for simple and consistent messages
- Primary care led services
- Bespoke services for patients and carers
- The use of assistive technologies.

Members of the SRG agreed to send Suzanne Wood any further comments on the Draft Strategy by 15 September

Action: All

SRG 17/26 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not a member of the SRG, apologies had been received from Abigail Harris, Peter Welsh and Keithley Wilkinson.

SRG 17/27 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 17/28 MINUTES OF THE STAKEHOLDER REFERENCE GROUP MEETING HELD ON 23 MAY 2017

The SRG **RECEIVED** and **APPROVED** the minutes of the meeting held on 23 May 2017.

SRG 17/29 MATTERS ARISING

Cardiff Council Nomination for SRG
Anne Wei reported that following the local elections she had written again to Cardiff Council seeking a nomination for the SRG. Although the local authority had followed due process it had thus far been unable to identify anyone for the SRG.

The Chair agreed to seek advice from Cllr Susan Elsmore on how the UHB could secure a nomination from Cardiff Council

Action: Chair

Major Trauma Centre (MTC)
Marie Davies informed the SRG that the independent panel of specialists had recommended that the MTC should be located in Cardiff. Although there had been no formal objections, Abertawe Bro Morgannwg UHB and its local Community Health Council had raised concerns about the engagement process and also with the travelling times between west Wales and Cardiff. Cardiff and Vale UHB required a formal mandate before it could commence the planning of the MTC.

New Chief Executive
Anne Wei confirmed that the new Chief Executive, Len Richards would be attending the SRG meeting on 13 September.

Marie Davies informed the SRG that the new Chief Executive had confirmed his commitment to the UHB's Shaping Our Future Wellbeing (SOFW) Strategy. The UHB remained in a position of significant financial deficit which Welsh Government (WG) had stipulated must be drastically reduced. In response to this the UHB has put in place an approach based on

implementing efficiencies and being smarter in the way it commissions services. Key to this will be an acceleration of its Transformation Programme based on the dual aims of reducing costs and improving quality of service. Another key issue will be negotiations with WG regarding a fair funding settlement. The UHB has a statutory duty to break even and during negotiations with WG, the Chief Executive will have to demonstrate that the UHB is taking responsibility for financial performance which will hopefully then open the door to more productive discussions about the challenges posed by population growth in Cardiff and the Vale of Glamorgan.

The SRG agreed that the new Chief Executive be asked to present his view on the impact of the financial challenge on delivering the SOFW Strategy and how the UHB would work with partners in this process.

24.10

Action: Anne Wei

SRG 17/30 FEEDBACK FROM BOARD

An apology was made that the incorrect Board agendas had been sent out with the papers for the meeting.

It was agreed that agendas from the Board meeting held on 25 May and Special Board meeting held on 1 June would be sent out to SRG members.

Action: Gareth Lloyd

SRG 17/31 UHB COMMISSIONING INTENTIONS

The SRG **RECEIVED** and **NOTED** the draft Cardiff and Vale UHB Commissioning Intentions 2017-2020.

Melanie Wilkey explained that the Commissioning Intentions were essentially the start of the commissioning process and were driven by the UHB's SOFW Strategy. Marie Davies added that the Commissioning Intentions provided the context and framework for the Integrated Medium Term Plan (IMTP).

The SRG was informed that some services were commissioned at a corporate level e.g. Child and Adolescent Mental Health Services, whereas others were commissioned by Clinical Boards. In addition, Welsh Health Specialised Services Committee (WHSSC) commissioned specialist services on an all Wales basis totalling approximately £600m worth of activity per annum.

The SRG was asked to consider some specific questions:

- How do we design the best value delivery mechanisms?

- How do we ensure that the needs of patients and carers are built into services?
- How do we create opportunities for designing and delivering integrated services within and outside the organisation?
- What can we learn from partners and stakeholders who commission well?
- Are there any key areas missing from the 2017-2020 commissioning areas that should be considered for 2018-2021?
- Are there any services of limited value or low evidence base that we should consider decommissioning?

24.10

Anne Wei explained that the Well-being of Future Generations (Wales) Act placed a duty on public bodies to improve sustainability. It sets out seven wellbeing goals and five ways of working which Public Bodies would need to demonstrate they are adopting: long term; integration; involvement; collaboration; and prevention. She suggested that it would be helpful to demonstrate how these would be adopted in the Commissioning Intentions and enquired whether this was being discussed at an all Wales level. Melanie Wilkey explained that there was no national forum for discussing commissioning outside of WHSSC. The five ways of working would be included in the fundamental principles of the UHB's Commissioning Framework but it was unlikely that there would be explicit reference to them in the Commissioning Intentions

The SRG made a number of observations.

- It is difficult to understand the UHB's priorities from the Commissioning Intentions. Emma Wilkins acknowledged that the list was overwhelming and there had been a discussion about how it could be broken down year by year.
- It would be helpful if there was an indication of 'invest to save' proposals. Melanie Wilkey explained that the Clinical Boards would identify such opportunities as part of the IMTP process.
- The Commissioning Intentions should not stifle innovation

It was agreed that the SRG would email any further comments to Melanie Wilkey.

Action: All

SRG 17/32 UHB TRANSFORMATION STRATEGY

Emma Wilkins provided the SRG with a brief update on the UHB's three Big Improvement Goals (BIG).

BIG 1 – The hypothesis was that at any given time there were a number of patients within hospital who no longer required medical care. A new type of facility had been piloted on half a ward at UHW. The staffing mix on the ward was changed with more health care support workers and third sector partners provided group activities. Patient and carer surveys had demonstrated that patient experience on the ward had improved and there had also been a reduction in length of stay. The financial savings had not however been as significant as anticipated and from an environmental perspective the consensus was that an acute hospital was not the best location for such a facility.
BIG 2 – The development of a specification for a 'Perfect Locality'.
BIG 3 – The elimination of avoidable harm, waste and unwarranted clinical variation. There are two pathfinders: eye care and musculoskeletal care. A single point of referral for musculoskeletal care is being piloted every Wednesday at The Barry Hospital run by a GP Cluster in the Vale of Glamorgan. All referrals are assessed by a multi disciplinary. The pilot is for six months and will be evaluated after three months. A one stop shop is being introduced for eye care.

Emma Wilkins explained that the Turning the Curve to Transformation programme takes BIG a step further. The programme is person-centred and reflects the principles in SOFW. A number of potential projects have been identified. A prioritisation panel is being established comprising of medical, nursing, therapies, finance and operational staff plus representatives from the UHB's Continuous Service Improvement Team and Programme Management Office. A scoring mechanism would be introduced with scoring based on financial benefit, strategic fit, operational fit, patient safety and quality.

The SRG was asked to consider a number of questions:

- How can we capture the ideas of our partners and stakeholders to progress through our transformation programme? Whose ideas do we need to capture?
- How might we balance delivering change quickly and the importance of engagement on these changes?
- What mechanisms should we be using to keep stakeholders updated on progress?

The SRG made a number of observations.

- The experience of partners such as the third sector and local authorities, should be utilised.
- Every member of staff must feel valued.
- If projects are to succeed there must be support and ownership of staff.
- There should be opportunities for staff suggestions.
- A GP may not be the most appropriate health care professional for a person to see but this will require a cultural change.

- Financial benefits should be measured and care must be taken to ensure that any financial benefits to the UHB do not result in increased costs to other organisations.
- Formal engagement will be required for any project that will potentially impact on the wider community.
- Social media and the local free press could be used to keep stakeholders updated.
- Different methods of communication are required for different stakeholders.
- A summary of the outcome of every Transformation project should be made available.

SRG 17/33 VICE CHAIR

The Chair enquired whether any of her SRG colleagues would like to put their name forward to replace Bob Tooby as Vice Chair. Richard Thomas indicated that he would be happy to assume this role. It was agreed that Anne Wei would write to all SRG members enquiring whether anyone else would like to be considered for this role.

Action: Anne Wei

SRG 17/34 NEXT MEETING

9.30am-12pm on Wednesday 13 September 2017, Seminar Room, Hafan Y Coed, University Hospital Llandough.

AGENDA ITEM 1.4

EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 28 MARCH 2017 AT THE NHS CONFERATION OFFICES, CATHEDRAL ROAD CARDIFF

24.11

PRESENT

Members:

Mrs Allison Williams (Chair)	Chief Executive, Cwm Taf UHB
Mr Stephen Harrhy	Chief Ambulance Services Commissioner
Dr Sharon Hopkins	'Interim' Chief Executive, Cardiff & Vale UHB
Ms Judith Paget	Chief Executive Aneurin Bevan UHB
Mr Steve Moore	Chief Executive, Hywel Dda UHB
Mrs Carol Shillabeer	Chief Executive, Powys tLHB

In Attendance:

Mr Geoff Lang	Director of Strategy Betsi Cadwaladr UHB (Via Video Conference)
Ms Joanne Abbott-Davies	Assistant Director of Planning & Strategy, ABM UHB (via Video Conference)
Ms Tracy Myhill	Chief Executive, WAST
Dr Tracey Cooper	Chief Executive, Public Health Wales
Mr Julian Baker	Director, National Collaborative Commissioning
Mr Stuart Davies	Director of Finance, EASC & WHSSC
Mr Shane Mills	Clinical Lead, National Collaborative Commissioning
Mr Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Ms Patsy Roseblade	Deputy Chief Executive, Welsh Ambulance Services NHS Trust
Ms Aimee McKinnon	Swansea University
Ms Gwenan Roberts	Committee Secretariat Host Body

AGENDA ITEM 1.4

		Action
Part 1. PRELIMINARY MATTERS		
EASC 17/17	**WELCOME AND INTRODUCTIONS** Mrs Allison Williams (Vice Chair) welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. Ms Aimee McKinnon was welcomed to the meeting.	
EASC 17/18	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Professor Siobhan McClelland, Mr Gary Doherty, Betsi Cadwaladr UHB; Ms Alexandra Howells, Abertawe Bro Morgannwg UHB; and Mr Robert Williams, Committee Secretary.	
EASC 17/19	**DECLARATIONS OF INTERESTS** There were no additional interests, to those already declared.	
EASC 17/20	**MINUTES OF THE MEETING HELD ON 17 JANUARY 2017** Members **CONFIRMED** the minutes of the meeting held on 17 January subject to the following minor amendments: • Page 12 – under 111 National Project update to amend to reflect that Richard Bowen would write to the Welsh Government; it was noted that this had been actioned.	*Committee Secretary*
EASC 17/21	**ACTION LOG** Members **received** the action log and **NOTED** that progress with some of the related matters would be considered within the substantive business meeting agenda. **111 National Project update** Strategic outline business case for the service – Members **NOTED** that Mr R Bowen had written to the Welsh Government for clarity whether this should be received by the Committee.	

24.11

AGENDA ITEM 1.4

Demand and Capacity Modelling

Members **NOTED** that this would be a substantive element for the June meeting; the work would also identify the requirements of the sub groups and would be linked to the Committee action and response to the Wales Audit Office (WAO) review of the commissioning arrangements.

WAO review of EASC Commissioning arrangements

24.11

Members **NOTED** that the final report had only been received within a week of the meeting and it had not been possible to develop the response in time for the Committee. Members **AGREED** to share the response with Board Secretaries and the expectation of the WAO was that the report would be received at Audit Committees. It was **AGREED** that a response would be drafted and sent to Members for comment. Members also **NOTED** that the Welsh Ambulance Services NHS Trust (WAST) and Welsh Government (WG) would also be asked to respond.

In terms of publishing the report Mrs A Williams reported that a conversation had taken place with Mr D Thomas from WAO and advice had been sought; it was **AGREED** that the report would be received by the host body Audit Committee (Cwm Taf University Health Board) and could then be published although it was suggested that good practice would be that every organisation receive the report at the respective Audit Committee.

Mr S Harrhy **AGREED** to meet with Mr D Thomas at WAO with the Chair of the EAS Committee to discuss the next steps. It was also **AGREED** that the management response would be received at the next Committee meeting in June to provide the basis for discussion on how actions would be taken forward. It was felt particularly important to provide clarity around the commissioning role and the development of the collaborative role in relation to ambulance services.

The Committee **RESOLVED** to:

- **NOTE** the Action Log

AGENDA ITEM 1.4

EASC 17/22	**MATTERS ARISING** There were no additional matters arising from the Minutes.	
Part 2. PROVIDER ISSUES		
EASC 17/23	**WELSH AMBULANCE SERVICES NHS TRUST UPDATE** Ms T Myhill provided an overview of the work of WAST. Members **NOTED** the work which was progressing on recruitment and rostering which would align to the work required on demand and capacity, it was anticipated that this could provide efficiencies of around 2%. Members welcomed the update on recruitment and **NOTED** the progress to date and plans for the near future. **Integrated Medium Term Plan (IMTP)** Ms T Myhill thanked the Committee for the speed of response in relation to the agreement of the uplift of 2%. It was **NOTED** that the WAST Board had recently approved the IMTP which had been changed following discussion at the last meeting. Members **NOTED** that a gap in resourcing of £4.9m had been identified but a plan of mitigation and action had been developed. The plan would be submitted at the end of the week and it was suggested that the WG response had been positive. Mr S Harrhy explained the actions taken since the last meeting when key issues had been requested and clarity was provided on the key matters raised. It was **NOTED** that WAST had confirmed that the plan reflected the pre requisites requested by the Committee at the last meeting. Members also **NOTED** that the funding for the anticipated uplift from Band 5 to 6, as previously discussed would not be provided from the EASC Committee members. The Welsh Government had acknowledged receipt of this information. In terms of monitoring delivery Members **NOTED** that an Integrated Performance Report would be received at the next meeting.	

24.11

AGENDA ITEM 1.4

	Members were also aware that progress was being made to the changes required in the collaborative commissioning agreement to capture the agreed pre requisites. Ms Myhill confirmed that the delivery of services would be monitored closely. In summarising, Mrs A Williams congratulated the team at WAST on their timely submission of the IMTP to WG, which included clarity in relation to the additional 2% uplift. In terms of progressing plans it was felt to be important that the mechanism for reporting delivery would be fully discussed at the workshop in June. It was suggested that additional information to manage demand could include the cluster plans, paramedic community pilots, virtual wards and other ideas to inform the workshop on how services could provide a different response. Mr S Harrhy explained that work was underway to plan the workshop, it was suggested that other staff could be invited to join such as GPs who are actively involved or operational staff. It was **AGREED** that an overview for the workshop would be drafted for further comment. Ms Myhill also gave a brief overview to highlight the key steps of the service care pathway which included: Step 1 Help me choose • Reported the success and significant benefits of the 111 pilot in the ABMU area, particularly the good response from GPs in the area and the great potential of the service • Frequent callers were 4.8% of the workload and this had improved by 75% when areas working together with WAST • big success and significant benefits in ABMU and good response from GPs – will be a real benefit Step 2 Answer my call • Hear and treat numbers improving and had an impact during the winter with slightly lower conveyance rates Step 3 Come to see me • Members **NOTED** still work to do in Hywel Dda and Powys areas	**24.11**

AGENDA ITEM 1.4

	• More work now needed on the AMBER category Step 4 Give me treatment • Clinical indicator improvement plan developed, further work required on clinical indicators such as pain scores Step 5 Take me to hospital • Members were pleased to **NOTE** that the number of patient being conveyed to hospital had reduced but there was still more work to do. Members were also updated on other key areas including: Non Emergency Patient Transport Services (NEPTS) • Some progress made, but more to do • Now has a higher profile and more ongoing discussion with improved leadership • Developing more innovative contracts Safe care • Members **NOTED** that more work was needed and whilst an improving area, there remained work to do on risk stratification. Band 6 Paramedic • Members **NOTED** that negotiations were progressing well through collaborative and collegiate discussions • Job descriptions have been agreed • The Cabinet Secretary was being kept updated on progress. National Staff Survey • Members **NOTED** that results were suggesting that WAST staff felt more positive and were more engaged, this was felt to be a significant improvement which was really pleasing. 111 Pilot • Members **NOTED** that the 111 Pilot would be reporting to the Unscheduled Care Board; Ms J Abbott Davies gave an overview on the success of the pilot to date • Members also **NOTED** that a Gateway Review would be taking place and additional information would be provided to the Chief Executive's group.	

24.11

AGENDA ITEM 1.4

	Mr S Harrhy explained that more AMBER calls and less green calls had been received. Further work would be required to investigate the acuity of the patients. Members **NOTED** the improvement against targets in all areas over the last year; the handover rates over the last six weeks had improved and it was noted that the whole system was recovering much quicker than before. Members **NOTED** that the data was providing evidence that working together was achieving improved results, Members welcomed the ability to measure the progress being made. The Committee **RESOLVED** to: • **NOTE** the updates presented	
Part 3. UPDATES OF RELEVANCE TO THE COMMITTEE		
EASC 17/24	**CHAIR'S REPORT** Mrs Allison Williams updated Members on the following key matters: **WAO Review** – Members were aware that a final version had been received and a draft response would be developed by Mr S Harrhy and the team and sent to Members for comment. **EASC IMTP** – Members **NOTED** that the Chief Ambulance Services Commissioner would provide an update.	
EASC 17/25	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** Mr S M Harrhy, Chief Ambulance Services Commissioner (CASC), presented an update on the following key areas of work: **Directories of Services** • More information was required • Would be included in the workshop session at the June meeting	

24.11

AGENDA ITEM 1.4

EASC IMTP

- Members **NOTED** that essentially the EASC IMTP was the agreed commissioning agreement repackaged to capture the key areas
- Key risk identified was the funding for the EASC team to undertake the activities required. Members **NOTED** that the team had been set up originally for emergency medical services (EMS); the move to include NEPTS and Emergency Medical Retrieval and Transport Service (EMRTS)

24.11

Following further discussion in terms of resourcing the EASC team, Members **NOTED** the concerns raised by the Chief Ambulance Services Commissioner in relation to the risks of not having enough resource to undertake the tasks required on behalf of the Committee. Overall, Members suggested that additional information was required to understand what commissioning was needed and the activities required. Members were also aware that the Chair of the Committee was supporting the Chief Ambulance Services Commissioner in his request for extra resources as this had been previously discussed.

Three potential options were discussed

1. Additional resources allocated
2. Staff allocated to the EAS Team from organisations
3. Invest to save opportunities.

Members **NOTED** that the additional costs in relation to the accommodation were unavoidable.

Mr S Harrhy explained that at present there were no staff to drive forward the commissioning requirements for EMRTS or NEPTS and without additional resources the EASC IMTP could not be delivered.

Following discussion it was agreed that Mrs A Williams and Mr S Harrhy would develop options which would be shared with the Chief Executives before the end of April. This information would include what could be delivered and would clearly identify the risks balanced against the activities required.

Members **RESOLVED** to:

- **NOTE** the Commissioner's update report and **AGREED** that additional information regarding

AGENDA ITEM 1.4

	resourcing would be sent before the end of April.	
EASC 17/26	**INDEPENDENT EVALUATION OF THE CLINICAL RESPONSE MODEL** Mr S Harrhy presented the report and drew attention to the letter received from the Cabinet Secretary which outlined his decision to implement the model on a permanent basis; this was announced in a written statement on the 27 February 2017. The letter requested the following action from EASC: 1. Publication of further clinical indicators 2. Better understanding of outcomes through data linking 3. Advice on the performance target threshold 4. An update on how EASC would be taking forward the PACEC (Public and Corporate Economic Consultants) recommendations: • A need to review the call categories. • Investment in information systems. • Providing alternative response options. • Reduce variation and improve health board's conveyance rates. Members supported the reiteration of the aim being to improve the patient experience and an update on each of the Cabinet Secretary's requirements was provided. A discussion took place in relation to the current target levels for RED1 category patients and whether the current performance level at 65% should be increased. Members felt that it was important to ensure the best patient experience across Wales. Members **NOTED** that an action plan was in place and work was progressing in collaboration to ensure the achievement of the objectives identified. Four recommendations were made within the report: 1. A need to review the call categories 2. Investment in information systems 3. Providing alternative response options 4. Reduce variation and improve health board's conveyance rates Following discussion Members felt that the work on the AMBER calls was really important and suggested that clear outcomes and timelines needed to be agreed to make progress.	

24.11

AGENDA ITEM 1.4

	It was **AGREED** that within 6 months a clear plan with evidence would be developed to take this forward. Members felt it was really important to not stop at 65% but to remain ambitious to improve attendance at life threatening situations. Members **NOTED** that WG had asked for a paper identifying the ambition and risks for the RED1 category to be available in conjunction with the IMTP to ensure looped through the commissioning process. Members also felt that more gain could be achieved within the AMBER calls than RED1. Overall, Members **AGREED** to: • Concentrate on 4 or 5 key areas for the winter • Try and improve coding in A&E – 40% remain uncoded and it was felt this missed an opportunity – some progress would be helpful. Members **RESOLVED** to: • **NOTE** the report and • **ENDORSED** the plan for moving forward.	
EASC 17/27	**UPDATE ON NON EMERGENCY PATIENT TRANSPORT (NEPTS)** Mr Julian Baker presented the report and drew attention to the methodology used to develop the assurance framework. Members **NOTED** the internal audit report which had provided a review of the baseline position. The report had been discussed at the NEPTS Delivery Assurance Group and feedback had been received on the baseline legacy report. Overall, it was felt that the report was not assuring in itself and Members **NOTED** that an agreed way forward in terms of the detailed work required was in place. Mr S Davies was surprised that information relating to the renal network was not as good as it might have been and suggested that he would provide assistance to interrogate the information further. The contrast between the information for EMS and NEPTs was **NOTED** and it was considered helpful as a baseline for the future commissioning.	

24.11

AGENDA ITEM 1.4

	Following discussion the following actions were identified: • Ministerial priorities need to be met, although noted that progress made on vast majority of those priorities • Areas for decision - to move from the current arrangements to a plurality model (once risks are mitigated and managed as far as possible); **AGREED** to gradually implement the plurality model - would take at least 6 months • Use a Framework agreement to manage risk – Patient Safety and financial - At present the patient safety risk cannot be quantified and acceptable standards not clear or uniform – this is a priority area for the NEPTS DAG - Financial risk – not including the WAST, the financial risks where contracts are in place; the more serious potential risks could be identified if a contract cannot be renewed and a tender process is required. • The NEPTS DAG now meets monthly and all Members agreed to ensure their organisation is suitably represented - Moving forward – divide actions into quarters using the Caremore Framework and report back to EASC • Any identified risks will be made available to any Health Board or Trust by letter from the CASC. Members **RESOLVED** to: • **NOTE** the assessment • **RECEIVE** an action plan on a quarterly basis to capture progress – work towards a plurality model • Take any opportunity to make the best use of resources • Aim to have a commissioned service against agreed standards and have quantitative baselines by 2018 • **NOTE** that WAST already providing information but need for other areas • Manage risks identified through the NEPTS DAG.	**24.11**

AGENDA ITEM 1.4

EASC 17/28	**UPDATE ON EMERGENCY MEDICAL RETRIEVAL AND TRANSPORT SERVICES (EMRTS)** Mr S Harrhy presented the report on the Collaborative Commissioning Quality and Delivery Framework for the Emergency Medical Retrieval and Transfer Service and updated the Committee on the hosting arrangements and the Caernarfon Airbase. Mr S Harrhy confirmed that work was ongoing to identify the complete resource envelope and was waiting for additional information from ABMU to fully understand the whole requirement. National Director Role Members **NOTED** that EMRTS were unable to appoint to the National Director following a competitive recruitment process. The EMRTS DAG had also supported a plan to engage the services of a recruitment consultancy to assist in the recruitment to this role, the costs of this would be met within the existing EMRTS budget. The hosting Health Board (Abertawe Bro Morgannwg University Health Board) were currently establishing a tender process for this. Caernarvon Air base Members **NOTED** that the Welsh Government had provided the capital investment required for the base and there was now an urgent requirement to make a decision on the revenue allocation for the base, in order to ensure continuity of service. The current proposed revenue costs represented a significant reduction from the original proposed costs and reflected the significant efficiencies being made within the current EMRTS budget to reduce the costs of operating the base. The option appraisal identified the base at Caernarvon as well as Welshpool which had been received by the EMRTS DAG. Members **NOTED** costs had now been identified at £90k following the introduction of additional efficiencies in the EMRT service. Members **NOTED** that the air ambulance service (charity) were introducing new helicopters in June which would be able to fly during night time hours which would provide better coverage across Wales.	

24.11

AGENDA ITEM 1.4

	This new fleet would also be able to move neonatal cases and the equipment required. At present, it was **NOTED** that the EMRTS budget was under-spent this year and would be carried forward – although this was non-recurrent and the current budget would not cover the additional cost of £90k recurrently. Members felt that this could be achieved from the budget of £2.8m for the service through cash releasing efficiency savings. In terms of the commissioning intent it was clear that if 3 operational bases were supported, funding was only available within year. Members **RESOLVED** to: • **NOTE** the financial position and shortfall of £90k and asked for additional efficiencies to cover this from within the service.	
Part 4. GOVERNANCE & ASSURANCE		
EASC 17/29	**CLINICAL RISK ASSURANCE REVIEW** Mr S Mills, Clinical Lead, National Collaborative Commissioning presented the review and gave an overview of the work undertaken. Members **NOTED** the limitation of the review in terms that it had now identified a baseline. Members **NOTED** the process undertaken and key issues were highlighted as: • An open and honest culture focused on clinical risk and clinically focused teams who were aiming to change the culture • Well identified internal escalation procedures • Self assessment of risk management which populated a comprehensive risk register including mitigating actions • An internal Quality Steering Group which oversees the concerns implementation plan dealing with one the spot issues and improved compliance with response times • A sample of 200 incidents were examined, some issues related to mental capacity assessments but this has also been improved • Safeguarding issues and the link to the patient record.	

24.11

AGENDA ITEM 1.4

	Members **NOTED** the review and accepted the caveat that the work had been undertaken by a single reviewer. Members were also made aware that Healthcare Inspectorate Wales had also reviewed WAST during the same period. Following discussion Members felt that it would have been helpful to have received the report, the management response and the action plan at the same time. However they agreed to note the report and findings and would receive the management response and action plan in due course. Members **RESOLVED** to: • **NOTE** the review and receive further information at a future meeting.	
EASC 17/30	**CHAIRS UPDATES FROM EASC SUB GROUPS** Members **NOTED** the updates provided by the Chairs of the sub groups established by the Joint Committee, these being: • NEPTS Commissioning and Delivery Assurance Group • Quality Assurance and Improvement Panel (QAIP) • EMRTS Delivery Assurance Group Members **RESOLVED** to: • **NOTE** the summary updates received.	
EASC 17/31	**NATIONAL COLLABORATIVE COMMISSIONING: QUALITY DELIVERY FRAMEWORK AGREEMENT SIX MONTHLY REVIEW** Mr J Baker, Director of National Collaborative Commissioning presented the report and gave a brief overview of the progress made over the last six months. Members **NOTED** that the information was presented in the same format as previous and areas had been highlighted to demonstrate what had been refreshed and where new information had been added. Members **AGREED** to receive the updated information electronically.	*JB*

24.11

AGENDA ITEM 1.4

	Members **RESOLVED** to: • **ENDORSE** the highlight report National Collaborative Commissioning: Quality Delivery Framework for Emergency Ambulance Services Operation & Ongoing Development of Framework; updating of the Framework Agreement in the form of the Document Control Version Four.	
EASC 17/32	**UPDATED RISK REGISTER** Miss G Roberts, Committee Secretariat, presented the updated Joint Committee Risk Register. Members **NOTED** the adjustments made to the risk register since the January meeting. Following discussion, Members **RESOLVED** to; • **NOTE** the contents of the report; and • **ENDORSE** the updated risk register.	**24.11**
EASC 17/33	**FINANCE REPORT** Mr S Davies presented the Month 11 EASC Finance Report. Members **NOTED** that there was no significant under or over spend position and that all of the cash related issues were now fully resolved. Members **RESOLVED** to: • **NOTE** the Month 11 finance report update	
EASC 17/34	**JOINT COMMITTEE FORWARD PLAN** Miss G Roberts, Committee Secretariat presented the forward plan and identified some of the changes agreed in advance of the meeting and those matters raised during the meeting. Members **AGREED** to add that they would receive a quarterly report from the NEPTS DAG. Further discussions would take place with the Chair outside of the meeting in relation to the plans for the workshop session at the next meeting. Members **RESOLVED** to: • **NOTE** the Forward Plan and the suggested	*Committee Secretariat* *CASC*

AGENDA ITEM 1.4

	amendments.	
OTHER MATTERS		
EASC 17/35	**DATE AND TIME OF NEXT MEETING** The date of the next Joint Committee meeting was scheduled for 09:30am on 27 June 2017, Health and Care Research Wales, Cowbridge Road East, Cardiff.	*Committee Secretary*

Signed …… (Chair)

Date ……

24.11

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Prof. Siobhan McClelland
Lead Executive Directors	Health Board / Trust Chief Executives
Author and contact details.	Robert.Williams@wales.nhs.uk
Date of last meeting	27 June 2017

24.11

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided below:
Emergency Ambulance Services Joint Committee Agenda and Meeting Papers 27 June 2017

WORKSHOP
The meeting commenced with a facilitated workshop that focused on the outcome of the Wales Audit Office (WAO) Report into Emergency Ambulance Services Commissioning and strengthening the related Management Response. This included a discussion on the strategic direction and work of the Committee going forward and consideration of matters reported in the PACEC Report which had been commissioned via the Joint Committee, on behalf of the Cabinet Secretary for Health, Well Being and Sport.

PROVIDER(S) UPDATE
Welsh Ambulance Services Trust update

Members **received** a report from the Welsh Ambulance Services Trust on progress in relation to the National (NHS Wales) negotiations on the Band 6 Paramedic role. Members **NOTED** that an agreed way forward had been reached, including a transitional model, and confirmation of the details would be published and released in due course. Members **NOTED** the update and reaffirmed the view that funding of the settlement would be addressed centrally as no provision had been made in Health Board IMTPs.

CHAIR'S UPDATE
Professor McClelland confirmed that she and the CASC were scheduled to meet with the Cabinet Secretary for Health, Well-Being and Sport later in the week and would be discussing his letter, which had been provided to Members for information. Professor McClelland confirmed that she would also be using some of the feedback from the morning workshop in relation to the Committee's response to the WAO Report and the views of Members on the proposed way forward, including key Strategic areas of focus for EASC.

CHIEF AMBULANCE SERVICES COMMISSIONER (CASC) UPDATE

Mr Stephen Harrhy, CASC, provided an update to the Committee on progress with the following key matters:

- **Wales Audit Office Report**

The requirement following the workshop to develop and approve a strengthened Management response to the WAO Report at the September meeting of the Joint Committee.

EMRTS Gateway review

Members NOTED the generally positive review and the CASC considered it was important to acknowledge the work of the EMRTS team and thanks to ABM UHB and other Health Boards for their support of the review, which has produced an Amber/Green rated report.

24.11

Actions around recommendations will inform the work programme for EASC going forward linked to the strategic direction for EMRTS against EASC's commissioning intentions.

3 key areas for focus include;

- Major Trauma, when appropriate
- Retrieval services and related impact
- Transfer element of EMRTS – pre hospital critical care yes, but also retrieval and transfer

Members **AGREED** that the CASC keep the Committee updated on progress.

Ambulance Quality Indicators (AQIs)

The CASC informed Members that the January to March publication was now available with overall performance maintained over the period.

Handover delays were lower than the same period last year even though there remains more scope and opportunities to reduce these further, linked to D&C work and more broadly within the Commissioning Framework Agreement.

In relation to making better use and more user friendly changes to AQIs, this is work in progress and the CASC confirmed that there was more work to do on patient experience measures, linked also to the PACEC report and importance of focusing on the amber category.

The CASC made reference to WAST's installation of a new Clinical Assessment Desk (CAD) and that there are potential risks with regards performance during this period but that he had sought assurance from WAST that they have appropriate mitigations in place to manage, what is a significant change project. Mrs Myhill reminded Members of the existing and significant risks being managed by WAST with the current and outdated CAD, which need to be balanced against the risks associated with installation of the new system. It was confirmed that Welsh Government were also aware of this planned change.

Annual Governance Statement
Members **NOTED** that these had been shared with all Members, as EASC is a Joint Committee of Boards it was felt important that all member organisations were sighted on related matters and that Health Boards receive the same.

EASC IMTP
In relation to the request for more resource to support the expansion of EASC Commissioning responsibilities, the CASC confirmed that he had produced a report as agreed for Mrs A Williams and that he had discussed same with Mrs A Williams. It was also **NOTED** that there are national discussions ongoing and at the last All Wales Chief Executives meeting with Dr A Goodall there was agreement for a broader discussion on national programmes which would also involve Mrs Judith Paget as lead CEO and Mrs Allison Williams.

24.11

FINANCE REPORT
Mr S Davies presented an oral update on the Month 2 EASC Finance position. Members **NOTED** that there was no significant under or over spend position and that all of the cash related issues were now fully resolved.

JOINT COMMITTEE RISK REGISTER
The Committee **received**, reviewed and **endorsed** the Joint Committee Risk Register. Members **noted** that many of the risks had not changed in their rating since the last meeting.

FORWARD WORK PROGRAMME
The Committee **received** and **noted** the Committee Forward Work Programme, which would be updated following discussions at the meeting.

Key risks and issues/matters of concern and any mitigating actions

- The Committee **noted** matters considered within the Risk Register and suggested that Joint Committee consider a discussion on risk appetite as there may be a view that risk tolerance levels need to change.

Matters requiring Board level consideration and/or approval

- It is important that generally Boards are aware at Board level and as appropriate, Sub Committee level, of matters relating to the work of the Emergency Ambulance Services Committee and their place within the broader unscheduled care system.

Forward Work Programme

- At its September 2017 meeting, in addition to the routine items that feature at every meeting of the Joint Committee, the following agenda items are planned:
  - Wales Audit Office Management Response
  - NEPTS update
  - EMRTS action plan in response to Gateway Review

Committee minutes submitted (insert √)	Yes	√	No	
Date of next meeting	**26 September 2017**			

MINUTES OF THE ORGAN DONATION COMMITTEE MEETING

Held at 16.00pm on Wednesday 7th June 2017

24.12

In Corporate Meeting Room, UHB Headquarters

Present:	Maria Battle	MB
	Graham Shortland	GS
	Katja Empson	KE
	Judith VanDeVoort	JV
	Michelle Jardine	MJ
	Elijah Ablorsu	EA
	Christopher Hingston	CH
	Duncan Thomas	DT
	Gail Melvin	GM
	Lucy Barnes	LB
	Leah McCloughlin	LM
	Gail Melvin	GM
	Secretariat: Nia Smith	
Apologies:	Charlotte Goodwin	
	Jayne Catherall	
	Tracey Skyrme	

1	**Welcome and Introduction** The Chair welcomed everyone to the meeting and introductions were made.	**Action**

2	**Minutes of Last Meeting** **Item 3 Paediatric CLOD** The Paediatric CLODs were welcomed by the Chair to the group and gave a brief update on how they are finding the role. **ITEM 4 ED Office Space:** The group noted that no office space had been identified. It was agreed that MB and GS were to arrange a walkround. New CLODS now in place. **ITEM 5 Documentary** was televised on the 6 December 2016 and was nominated for a Welsh BAFTA As Jayne Catherall sent her apologies to the meeting it was agreed to be set for the next agenda. **ITEM 7 Performance Update** It was advised that issues in ITU withfamilies overriding opt in wishes means that there has been no great increase in performance rates. It was agreed that the UHB still has an issue with accessing beds. . **ITEM 8 Remembrance in Theatre** As a mark of respect the donor will receive a minutes silence pre retrieval surgery by all staff within the theatre.	GS and MB to walkround to find a suitable office space. JC CH, KE
3.	**Planting of tree ceremony** It was confirmed that the tree had been bought but no date had been confirmed for the planting ceremony. The Chair agreed that she would ensure that Estates would undertake the necessary groundwork for the ceremony to take place. Estates have now found location for tree and CG has contacted the Garden Centre for the tree's delivery.	CG
4.	**ED Office Space**	
5.	**Communications Update**	
6.	**Performance Update** figures show that there were 22	

24.12

	donors, 66 patients transplanted and a 3.5% average number of organs donated. Charts show that there was a 96% referral rate from April 2016 to 31 March 2017 of DBD patients which was down from 2015/16. Figures show that referral of DCD patients has also declined to 89%, with 2 missed opportunities due to processes and decisions and communication with families. DT raised the issue of the potential benefits of a pathway where donors and their families went into ITU as this would assist clinicians with the process and also give families more time to make an informed decision in the more appropriate environment of ITU. He advised this was followed in Southmead during his training and that he felt it would lead to a higher rate of consent of families and would prevent the need for ITU nurses to remain in EU whilst the process is ongoing. KE advised that a new organ donation policy advises quality of engagement of process rather than venue as important. However the information that was provided by DT on Southmead's model was noted. The group noted that capacity issues had led to paediatrics loosing opportunities for donation KE advised that NHSBT are changing their way of reporting f case reviews. Monthly reports will now be sent to Regional Managers and will concentrate on missed opportunities. This then allows clinical leads to meet with specialist nurses undertaking root cause analysis to identify and resolve issues. MB requested these reports to be circulated to all clinical leads and yo Chair of the Committee **Action** GS suggested that KE speak to Maria Roberts in the Information Governance to create a code on E-datix specifically for missed opportunities to allow for easy identification filtering. MB also requested that KE consider how MB could assist with the process of proactively identifying missed opportunities. Serious Case review after donor was admitted to theatre and reflexed. Anesthetist refused to go ahead. The family supported donation and the donor agreed to give kidney to grandchild, however when they searched the NHS number it didn't appear. It was then found that the Donor had opted out of the ODR. This allowed NHSBT to look into this problem and learn. This was classed as a Never Event. Potential of media interest. KE to alert Communications Team.	24.12 KE KE KE

6.	GS asked KE to check that transplantation information was being fed into Critical Care Implementation Group to inform capacity planning.	KE
7.	**Up and Coming Events:** Transplant Week 1st, 2nd September. GS requested to incorporate into UHL National Sim Transplantation Course to be held in Cochrane Building Transplantation event on the 1st December at the All Nations Centre. MB has requested KE to circulate (Welsh Government and Regional Collaborative to attend too)	KE KE
8.	**Any Other Business** • CH is stepping down as Clinical Lead. MB to write to CH. GS has requested a meeting with Andrew Crooke to identify another lead. The group noted that the 'Gift of Life' book was placed in ITU for families.	NS to draft GS, MB
9.	**Date and Time of Next Meeting:** • 8 November, 13.30pm Large Meeting Room, Headquarters	NS

24.12

PRIVATE MEETING OF THE BOARD
28 SEPTEMBER 2017

AGENDA

PART 1: PRELIMINARIES		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declaration of Interest	*Chair*
4	To approve the Minutes of the Private Board meeting held on 27th July 2017	*Chair*
5	Action Log	*Chair*
PART 2: REPORTS		
6	Report of the Chair	Oral *Chair*
7	Report of the Chief Executive	Oral *Chief Executive*
8	Management of Fetal Remains, Stillbirth and Neonatal Death Policy Review	*Medical Director*
9	IMTP Key Priorities for Delivery 2018-2021	*Director of Planning*
10	Paediatric Surgery	Oral *Medical and Nurse Directors*
11	HTA Inspection of the Mortuary	Oral *Interim Chief Operating Officer*
12	Confidential Medical Staff Issues	Oral *Medical Director*
13	Interventional Radiology	Oral *Interim Chief Operating Officer*
PART 3: MINUTES FROM PRIVATE COMMITTEES FOR INFORMATION ONLY		
14.1	Remuneration and Terms of Service Committee – August x 2	*M Battle*
14.2	Welsh Health Specialised Services Committee Joint Committee – June & July briefing	*Prof M Longley*
PART 4: FINAL CLOSURE AND FUTURE MEETINGS		
15	Review of the Meeting	Oral
16	Date of the next meeting : Thursday 30 November 2017	